Sutter Health
Sutter Davis Hospital

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

2000 Sutter Place, Davis, CA 95616
FACILITY LICENSE # 30000124
www.sutterhealth.org

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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.

Executive Summary

SDH 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 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 to specialty and extended care
7. Access to dental care and preventive services

ACCESS TO MENTAL/BEHAVORIAL/SUBSTANCE ABUSE SERVICES

Name of program/activity/initiative	Emergency Department (ED) Suicide Prevention Follow-up Program
Description	The ED Suicide Prevention Follow-up Program will follow up with any clients referred at the time of discharge from the ED. The additional telephone support will allow patients access to trained crisis line counselors who can mediate the need for readmission to the ED during the critical days after discharge and also provide the added benefit of evening/weekend support when most mental health services are unavailable.
Goals	The goal is to provide referred patients mental health support immediately after discharge from the hospital with extended, on-going follow-up calls to help the patient remain stable and continue working on the problems which caused them to escalate into crises originally.
Anticipated Outcomes	The expected outcomes are to maintain the patient's overall well-being and provide appropriate linkages to community resources. This support may divert a crisis, limit the crisis or avoid it altogether.
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

Name of program/activity/initiative	Haven House
Description	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, people

	experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and 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 work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

INJURY AND DISEASE PREVENTION AND MANAGEMENT

Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist 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. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive 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.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	Nourish Yolo
Description	Nourish Yolo will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County. In addition, the program will 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, education and resources they so desperately need. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to provide access to fresh, healthy foods in Yolo County and education through programs.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

Name of program/activity/initiative	Kids Farmers Market
Description	The Kids Farmers Market program provides 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 participating schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to positively impact healthy eating and disease prevention and management through students learning about and sampling the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
Anticipated Outcomes	The anticipated outcome is that students will have the opportunity to access fresh and healthy food, for themselves and their entire families. This program will reach hundreds of kids and will encourage nutrition education and families in Yolo eating healthier. Ultimately, offering the potential for generational impact upon food security in Yolo County.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, active schools, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)

Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of 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 outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits
Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

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

Name of program/activity/initiative	Crisis Nursery Program
Description	The only crisis nursery program in Yolo County offers 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. Early intervention services focus on building successful and resilient children, strengthening parents and preserving families. The services and support provided helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone.
Goals	The goals of the program 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.

Anticipated Outcomes	The program will reach hundreds of children in need, providing them with the stability and support, necessary for them to escape chaotic and/or dangerous situations, and set them on a more positive path.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	Haven House
Description	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, people experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and 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 work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist 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. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting

	parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive 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.
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Name of program/activity/initiative	Nourish Yolo
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Goals	The goal of the program is to provide access to fresh, healthy foods in Yolo County and education through programs.
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Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

Name of program/activity/initiative	Kids Farmers Market
Description	The Kids Farmers Market program provides 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 participating schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to positively impact healthy eating and disease prevention and management through students learning about and sampling the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
Anticipated Outcomes	The anticipated outcome is that students will have the opportunity to access fresh and healthy food, for themselves and their entire families. This program will reach hundreds of kids and will encourage nutrition

	education and families in Yolo eating healthier. Ultimately, offering the potential for generational impact upon food security in Yolo County.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, active schools, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)
Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of 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 outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits
Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
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Name of program/activity/initiative	Eviction Prevention Program
Description	The Eviction Prevention Program provides up to $700 in rental assistance to pay rent for families who have received an eviction notice.
Goals	The goals of the program is to prevent homelessness by keeping individuals and families housed during a short-term financial emergency.

Anticipated Outcomes	The anticipated outcome of the program is to increase the number of individuals and families housed and prevent homelessness.
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

ACTIVE LIVING AND HEALTHY EATING

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	assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
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Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES

Name of program/activity/initiative	Haven House
Description	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, people experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and 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 work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reports.

Name of program/activity/initiative	Expand Care for Underserved Populations

Description	Funding will increase clinic capacity and services offered to care for underserved populations. Services provided include 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. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and access to dental care and preventative services.
Goals	The goal is to expand access to 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	The plan to evaluate will follow the same process as many of our other community benefit programs with bi-annual reporting.

Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist 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. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive 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.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.

ACCESS TO SPECIALTY AND EXTENDED CARE

Name of program/activity/initiative	TBD
Description	SDH plans to identify partnerships and strengthen relationships with organizations in the near future to collaborate on initiatives to address access to extended care in Yolo County.
Goals	TBD
Anticipated Outcomes	TBD
Metrics Used to Evaluate the program/activity/initiative	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

ACCESS TO DENTAL CARE AND PREVENTATIVE SERVICES

Name of program/activity/initiative	Expand Care for Underserved Populations
Description	Funding will increase clinic capacity and services offered to care for underserved populations. Services provided include 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. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and access to dental care and preventative services.
Goals	The goal is to expand access to 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	The plan to evaluate will follow the same process as many of our other community benefit programs with bi-annual reporting.

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. Access and functional needs: While this is an important issue, SDH is currently focusing its resources in other areas; however, we'll continue to look for opportunities to increase access to transportation.

2. Safe and violence-free environment: While this is an important issue, SDH is currently focusing its resources in other areas; however, we'll continue to look for opportunities to increase safe and violence-free environments.

3. Pollution-free living environment: While this is an important issue, SDH is currently focusing its resources in other areas; however, we'll continue to look for opportunities to increase pollution-free living environments.

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.