



SUTTER SOLANO MEDICAL CENTER

2025 – 2027 Community Benefit Plan Responding to the 2025 Community Health Needs Assessment

Submitted to the Department of Health Care Access and Information
July 2026

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Note: This Community Benefit Plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

General Information

Date written plan was adopted by organization's governing body	October 17, 2025
Date written plan was required to be adopted	May 15, 2026
Authorized governing body that adopted the written plan	Sutter Bay Hospitals Board and Sutter Valley Hospitals Board
Was the written plan adopted by the authorized governing body on or before the 15 th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body	July 21, 2022

Summary: 2025 Implementation Strategy

The Implementation Strategy (IS) describes how Sutter Solano Medical Center (SSMC), a Sutter Health system not-for-profit hospital, plans to address significant health needs identified in the 2025 Community Health Needs Assessment (CHNA) in calendar (tax) years 2025 through 2027.

The 2025 CHNA and the 2025 - 2027 IS were undertaken by the hospital to understand and address community health needs, in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The hospital reserves the right to amend this IS as circumstances warrant. As outlined in this document, SSMD has identified the following significant health needs to be addressed in 2025-2027:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Injury and Disease Prevention and Management
5. Access to Specialty and Extended Care

SSMC welcomes comments from the public on the 2025 CHNA and 2025 - 2027 IS. 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 300 Hospital Dr, Vallejo, CA 94589; and
- In-person at the hospital's Information Desk.

Sutter Health's CHNA reports and IS plans are publicly available online at <http://sutterhealth.org/about-us/community-benefit/community-health-needs-assessment>. In addition, the IS will be filed with the Internal Revenue Service using Form 990, Schedule H.

Introduction/Background

About Sutter Health

Sutter Solano Medical Center (SSMC) is affiliated with Sutter Health, a not-for-profit healthcare system dedicated to providing comprehensive, high-quality care throughout California. Committed to closing care gaps and driving innovative healthcare solutions, Sutter is pursuing a bold new plan to reach more people and make excellent healthcare more connected and accessible. Currently serving 3.6 million patients, thanks to our dedicated team of approximately 64,000 employees (including nurses) and 15,000+ affiliated physicians and advanced practice clinicians, with a unified focus on expanding care to serve more patients.

2025 Activities to Address Community Health Needs

As part of Sutter Health's commitment to fulfill its not-for-profit mission, Sutter invests deeply in the communities it serves to help close health care gaps and improve individual and community wellness. Sutter's investments in community benefit programs and services increased to nearly \$1.2 billion in 2025, including \$101 million in traditional charity care, \$830 million in unreimbursed costs of providing care to Medi-Cal patients, \$101 million in training, education and development of future health care professionals, as well as investments in programs to address identified community health needs.

In 2025, SSMC's investments in community health programs addressed pressing community needs in three main priority areas: access to care, including chronic disease prevention and management; mental health and substance use treatment; and workforce development.

Learn more about how Sutter Health reinvests into communities and works to advance healthy outcomes for all by visiting sutterhealth.org/community-benefit.

2025 Community Health Needs Assessment Approach

Community Health Insights (www.communityhealthinsights.com) conducted the 2025 CHNA on behalf of SSMC. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.¹ This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, 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 15 community health experts, social service providers, and medical personnel. Furthermore, 29 community residents participated in three focus groups across the service area. Finally, two community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization, and the two

¹ Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from <https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods>.

responses were added into the key informant interview analysis (see Appendix A for CHNA participants).

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. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

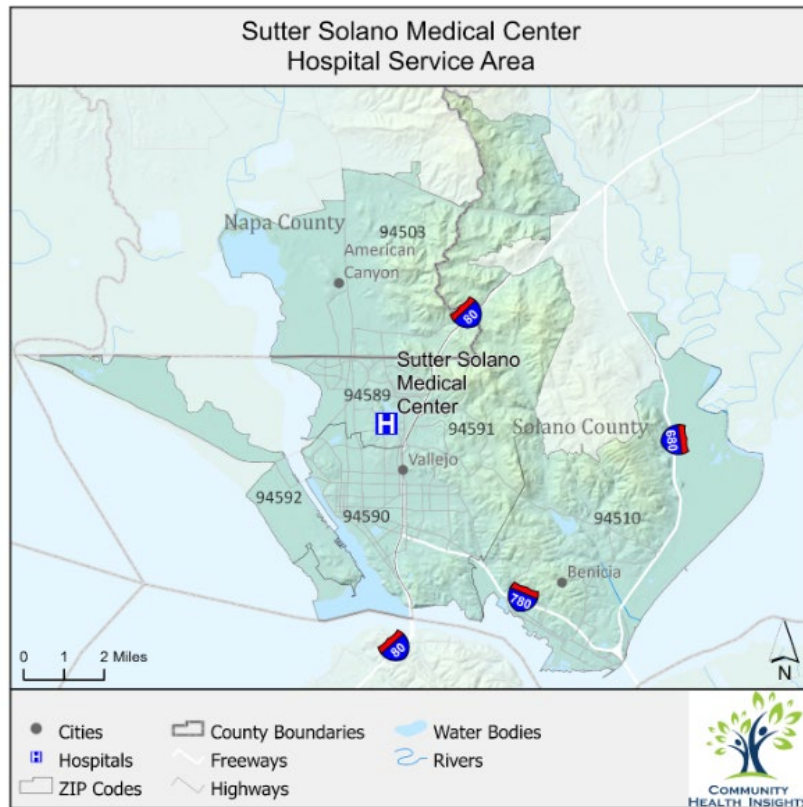
Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize SHNs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs (SHN). These SHN were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

Community Served

The definition of the community served included the primary service area of the hospital, Sutter Solano Medical Center, the City of Vallejo, California, and surrounding communities as defined by six ZIP Codes in Solano County consisting of ZIP Codes 94510, 94589, 94590, 94591, and 94592 and the ZIP code 94503 (American Canyon) in Napa County, CA. This was the designated service area because most patients served by SSMC resided in these ZIP Codes. Considered a North San Francisco Bay community, Vallejo is an incorporated city in Solano County. The total population of the service area was 177,010 (Figure 1).

Figure 1: Community served by SSMC.



Selected population characteristics for SSMC's service area are found in Table 1, below.

Table 1. Population Characteristics: Solano County	
Total Population	450,995
Median Age (yrs.)	38.8
Median Income	97,037
% Poverty	9
% Unemployed	5.9
% Uninsured	4.9
% Without High School Degree	11.1
% With High Housing Costs	37.4
% With Disability	12.4
Race/ethnicity	
% White	34.3
% Asian	15.6
% Hispanic or Latino	29.0
% Black or African American	12.6
% Multiracial	6.6
% Another race/ethnicity	0.9
% Native Hawaiian or Pacific Islander	0.8
% American Indian or Alaska Native	0.3

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Significant Health Needs Identified in the 2025 CHNA

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. The following significant health needs were identified in the 2025 CHNA:

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

Sutter Health's Approach to Implementation Strategies

We are passionate about giving back to the communities that trust us with their health. As a not-for-profit health system, we improve health outcomes beyond the walls of our hospitals and care facilities through community benefit investments and collaborative partnerships. Community-based services, mobile clinics, transportation services, and prevention and wellness programs are among the ways Sutter Health seeks to put its mission into action. Our commitment to healthier lives begins with building stronger communities.

When creating our IS, we focus on innovative and effective strategies, collaborative partnerships and sustainable solutions to address the most pressing community health issues. Using the CHNA as our guide, we tailor our approach in each community to consider the unique needs of those living in the hospital service area. In addition to the CHNA, we also consider:

- Key stakeholder input from community leaders and service providers.
- Data analysis showing gaps in care for Medi-Cal and uninsured individuals.
- Where we can lend our health care expertise to provide valuable tools, perspective or services.
- Existing community capacity to determine where more resources are needed and avoid duplication of efforts.

We have streamlined our IS approach across the Sutter Health system to be more effective in meeting community needs and share best practices across regions. We have identified these three areas as our overarching community health goals:

- **Access to Care, including Chronic Disease Prevention and Management** – increase capacity and reduce barriers for vulnerable patients accessing primary and specialty care, and implement programs to prevent and manage chronic diseases.
- **Mental Health and Substance Use Treatment** – improve access to and quality of mental health and substance use disorder services in clinics, schools, community-based settings, and counties.
- **Workforce Development** – invest in the future generation of healthcare workers to improve the workforce pipeline and access to care.

Health Needs SSMC Plans to Address

The health needs the hospital will address in 2025-2027 are:

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 Needs² 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.³
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 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.
4. **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.
5. **Access to Specialty and Extended Care** - Extended care, which includes specialty care, is 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.

² McLeod, S. 2020. Maslow's Hierarchy of Needs. Retrieved 31 Jan 2022 from <http://www.simplypsychology.org/maslow.html>.

³ Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale>.

SSMC Implementation Strategies

To ensure we are meeting the needs outlined in our CHNA, each hospital's IS aligns with the prioritized health needs of the hospital's service area while also supporting our organization's strategic approach.

This IS describes how SSMC plans to address significant health needs identified in the 2025 CHNA 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 2025 CHNA.

Below is an outline of the priority health needs SSMC plans to address by the end of 2027, as well as the goals and strategies we will implement to achieve the listed outcomes.

Priority Health Need	Goal	Strategies	Anticipated Outcomes	2025 Outcomes
Access to Basic Needs Such as Housing, Jobs, and Food	Cultivate a talent pipeline, enhance workforce readiness, and support the broader community.	Develop and improve sustainable career pathways in healthcare and other fields through investments in education, job training, technical and soft skill building, leadership development, employment services and supports, and financial coaching, among other programs and services.	Program participants will have access to education or job training and other services to support employment and address basic needs.	Planning for future investments to advance this strategy is underway.
Access to Mental/Behavioral Health and Substance Use Services	Cultivate community mental health by expanding access to inclusive, trauma-informed prevention, intervention, crisis and substance use disorder services through innovative, culturally responsive delivery systems.	Invest in a coordinated network of culturally responsive, trauma-informed, and community-based mental health and/or substance use prevention and intervention strategies—spanning prevention, crisis care and post-stabilization, housing and vocational support, integrated healthcare models, and workforce development—to optimize access, strengthen service capacity, and improve behavioral health outcomes for underserved, uninsured, and high-risk populations across all age groups.	Community members will have access to services addressing behavioral health, primary care and basic needs.	Planning for future investments to advance this strategy is underway.

Priority Health Need	Goal	Strategies	Anticipated Outcomes	2025 Outcomes
Access to Quality Primary Care Health Services/ Access to Specialty and Extended Care	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Invest in Community Health Worker/Promotores/Navigat or initiatives in which trusted community members connect individuals and families with community healthcare providers, clinics, care teams, and resources to address their health, social and/or economic needs.	Patients experience increased access to primary care and other community-based services that support health and address basic needs.	In 2025, 1,115 community members were served as a result of investments in this strategy: • 204 individuals received primary care services, • 171 received specialty care services, and • 755 healthcare navigation services were provided.
Injury and Disease Prevention and Management	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with programs that focus on chronic disease prevention, risk reduction, and management through improved access to screenings and treatment for chronic disease, health behavior and nutrition education, healthy and culturally appropriate foods, and physical activity opportunities for seniors, youth, and other vulnerable community members.	Community members experience access to chronic disease risk reduction education, screenings, and treatment, healthy foods, and physical activity opportunities.	In 2025, 1,685 community members were served as a result of investment in this strategy: • 112 individuals received support for managing a chronic condition, and • 648 screenings were provided, and • 637 nutrition sessions were provided.

Evaluation of Effectiveness

Sutter Health regularly monitors the impact and effectiveness of our community health strategies to ensure programs meet the needs of the communities we serve. We require all community partners who receive funding to report measurable outcomes, including but not limited to the outcomes identified in the table above, to demonstrate the impact of their programs. These reports help track program success, so that we may shift our strategies to more effectively meet the needs in the CHNA if needed.

Health Needs SSMC Does Not Plan to Address

While no hospital can address all of the health needs present in its community, many health needs are interrelated. The following were not identified as the primary health needs to be addressed through this IS, though they remain important and are closely connected to our priorities: Safe and Violence-Free Environment, System Navigation, Active Living and Healthy Eating, Access to Functional Needs, and Healthy Physical Environment.

SSMC is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong community partner so that it can continue to give back to the areas we serve. To leverage our resources and expertise, we are prioritizing the needs we are positioned to most effectively address.

Appendix A: 2025 CHNA Participants

Key Informant Interviews

Table A1 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the date of the interview, the number of participants, area of expertise, and the populations served by the organization.

Table A1: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
La Clinica	04/09/2024	1	Primary care, health education, behavioral health, social services	Residents of Solano County
Caminar	04/17/2024	1	Behavioral health services	At risk, struggling families and individuals
Fighting Back Partnership	04/18/2024	1	Community resources and referrals	Low income, struggling families, undocumented, homeless
Solano County Public Health Staff	05/22/2024	4	Public Health	Residents of Solano County
Touro University	04/22/2024	2	Mobile diabetes service	Low income, uninsured
On the Move / Voices Solano Youth Center	04/23/2024	2	Foster youth, at risk youth, homeless	Napa and Solano Counties
Emmanuel Temple Apostolic Church	04/23/2024	1	Faith based services	South Vallejo, low income, food insecure
Sutter Solano Medical Center - Care Coordination	06/04/2024	1	Acute care hospital: Healthcare services	Residents of Solano County including low income, unemployed, Medi-Cal recipients
Solano County Public Health Staff Leadership*	06/06/2024	2	Public Health Leadership	Residents of Solano County

Organization	Date	Number of Participants	Area of Expertise	Populations Served
*Interview was collected by ASR on behalf of Kaiser Permanente and used in this CHNA as a part of a data sharing agreement				

Focus Groups

Table A2 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table A2: Focus group list.

Hosting Organization	Date	Number of Participants	Population Represented
Fighting Back Partnership	07/11/2024	8	Low income, struggling families, undocumented, homeless
Emmanuel Temple Apostolic Church	07/15/2024	14	Low income, food insecure
La Clinica	07/17/2024	7	Northern Vallejo at risk pregnant moms, unhoused, low income

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to community residents of the HSA. Given that only two respondents completed the survey for the SSMC, their responses were included as a part of the key informant interview data analysis.

Appendix B: 2025 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 expenses are reported based on total cost incurred, offset by any restricted revenue received to determine net community benefit expense. 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 underserved 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 hospitals provide some or all of these community benefit activities.

Sutter Solano Medical Center
Total Community Benefits & Unpaid Costs of Medicare
For period from 01/01/2025 through 12/31/2025

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	\$2,171,096		\$2,171,096
Medi-Cal	\$24,910,284		\$24,910,284
Other Means-Tested Government (Indigent Care)	\$2,797		\$2,797
Sum Financial Assistance and Means-Tested Government Program	\$27,084,177		\$27,084,177
Other Benefits			
Community Health Improvement Services	\$65,416	\$0	\$65,416
Community Benefit Operations	\$0	\$51,561	\$51,561
Health Professions Education	\$0	\$0	\$0
Subsidized Health Services	\$0	\$55,658	\$55,658
Research	\$0	\$26,485	\$26,485
Cash and in-kind Contributions for Community Benefits	\$429,591	\$175,000	\$604,591
Other Community Benefits	\$0	\$0	\$0
Total Other Benefits	\$495,007	\$308,704	\$803,711

Community Benefits Spending			
Total Community Benefits	\$27,579,184	\$308,704	\$27,887,888
Medicare	\$28,113,186		\$28,113,186
Total Community Benefits with Medicare	\$55,692,370	\$308,704	\$56,001,074