Sutter Health
Sutter Davis Hospital

Sutter Health

2022–2024 Community Benefit Plan

Responding to the 2022 Community Health Needs Assessment
Submitted to the Department of Health Care Access and Information May 2025

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

Table of Contents

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 HCAI 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, a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022 - 2024 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

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

Sutter Davis Hospital welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022 - 2024 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 2000 Sutter Place, Davis, CA 95616; and

- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Davis Hospital is affiliated with Sutter Health, a not-for-profit, integrated healthcare system that is committed to delivering innovative, high-quality, equitable patient care and helping to improve the overall health of the communities it serves.

Sutter Health is a not-for-profit healthcare system dedicated to providing comprehensive, high-quality care throughout California. Committed to innovative, high-quality patient care and community partnerships, Sutter Health is pursuing a bold new plan to reach more people and make excellent healthcare more connected and accessible. Currently serving 3.5 million patients, thanks to our dedicated team of approximately 60,000 employees and clinicians, and 14,000+ affiliated physicians and advanced practice clinicians, with a unified focus on expanding care to serve more patients.

Sutter Health delivers exceptional and affordable care through its hospitals, medical groups, ambulatory surgery centers, urgent care clinics, telehealth, home health, and hospice services. Dedicated to transforming healthcare, at Sutter Health, getting better never stops. Learn more about how Sutter Health is transforming healthcare at sutterhealth.org and vitals.sutterhealth.org.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and to help serve some of the most vulnerable in its communities, Sutter invests annually in community benefit programs that help improve the overall health and wellbeing of the regions Sutter serves. Sutter's investments in community benefit programs and services increased to more than $1 billion in 2024. This investment includes $96 million in traditional charity care, which covers medically necessary care to eligible patients, regardless of their ability to pay; $665 million in unreimbursed costs of providing care to Medi-Cal patients; and investments in community health programs to address identified community health needs.[1] In 2024, Sutter sharpened its focus to address pressing community needs in three main priority

[1] Sutter's charity care policy for hospital services is posted on Sutter's web site at sutterhealth.org/for-patients/financial-assistance and can be found here.

areas: workforce development, access to mental healthcare services and substance use treatment, and chronic disease prevention. See more about how Sutter Health reinvests into the community and works to achieve health equity by visiting sutterhealth.org/community-benefit.

Through the 2022 Community Health Needs Assessment process for Sutter Davis Hospital, the following significant community health needs were identified:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

The 2022 Community Healthy Needs Assessment conducted by Sutter Davis Hospital is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sutter Davis Hospital. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 29 community health experts, social service providers, and medical personnel. Additionally, 18 community residents or community service provider organizations participated in 3 focus groups across the county. Finally, 14 community service providers responded to a Service Provider Survey asking about health need identification and prioritization and 1,574 community residents participated in the Community Health Status Survey (community survey).

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

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SDH's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

The full 2022 Community Health Needs Assessment conducted by Sutter Davis Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Yolo County was chosen as the geographical area for the CHNA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County.

Significant Health Needs Identified in the 2022 CHNA

Quantitative and qualitative data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs) based on a review of CHNAs previously conducted throughout Northern California. The data associated with each PHN were then analyzed to discover which, if any, of them were significant health needs for the service area.

PHNs were selected as significant health needs if the percentage of associated quantitative indicators and qualitative themes exceeded selected thresholds. Data were also analyzed determine if there were any emerging significant health needs in the service area beyond the initial 12 PHNs.

All significant health needs were then prioritized based on 1) the percentage of key informant interviews and focus groups that indicated the health needs was present within the service area; 2) the percentage of times key informant interviews and focus groups identified the health needs as being a top priority; and, when available, 3) the percentage of service provider survey respondents who identified the health needs as being a top priority.

The following significant health needs were identified in the 2022 CHNA:

1. **Access to Basic Needs Such as Housing, Jobs, and Food**
   Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavioral Health and Substance-Use Services**
   Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Injury and Disease Prevention and Management**
   Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

4. **Active Living and Healthy Eating**
   Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities

may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health.

5. **Access to Quality Primary Care Health Services**
   Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

6. **System Navigation**
   System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities. Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

7. **Access to Specialty and Extended Care**
   Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

8. **Increased Community Connections**
   As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

9. **Safe and Violence-Free Environment**
   Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

10. **Access to Functional Needs**
    Functional needs include adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

11. **Access to Dental Care and Preventive Services**
    Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Davis Hospital plans to address significant health needs identified in the 2022 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 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

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

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

Access to Basic Needs Such as Housing, Jobs, and Food

Name of program/activity/initiative	Permanent Supportive Housing Project
Description	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.
2024 Outcomes	This program ended in 2022.

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 Centering Pregnancy 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 Centering Pregnancy group visits
2024 Outcomes	In 2024, the program served 1,251 individuals with 10,674 services.

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS

	Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2-year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
2024 Outcomes	This program ended in 2023.

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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
2024 Outcomes	This program ended in 2022.

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 goal of the program is to prevent homelessness by keeping individuals and families housed during a short-term financial emergency.
2024 Outcomes	In 2024, the program served 508 individuals with 508 services.

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.
2024 Outcomes	In 2024, the program served 248 individuals with 5,570 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.
2024 Outcomes	This program ended in 2023.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Communications Strategy for West Sacramento Family Resource Center
Description	The Yolo County Children's Alliance will be transitioning Executive Directors in June,2021 and will update the internal and external communications plan. The purpose of this plan is not only to assist in implementing communication strategies for the transition of Executive Directors, but also to modernize the organization's internal communications, and public-facing communications with clients, partners, the media, and existing and potential donors. This plan would incorporate the Yolo County Children's Alliance brand and most current strategic plan, while outlining a strategy to ensure all communications are consistent throughout the various programs within our organization to provide more effective outreach and awareness, especially for vulnerable and hard to reach populations in Yolo County.
Goals	The goal of the program is to provide more effective outreach and awareness, especially to vulnerable and hard to reach populations in Yolo County.
2024 Outcomes	Program ended in 2021.

Name of program/activity/initiative	VITA Tax Support
Description	The VITA Tax Support program assists low-income individuals and families with completion of tax documents along with financial literacy education.
Goals	The goal of the program is to help individuals accurately complete tax documents and provide financial literacy education to clients.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Brighter Tomorrows Campaign

Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
2024 Outcomes	In 2024, construction of the new building began.

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
2024 Outcomes	This program ended in 2022.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Nurture Yolo
Description	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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
2024 Outcomes	In 2024, the program served 2,814 individuals with 1,343 services.

Name of program/activity/initiative	Thanksgiving Food Distribution
Description	The "Adopt-a-Holiday" program celebrates uninterrupted senior nutrition in Yolo County, even when Meals on Wheels Yolo County staff and volunteers are observing much-needed holiday time-off. Funding is specific to the Thanksgiving holiday period to ensure that 1,000 local seniors served by MOW Yolo are nourished and engaged without interruption on Thanksgiving and the day after with two meals home delivered in advance of the holiday dates.
Goals	Ensure that nutrition services and doorstep engagement by trained volunteers continue uninterrupted during the holiday period, leading to sustained healthy outcomes that support aging in place at a critical time of the year.
2024 Outcomes	In 2024, the program served 1,000 individuals with 2,000 services.

Name of program/activity/initiative	Refugee Support
Description	Yolo County Children's Alliance "YCCA" provides families of different cultures the assistance needed, whether it be from our satellite office at West Gateway Place apartments in West Sacramento and/or our full-service West Sacramento Family Resource Center "WSFRC." Along with those two locations, YCCA provides services and resources to others within Yolo County. The target populations we serve are immigrants, refugees, homeless, parents, children, seniors, disabled, and limited English proficient individuals. Access to Basic Needs which includes refugee and immigrant services, employment support, enrollment and retention in CalFresh, weekly food distribution and maintenance of a food pantry, transportation support, housing stability support including direct financial assistance, income stability support including free tax preparation assistance, access to diapers, formula, and basic hygiene items, and resource and referral.

Goals	To provide increased Access to Basic Needs for immigrant and refugee families; un-housed individuals and those experiencing housing insecurity; households in poverty; and youth and older adults seeking employment.
2024 Outcomes	In 2024, the program served 1,315 individuals with 2,172 services.

Access to Mental/Behavioral Health and Substance Use Services

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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2-year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Mobile Medicine Program
Description	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.
2024 Outcomes	In 2024, the program served 364 individuals with 7,266 services.

Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.
Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
2024 Outcomes	The construction of the 24/7 Crisis Receiving Center is in progress. Yolo County HHSA has already launched the other elements of the Crisis Care Continuum of services which includes 24/7High-Tech Call Center, 24/7 Mobile Crisis Response services, and 24-hour short-term Crisis Residential beds.

Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
2024 Outcomes	This program ended in 2022.
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.
2024 Outcomes	In 2024, the program served 248 individuals with 5,570 services.

Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support 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 depends 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 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.
2024 Outcomes	In 2024, the program served 38 individuals with 30 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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
2024 Outcomes	In 2024, the program served 532 individuals with 5,012 services.

Name of program/activity/initiative	Mosaic Village
Description	The Mosaic Village is an interconnected ecosystem of services and opportunities rising up around Recovery Cafe West Sacramento. It provides workforce development and restorative community for those impacted by substance-use disorders, mental-health disorders, homelessness, domestic violence, grief, and other traumas. Job-skills training (JAM Academy), life-skills training (Thrive Lives program), Recovery Circle support groups, an onsite School for Recovery, and paid 1-year internships all are braided together for our priority population.
Goals	Create a pocket of safe, healing, restorative community for our priority population. Serve hundreds with daily offerings of services in and around the Recovery Cafe and provide a trauma-informed work experience.
2024 Outcomes	In 2024, the program served 915 individuals with 56,895 services.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
2024 Outcomes	In 2024, the program served 532 individuals with 5,012 services.

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 Centering Pregnancy 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 Centering Pregnancy group visits
2024 Outcomes	In 2024, the program served 1,251 individuals with 10,674 services.

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2-year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.

2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Mobile Medicine Program
Description	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.
2024 Outcomes	In 2024, the program served 364 individuals with 7,266 services.

Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.
Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
2024 Outcomes	The construction of the 24/7 Crisis Receiving Center is in progress. Yolo County HHSA has already launched the other elements of the Crisis Care Continuum of services which includes 24/7High-Tech Call Center, 24/7 Mobile Crisis Response services, and 24-hour short-term Crisis Residential beds.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Nurture Yolo
Description	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.
2024	This program ended in 2022.

Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
2024 Outcomes	In 2024, the program served 2,814 individuals with 1,343 services.

Active Living and Healthy Eating

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 Centering Pregnancy 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 Centering Pregnancy group visits
2024 Outcomes	In 2024, the program served 1,251 individuals with 10,674 services.

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.
2024 Outcomes	This program ended in 2023.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Nurture Yolo
Description	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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
2024 Outcomes	In 2024, the program served 2,814 individuals with 1,343 services.

Name of program/activity/initiative	Winters Kitchen
Description	Launch and advancement of the MOW Yolo-Sutter Health Senior Nutrition Kitchen, not only allowing for more meals for more seniors countywide meeting more dietary needs but also communicating the powerful potentials for transformation in the lives of aging adults when the nonprofit and healthcare sectors partner to support healthy outcomes.
Goals	To nourish and engage more seniors in more Yolo County communities. To provide meals that are more nutritious, incorporating fresh and local ingredients. To provide meals that are more equitable, both culturally and geographically.
2024 Outcomes	In 2024, the program served 2,203 individuals with 227,782 services.

Name of program/activity/initiative	Positive Behavioral Interventions Supports

Description	Each year of the three-year grant, fifty participating schools across seven counties will receive professional development and technical assistance/coaching supports to implement and scale up Positive Behavioral Interventions Supports (PBIS). Participating schools will create a Tier 1 universal (prevention) system by establishing, teaching and reinforcing school wide positive social and behavioral expectations. Participating schools will also adopt evidence-based early intervention behavior supports such as Check in Check Out and social/emotional/wellness and behavioral supports and will build a system for identifying and matching students to these supports at Tier 2. Schools will advance into adopting intensive/individualized supports for students in need of Tier 3 intervention.
Goals	1) Increase/improvement of the fidelity of implementation of PBIS, as demonstrated by TFI scores2) Decreases in suspensions of students at school sites participating in funded PBIS training/technical assistance3) Staff participation in funded PBIS training/technical assistance
2024 Outcomes	In 2024, the program served 92 individuals with 92 services.

Name of program/activity/initiative	West Acre Reflexology Path and Labyrinth
Description	We are targeting the "West Capitol Corridor" area of West Sacramento - this neighborhood is located in the middle of the City between Bryte/Broderick and Old West Sacramento/Southport/Bridgeway Island. This neighborhood is bound by the railroad tracks, Jefferson Blvd, I-80 Freeway and Harbor Blvd. The residents living in this community have tremendous health disparities including a life expectancy 20 years less than their neighbors living just 15 minutes away in Davis, CA. Poverty, unemployment/underemployment, lack of healthy food choices and safe exercise opportunities, lack of community connection all contribute to the poor health outcomes and it has been this way for over a decade. The residents are a melting pot of immigrants, seniors, children, single parent households, children being raised by their grandparents, etc., all bound together by poverty and a lack of opportunity, we'd like to help provide long term change in this neighborhood. The proposed Labyrinth and the Reflexology Path are located in Westacre Park on the south side of the target neighborhood, Rotary Club of West Sacramento will also plant 400 fruit trees along the Sycamore Trail on the north side of the West Capitol Corridor neighborhood.
Goals	To Install a Labyrinth and a Reflexology Path to the Westacre Park Remodel.
2024 Outcomes	A proposal was submitted in the fall 2024 to a long-time, supportive foundation for the remaining balance.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income

	stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2-year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
2024 Outcomes	In 2024, the program served 532 individuals with 5,012 services.

	Welcome Baby

Name of program/activity/initiative	
Description	Welcome Baby is a systems transformation project designed to improve maternal and child health/mental health outcomes and prevent conditions that contribute to child maltreatment and adverse childhood experiences by providing one nurse visit immediately postpartum and opening access to longer-term home visiting in either Behavioral Health or Healthy Families America home visiting pathways.
Goals	Identify and enroll higher-risk families prenatally/at birth via medical systems, administrative data risk screening at RQHC perinatal clinics, hospital Labor/Delivery rounding by program staff2. Provide Welcome Baby: Road to Resilience nurse home visit and phone follow-up to all MediCal/Uninsured/high risk births to Yolo County residents within 1-2 weeks hospital discharge.3. Network all major medical systems (10) serving Yolo County residents with MediCal or uninsured to refer into services and coordinate care.4. Co-locate navigators in FQHC (CommuniCare+Ole) clinics to assess and connect eligible highest-risk perinatal population to WB:R2R services.5. Provide evidence-based, trauma-informed home visiting (BH/HFA) to highest-risk population, inclusive of substance use/abuse risk and deliver intensive home visiting services for 6/12 months.
2024 Outcomes	In 2024, the program served 816 individuals with 2,854 services.

Name of program/activity/initiative	Capay Valley Health and Community Center
Description	RISE, Inc in Partnership with the Yocha Dehe Wintun Nation is constructing a Health and Community Center in Esparto. The health center will provide medical, dental, and pharmacy services to the isolated rural population of Western Yolo County. The community side of the building will be the new home to RISE, Inc. to provide a wide range of social services.
Goals	The health center will provide medical, dental, and pharmacy services to the isolated rural population of Western Yolo County.
2024 Outcomes	In 2024, the program purchased furniture and equipment for the health center.

Name of program/activity/initiative	Epic Implementation
Description	To move Winters Healthcare from its current EHR, eClinical Works to EPIC, specifically OCHIN-EPIC, which will allow Winters Healthcare to integrate data from outside health systems that use EPIC
Goals	To move Winters Healthcare from its current EHR, eClinical Works to EPIC, specifically OCHIN-EPIC.
2024 Outcomes	In 2024 the program implemented transition to EPIC.

Name of program/activity/initiative	Home Visiting
Description	YCCA's comprehensive Home Visiting initiative encompasses the Healthy Families America accredited Healthy Families Yolo County program, the Family Check-Up program, and YCCA's other home visiting programs which include culturally responsive support, education, and skills development for parents of children in households

	that have experienced repeated trauma. This multi-faceted approach is designed to support vulnerable families, promote healthy child development, and prevent child abuse and neglect in Yolo County.
Goals	Provide culturally responsive support to diverse families, ensuring services are accessible and relevant. Deliver evidence-based education and support services that strengthen family functioning. Support families in accessing community resources and building support networks.
2024 Outcomes	In 2024, the program served 452 individuals with 2,293 services.

System Navigation

Name of program/activity/initiative	Patient Navigation
Description	Patient Navigation services which include assisting families, seniors, and individuals to enroll in and maintain coverage with Medi-Cal and Covered California. Services also include assistance in establishing a medical home, understanding benefits, using and navigating health care and preventative care services.
Goals	YCCA's Family Resource Center will provide Access to Quality Primary Care Health Services for over 200 low-income individuals. Services will include supporting parents, children, individuals, and seniors to enroll in, maintain coverage, and connect to medical services, including preventative care. Patient Navigation targets recent immigrants, refugees, those for whom English isn't their first language, families, seniors, and individuals with limited income, and other under-served populations. Services include providing assistance to enroll in and maintain coverage with MediCal and Covered California as well as assisting at least 200 clients to establish a medical home and understand and use their benefits to access health care and preventative services.
2024 Outcomes	In 2024, the program served 1,019 individuals with 3,652 services.

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.

Goals	The goals of the program are to successfully complete a 2-year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.
Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
2024 Outcomes	The construction of the 24/7 Crisis Receiving Center is in progress. Yolo County HHSA has already launched the other elements of the Crisis Care Continuum of services which includes 24/7High-Tech Call Center, 24/7 Mobile Crisis Response services, and 24-hour short-term Crisis Residential beds.

Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
2024 Outcomes	This program ended in 2022.

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.
2024 Outcomes	In 2024, the program served 248 individuals with 5,570 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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support 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 depends 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 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.

2024 Outcomes	In 2024, the program served 38 individuals with 30 services.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
2024 Outcomes	In 2024, construction of the new building began.

	Emergency Childcare and Wrap-Around Services for Families in Crisis

Name of program/activity/initiative	
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move someone with no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.
Goals	The goal of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
2024 Outcomes	In 2024, the program served 1,902 individuals with 10.977 services.

Access to Specialty and Extended Care

Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move

	someone with no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.
Goals	The goal of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
2024 Outcomes	In 2024, the program served 1,902 individuals with 10.977 services.

Increased Community Connections

Name of program/activity/initiative	Permanent Supportive Housing Project
Description	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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
2024 Outcomes	In 2024, the program served 532 individuals with 5,012 services.

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 Centering Pregnancy 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 Centering Pregnancy group visits
2024 Outcomes	In 2024, the program served 1,251 individuals with 10,674 services.

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.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Mobile Medicine Program
Description	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.
2024 Outcomes	In 2024, the program served 364 individuals with 7,266 services.

Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
2024 Outcomes	This program ended in 2022.

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.
2024 Outcomes	In 2024, the program served 248 individuals with 5,570 services.

Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support 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 depends 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 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.
2024 Outcomes	In 2024, the program served 38 individuals with 30 services.

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.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent

	child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
2024 Outcomes	In 2024, construction of the new building began.

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
2024 Outcomes	This program ended in 2022.

Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
2024 Outcomes	This program ended in 2023.

Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move someone with no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.

Goals	The goal of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
2024 Outcomes	In 2024, the program served 1,902 individuals with 10.977 services.

Safe and Violence-Free Environment

Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
2024 Outcomes	In 2024, construction of the new building began.

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
2024 Outcomes	This program ended in 2022.

Access to Functional 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.
2024 Outcomes	In 2024, the program served 248 individuals with 5,570 services.

Access to Dental Care and Preventative Services

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
2024 Outcomes	In 2024, the program served 532 individuals with 5,012 services.

Needs Sutter Davis Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Davis Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2022 Community Health Needs Assessment:

N/A

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on July 21, 2022.

Appendix: 2024 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
2024 Total Community Benefit
& Unpaid Costs of Medicare