Sutter Health

Sutter Amador Hospital

2022 – 2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

200 Mission Blvd, Jackson, CA 95642
FACILITY LICENSE # 30000008
www.sutterhealth.org

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Introduction

The Implementation Strategy Plan describes how Sutter Amador 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 Amador 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 200 Mission Blvd, Jackson, CA 95642; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Amador Hospitals is affiliated with Sutter Health, a not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

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

Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

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

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

Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

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

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

The 2022 Community Healthy Needs Assessment conducted by Sutter Amador 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 Amador 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 10 one-on-one and group interviews with 20 community health experts, social-service providers, and medical personnel. Furthermore, 18 community residents or community service provider organizations participated in 2 focus groups across the service area. Finally, 9 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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 SAH'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 Amador Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The definition of the community served included the primary service area of the hospital, which consists of 19 ZIP codes across Amador, Calaveras, and Tuolumne Counties. The main area used for this assessment were the ZIP codes and county rates for Amador and Calaveras county as most data indicates to these two counties are the main area of which Sutter Amador Hospital provides services for.

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 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.

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. **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.

4. **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.

5. **Access to Functional Needs**
   Functional needs refers to needs related to 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.

6. **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. Further, healthcare and community support services are more effective when they are delivered in a coordinate fashion, where individual organizations collaborate with others to build a network of care.

7. **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

8. **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.

9. ***Safe and Violence-Free Environment***
   Feeling safe in one’s home and community are 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. Further, 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.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Amador 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 Amador 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 Quality Primary Care Health Services
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Basic Needs Such as Housing, Jobs, and Food
4. Access to Specialty and Extended Care
5. Access to Functional Needs
6. Increased Community Connections
7. Active Living and Healthy Eating
8. Injury and Disease Prevention and Management

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Amador Rides
Description	Amador Rides utilizes volunteer drives to provide transportation to and from medical appointments for Amador County's underserved who are unable to access necessary medical care, due to transportation constraints, especially in the rural areas of Amador County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness.
Goals	The goal of Amador Rides is to provide rides to and from medical appointments for seniors and disabled residents of Amador County.
Anticipated Outcomes	The anticipated outcome of the Amador Rides program is hundreds of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	SAH will continue to evaluate the impact of Amador Rides on a biannual basis, by tracking the number of people served and number of rides provided. We will look at metrics including (but not limited to) number of people served and number of rides provided.
Name of program/activity/initiative	Silver Streak

Description	Silver Streak is a non-emergency medical transport service operating Monday through Friday, 8:30 a.m. to 5 p.m. except scheduled holidays. This program is for Amador County residents 60 and older for out-of-county door-to-door non-emergency transportation service for scheduled medical appointments. Eligible clients must have Medicare, Medi-cal or be uninsured. All transportation services are contingent on driver availability, weather conditions, and subject to cancellation at any time. ADA compliant vehicles are available. Caregivers/attendants may accompany clients.
Goals	Remove transportation barriers to medical appointments out-of-county.
Anticipated Outcomes	The anticipated outcome is increased access to out-of-county medical needs for Amador residents.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Patient Navigator
Description	WellSpace Health will place a Patient Navigator within Sutter Amador Hospital to act as part of WellSpace Health's T3 program approach: to triage, transport, and treat patients in an appropriate Primary Care setting. The navigator will help connect Amador County uninsured and under-insured patients from Sutter Amador Hospital's ED and in-patient settings to appropriate Primary Care services in the community. Follow up contact will be provided to the patient telephonically to encourage kept appointments with appropriate care, as well as connection to resources and referrals to community resources. Through the use of grant funding a van will be purchased specifically for this program to help reduce barriers for access to improve health and the navigator will provide transport to patients as needed.
Goals	The goals of the program are to improve access to primary care and community resources, as well as remove transportation barriers.
Anticipated Outcomes	The anticipated outcomes are increased connections to community resources, established primary care homes and reduced transportation barriers to access.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.

Access to Mental/Behavioral Health and Substance Use Services

Name of program/activity/initiative	Amador Rides
Description	Amador Rides utilizes volunteer drives to provide transportation to and from medical appointments for Amador County's underserved who are unable to access necessary medical care, due to transportation constraints, especially in the rural areas of Amador County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness.
Goals	The goal of Amador Rides is to provide rides to and from medical appointments for seniors and disabled residents of Amador County.
Anticipated Outcomes	The anticipated outcome of the Amador Rides program is hundreds of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.

Metrics Used to Evaluate the program/activity/initiative	SAH will continue to evaluate the impact of Amador Rides on a biannual basis, by tracking the number of people served and number of rides provided. We will look at metrics including (but not limited to) number of people served and number of rides provided.
Name of program/activity/initiative	ILP - Independent Living Program, XY Advocacy Program
Description	The Nexus Youth Programs Enrichment Activities project will allow youth to participate in a variety of enrichment activities throughout the year. These will include experiences such as nature hikes, educational outings, support for extra-curricular activities, youth development and leadership opportunities, camping trips, and other experiences they would not be exposed to due to their families inability to fund such activities. The youth that we serve come from a variety of backgrounds including broken homes, foster youth, low-income families and living with parents who are experiencing mental health challenges or abusing substances.
Goals	The goal of this program is to ensure that kids are given the opportunity to have fun, practice leadership skills, and develop healthy physical, social and emotional well-being.
Anticipated Outcomes	The anticipated outcome of the program is to improve community connections and mental health amongst participants, as well as foster future leaders.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.
Name of program/activity/initiative	Unhoused Youth, Seniors and Family Outreach
Description	The outreach program focuses on providing access to basic needs to unhoused individuals and helping youth, families and seniors get access to the resources that they might need in Amador County. Operation Care recognizes that under the HUD definition, youth also include ages 18 – 24. In addition, bus passes and/or transportation will be provided, as needed, to access health care services including prescriptions and scheduling appointments. Youth will be referred into Operation Care's Go! Youth program in an effort to provide these youth with a safe, healthy supportive environment with their peers. This program has classes for youth ages 7-11 and 12-17 that discuss healthy relationships, drugs and alcohol, self-esteem among other topics. We plan to collaborate with partner agencies that work with unhoused youth as well to ensure that our outreach is successful.
Goals	The goal of the program is to assist unhoused individuals to become self-sufficient, establish a support system and get connected with resources that will help them ultimately become housed.
Anticipated Outcomes	The anticipated outcome is improved community connections, housing individuals and reduced substance use amongst youth.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.

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

Name of program/activity/initiative	Modified Project Roomkey

Description	The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital.
Goals	The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients.
Anticipated Outcomes	The anticipated outcome of the program is to safely quarantine those impacted by COVID-19 and connect those individuals with wrap around services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, and other successful linkages.
Name of program/activity/initiative	Senior Protein Program
Description	The Senior Meal Bag Program provides fresh and nutritious foods to senior citizens of Amador County. Funding will help add a protein component to the meal bags, such as poultry and beef. In addition, funding will allow the program's expansion to new distribution sites in River pines, Plymouth and Ione.
Goals	The goal of the program is to provide seniors with more protein rich foods and reach rural locations of the community.
Anticipated Outcomes	The anticipated outcomes of the program are improved access to protein rich foods and remove barriers to access to food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food provided, and anecdotal success stories.
Name of program/activity/initiative	Unhoused Youth, Seniors and Family Outreach
Description	The outreach program focuses on providing access to basic needs to unhoused individuals and helping youth, families and seniors get access to the resources that they might need in Amador County. Operation Care recognizes that under the HUD definition, youth also include ages 18 – 24. In addition, bus passes and/or transportation will be provided, as needed, to access health care services including prescriptions and scheduling appointments. Youth will be referred into Operation Care's Go! Youth program in an effort to provide these youth with a safe, healthy supportive environment with their peers. This program has classes for youth ages 7-11 and 12-17 that discuss healthy relationships, drugs and alcohol, self-esteem among other topics. We plan to collaborate with partner agencies that work with unhoused youth as well to ensure that our outreach is successful.
Goals	The goal of the program is to assist unhoused individuals to become self-sufficient, establish a support system and get connected with resources that will help them ultimately become housed.

Anticipated Outcomes	The anticipated outcome is improved community connections, housing individuals and reduced substance use amongst youth.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Patient Navigator
Description	WellSpace Health will place a Patient Navigator within Sutter Amador Hospital to act as part of WellSpace Health's T3 program approach: to triage, transport, and treat patients in an appropriate Primary Care setting. The navigator will help connect Amador County uninsured and under-insured patients from Sutter Amador Hospital's ED and in-patient settings to appropriate Primary Care services in the community. Follow up contact will be provided to the patient telephonically to encourage kept appointments with appropriate care, as well as connection to resources and referrals to community resources. Through the use of grant funding a van will be purchased specifically for this program to help reduce barriers for access to improve health and the navigator will provide transport to patients as needed.
Goals	The goals of the program are to improve access to primary care and community resources, as well as remove transportation barriers.
Anticipated Outcomes	The anticipated outcomes are increased connections to community resources, established primary care homes and reduced transportation barriers to access.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.

Access to Specialty and Extended Care

Name of program/activity/initiative	Transportation Program for Cancer Patients
Description	Support, Transportation, and Resource Services are provided to patients in cancer treatment or follow up from cancer treatment. We offer support groups, a resource community library, a free wig program (provided by a licensed cosmetologist).
Goals	The goal of the program is to provide support and transportation services to patients who live in Amador County.
Anticipated Outcomes	This program will result in more rides to and from medical appointments related to cancer treatment, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and number of rides provided.
Name of program/activity/initiative	Silver Streak
Description	Silver Streak is a non-emergency medical transport service operating Monday through Friday, 8:30 a.m. to 5 p.m. except scheduled holidays. This program is for Amador County residents 60 and older for out-of-county door-to-door non-emergency transportation service for scheduled medical appointments. Eligible clients must have Medicare, Medi-cal or be uninsured. All transportation services are contingent on driver availability, weather conditions, and subject to cancellation at any time.

	ADA compliant vehicles are available. Caregivers/attendants may accompany clients.
Goals	Remove transportation barriers to medical appointments out-of-county.
Anticipated Outcomes	The anticipated outcome is increased access to out-of-county medical needs for Amador residents.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Amador Lifeline
Description	Amador Lifeline is a paid subscription program that allows for seniors and individuals with disabilities, chronic illnesses and those in rehabilitative care in Amador County to remain living independently in their own homes with some sense of security and peace of mind. We are helping to supplement funding, which ensures that low-income Amador County residents can afford the paid subscription program by utilizing a sliding scale schedule.
Goals	The goal of this program is to link isolated, disabled and/or senior residents of Amador County with assistance and resources with the simple touch of a button. Given Amador's rural environment, this program is incredibly important to seniors.
Anticipated Outcomes	The anticipated outcomes are for clients to maintain their self- respect, confidence, dignity and independence by continuing to live in their own residences with the safety and security with the help of the program's emergency response service.
Metrics Used to Evaluate the program/activity/initiative	We will track and report the number of individuals served by the Lifeline program each year, as well as success stories and other programmatic outcomes. We will look at metrics including (but not limited to) number of people served, number/type of resources provided, anecdotal stories and other successful linkages.

Access to Functional Needs

Name of program/activity/initiative	Transportation Program for Cancer Patients
Description	Support, Transportation, and Resource Services are provided to patients in cancer treatment or follow up from cancer treatment. We offer support groups, a resource community library, a free wig program (provided by a licensed cosmetologist).
Goals	The goal of the program is to provide support and transportation services to patients who live in Amador County.
Anticipated Outcomes	This program will result in more rides to and from medical appointments related to cancer treatment, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and number of rides provided.
Name of program/activity/initiative	Silver Streak
Description	Silver Streak is a non-emergency medical transport service operating Monday through Friday, 8:30 a.m. to 5 p.m. except scheduled holidays. This program is for Amador County residents 60 and older for out-of-county door-to-door non-emergency transportation service for scheduled

	medical appointments. Eligible clients must have Medicare, Medi-cal or be uninsured. All transportation services are contingent on driver availability, weather conditions, and subject to cancellation at any time. ADA compliant vehicles are available. Caregivers/attendants may accompany clients.
Goals	Remove transportation barriers to medical appointments out-of-county.
Anticipated Outcomes	The anticipated outcome is increased access to out-of-county medical needs for Amador residents.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Modified Project Roomkey
Description	The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital.
Goals	The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients.
Anticipated Outcomes	The anticipated outcome of the program is to safely quarantine those impacted by COVID-19 and connect those individuals with wrap around services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, and other successful linkages.
Name of program/activity/initiative	Amador Rides
Description	Amador Rides utilizes volunteer drives to provide transportation to and from medical appointments for Amador County's underserved who are unable to access necessary medical care, due to transportation constraints, especially in the rural areas of Amador County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness.
Goals	The goal of Amador Rides is to provide rides to and from medical appointments for seniors and disabled residents of Amador County.
Anticipated Outcomes	The anticipated outcome of the Amador Rides program is hundreds of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	SAH will continue to evaluate the impact of Amador Rides on a biannual basis, by tracking the number of people served and number of rides provided. We will look at metrics including (but not limited to) number of people served and number of rides provided.
Name of program/activity/initiative	Unhoused Youth, Seniors and Family Outreach

Description	The outreach program focuses on providing access to basic needs to unhoused individuals and helping youth, families and seniors get access to the resources that they might need in Amador County. Operation Care recognizes that under the HUD definition, youth also include ages 18 – 24. In addition, bus passes and/or transportation will be provided, as needed, to access health care services including prescriptions and scheduling appointments. Youth will be referred into Operation Care's Go! Youth program in an effort to provide these youth with a safe, healthy supportive environment with their peers. This program has classes for youth ages 7-11 and 12-17 that discuss healthy relationships, drugs and alcohol, self-esteem among other topics. We plan to collaborate with partner agencies that work with unhoused youth as well to ensure that our outreach is successful.
Goals	The goal of the program is to assist unhoused individuals to become self-sufficient, establish a support system and get connected with resources that will help them ultimately become housed.
Anticipated Outcomes	The anticipated outcome is improved community connections, housing individuals and reduced substance use amongst youth.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Patient Navigator
Description	WellSpace Health will place a Patient Navigator within Sutter Amador Hospital to act as part of WellSpace Health's T3 program approach: to triage, transport, and treat patients in an appropriate Primary Care setting. The navigator will help connect Amador County uninsured and under-insured patients from Sutter Amador Hospital's ED and in-patient settings to appropriate Primary Care services in the community. Follow up contact will be provided to the patient telephonically to encourage kept appointments with appropriate care, as well as connection to resources and referrals to community resources. Through the use of grant funding a van will be purchased specifically for this program to help reduce barriers for access to improve health and the navigator will provide transport to patients as needed.
Goals	The goals of the program are to improve access to primary care and community resources, as well as remove transportation barriers.
Anticipated Outcomes	The anticipated outcomes are increased connections to community resources, established primary care homes and reduced transportation barriers to access.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.

Increased Community Connections

Name of program/activity/initiative	Amador Lifeline
Description	Amador Lifeline is a paid subscription program that allows for seniors and individuals with disabilities, chronic illnesses and those in rehabilitative care in Amador County to remain living independently in their own homes with some sense of security and peace of mind. We are helping to supplement funding, which ensures that low-income Amador County

	residents can afford the paid subscription program by utilizing a sliding scale schedule.
Goals	The goal of this program is to link isolated, disabled and/or senior residents of Amador County with assistance and resources with the simple touch of a button. Given Amador's rural environment, this program is incredibly important to seniors.
Anticipated Outcomes	The anticipated outcomes are for clients to maintain their self- respect, confidence, dignity and independence by continuing to live in their own residences with the safety and security with the help of the program's emergency response service.
Metrics Used to Evaluate the program/activity/initiative	We will track and report the number of individuals served by the Lifeline program each year, as well as success stories and other programmatic outcomes. We will look at metrics including (but not limited to) number of people served, number/type of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Modified Project Roomkey
Description	The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital.
Goals	The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients.
Anticipated Outcomes	The anticipated outcome of the program is to safely quarantine those impacted by COVID-19 and connect those individuals with wrap around services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, and other successful linkages.
Name of program/activity/initiative	ILP - Independent Living Program, XY Advocacy Program
Description	The Nexus Youth Programs Enrichment Activities project will allow youth to participate in a variety of enrichment activities throughout the year. These will include experiences such as nature hikes, educational outings, support for extra-curricular activities, youth development and leadership opportunities, camping trips, and other experiences they would not be exposed to due to their families inability to fund such activities. The youth that we serve come from a variety of backgrounds including broken homes, foster youth, low-income families and living with parents who are experiencing mental health challenges or abusing substances.
Goals	The goal of this program is to ensure that kids are given the opportunity to have fun, practice leadership skills, and develop healthy physical, social and emotional well-being.

Anticipated Outcomes	The anticipated outcome of the program is to improve community connections and mental health amongst participants, as well as foster future leaders.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.
Name of program/activity/initiative	Unhoused Youth, Seniors and Family Outreach
Description	The outreach program focuses on providing access to basic needs to unhoused individuals and helping youth, families and seniors get access to the resources that they might need in Amador County. Operation Care recognizes that under the HUD definition, youth also include ages 18 – 24. In addition, bus passes and/or transportation will be provided, as needed, to access health care services including prescriptions and scheduling appointments. Youth will be referred into Operation Care's Go! Youth program in an effort to provide these youth with a safe, healthy supportive environment with their peers. This program has classes for youth ages 7-11 and 12-17 that discuss healthy relationships, drugs and alcohol, self-esteem among other topics. We plan to collaborate with partner agencies that work with unhoused youth as well to ensure that our outreach is successful.
Goals	The goal of the program is to assist unhoused individuals to become self-sufficient, establish a support system and get connected with resources that will help them ultimately become housed.
Anticipated Outcomes	The anticipated outcome is improved community connections, housing individuals and reduced substance use amongst youth.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Patient Navigator
Description	WellSpace Health will place a Patient Navigator within Sutter Amador Hospital to act as part of WellSpace Health's T3 program approach: to triage, transport, and treat patients in an appropriate Primary Care setting. The navigator will help connect Amador County uninsured and under-insured patients from Sutter Amador Hospital's ED and in-patient settings to appropriate Primary Care services in the community. Follow up contact will be provided to the patient telephonically to encourage kept appointments with appropriate care, as well as connection to resources and referrals to community resources. Through the use of grant funding a van will be purchased specifically for this program to help reduce barriers for access to improve health and the navigator will provide transport to patients as needed.
Goals	The goals of the program are to improve access to primary care and community resources, as well as remove transportation barriers.
Anticipated Outcomes	The anticipated outcomes are increased connections to community resources, established primary care homes and reduced transportation barriers to access.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of rides provided, anecdotal stories, and other successful linkages.

Active Living and Healthy Eating

Name of program/activity/initiative	Senior Protein Program
Description	The Senior Meal Bag Program provides fresh and nutritious foods to senior citizens of Amador County. Funding will help add a protein component to the meal bags, such as poultry and beef. In addition, funding will allow the program's expansion to new distribution sites in River pines, Plymouth and Ione.
Goals	The goal of the program is to provide seniors with more protein rich foods and reach rural locations of the community.
Anticipated Outcomes	The anticipated outcomes of the program are improved access to protein rich foods and remove barriers to access to food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food provided, and anecdotal success stories.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Amador Lifeline
Description	Amador Lifeline is a paid subscription program that allows for seniors and individuals with disabilities, chronic illnesses and those in rehabilitative care in Amador County to remain living independently in their own homes with some sense of security and peace of mind. We are helping to supplement funding, which ensures that low-income Amador County residents can afford the paid subscription program by utilizing a sliding scale schedule.
Goals	The goal of this program is to link isolated, disabled and/or senior residents of Amador County with assistance and resources with the simple touch of a button. Given Amador's rural environment, this program is incredibly important to seniors.
Anticipated Outcomes	The anticipated outcomes are for clients to maintain their self- respect, confidence, dignity and independence by continuing to live in their own residences with the safety and security with the help of the program's emergency response service.
Metrics Used to Evaluate the program/activity/initiative	We will track and report the number of individuals served by the Lifeline program each year, as well as success stories and other programmatic outcomes. We will look at metrics including (but not limited to) number of people served, number/type of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Modified Project Roomkey
Description	The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be

	received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital.
Goals	The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients.
Anticipated Outcomes	The anticipated outcome of the program is to safely quarantine those impacted by COVID-19 and connect those individuals with wrap around services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, and other successful linkages.
Name of program/activity/initiative	Senior Protein Program
Description	The Senior Meal Bag Program provides fresh and nutritious foods to senior citizens of Amador County. Funding will help add a protein component to the meal bags, such as poultry and beef. In addition, funding will allow the program's expansion to new distribution sites in River pines, Plymouth and Ione.
Goals	The goal of the program is to provide seniors with more protein rich foods and reach rural locations of the community.
Anticipated Outcomes	The anticipated outcomes of the program are improved access to protein rich foods and remove barriers to access to food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food provided, and anecdotal success stories.
Name of program/activity/initiative	Unhoused Youth, Seniors and Family Outreach
Description	The outreach program focuses on providing access to basic needs to unhoused individuals and helping youth, families and seniors get access to the resources that they might need in Amador County. Operation Care recognizes that under the HUD definition, youth also include ages 18 – 24. In addition, bus passes and/or transportation will be provided, as needed, to access health care services including prescriptions and scheduling appointments. Youth will be referred into Operation Care's Go! Youth program in an effort to provide these youth with a safe, healthy supportive environment with their peers. This program has classes for youth ages 7-11 and 12-17 that discuss healthy relationships, drugs and alcohol, self-esteem among other topics. We plan to collaborate with partner agencies that work with unhoused youth as well to ensure that our outreach is successful.
Goals	The goal of the program is to assist unhoused individuals to become self-sufficient, establish a support system and get connected with resources that will help them ultimately become housed.
Anticipated Outcomes	The anticipated outcome is improved community connections, housing individuals and reduced substance use amongst youth.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.

Needs Sutter Amador Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Amador 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:

1. **Safe and Violence-Free Environment:** Sutter Amador Hospital plans to seek out opportunities for community benefit programs that address fostering a safe and violence-free environment with local community benefit organizations.

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.