Sutter Health

Sutter Santa Rosa Regional Hospital

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

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Introduction

The Implementation Strategy Plan describes how Sutter Santa Rosa Regional Hospital (SSRRH), 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.

SSRRH 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 30 Mark West Springs Road, Santa Rosa, CA 95403, ATTN TO: Community Benefit; and
- In-person at the hospital's Information Desk.

1. Executive Summary

Sutter Santa Rosa Regional Hospital (SSRRH) 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, 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. Access to Quality Primary Care Health Services
4. Increased Community Connections
5. Injury and Disease Prevention and Management
6. Access to Specialty and Extended Care
7. Access to Dental Care and Preventive Services

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

2. 2022 Community Health Needs Assessment Summary

Sutter Santa Rosa Regional Hospital (SSRRH) completes a Community Health Needs Assessment (CHNA) every three years, which uses primary and secondary data to identify priority issues affecting the health of Sonoma County residents. Community Health Insights was contracted to conduct the 2022 – 2024 CHNA on behalf of SSRRH over a seven-month period from November 2021 through May 2022.

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, focus groups, and 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, 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.

A total of seven health needs were identified in the 2022 CHNA, described later in this report. The full 2022 Community Health Needs Assessment conducted by SSRRH is available at https://www.sutterhealth.org/.

3. Definition of the Community Served by the Hospital

The definition of the community served was all of Sonoma County, which is the primary service area of SSRRH.

Located in Northern California, Sonoma County includes three distinct regions with 30 towns and cities, each with its own unique scenery. The Valleys and Vineyards region is known for its lush countryside and is home to 18 wine regions. The Redwoods and Rivers region includes wineries as well as redwood reserves with towering trees. The western edge of Sonoma County runs 55 miles along the Pacific Ocean and makes up the Coast region of the county.

The total population of the service area was 507,669 in 2019. The majority of the county's population is white (63%), followed by Latinx (27%).

Health outcome data by race and ethnicity reveal some clear inequities. The American Indian/Alaskan Native community, making up only 0.5% of the population of Sonoma County, has the lowest life expectancy, highest premature age-adjusted mortality, highest premature death due to years of potential life lost, and highest percentage of low birthweight babies. Additionally, the Black community, representing 1.5% of the county population, has the second-lowest life expectancy and the second highest rates of premature age-adjusted mortality and premature death due to years of potential life lost.

Examination of inequities in health factors by race and ethnicity revealed that Hispanic/Latinx community members have the lowest percentages of college attainment, high school completion, third grade reading and math levels, highest percentage of children living in poverty, lowest median income and highest percentage of population that is uninsured.

The county consists of 36 ZIP codes. Those with the highest poverty levels are 95431 (Eldridge), 95439 (Fulton), and 95471 (Rio Nido). In addition, ZIP codes with median household incomes lower than the state's $75,235 include 94922 (Bodega), 94928 (Rohnert Park), 95401 (Santa Rosa),

[1] Robert Wood Johnson Foundation & University of Wisconsin. (2021). *County Health Rankings Model*. Retrieved January 2022 from http://www.countyhealthrankings.org/.

95403 (Santa Rosa), 95404 (Santa Rosa), 95407 (Roseland), 95421 (Cazadero), 95436 (Forestville), 95441 (Geyserville), 95446 (Guerneville), 95452 (Kenwood), 95462 (Sheridan), and 95465 (Occidental). Finally, ZIP codes 95412 (Annapolis), 95425 (Cloverdale), and 95448 (Healdsburg) have a higher percentage of uninsured people compared to the state's 7.5%.

Of these ZIP codes, eight (95401, 95403, 95404, 95407, 95436, 95446, 95462, and 95425) were identified as Communities of Concern, geographic areas within Sonoma County that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Additional Communities of Concern include 95472 (Sebastopol) and 95476 (Sonoma).

4. Significant Health Needs Identified in the 2022 CHNA

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[2] 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. **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

[2] McLeod, S. (2020). *Maslow's Hierarchy of Needs.* Retrieved from http://www.simplypsychology.org/maslow.html.

[3] Robert Wood Johnson Foundation and University of Wisconsin. (2022). *Research Articles.* Retrieved from http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale.

well-being for all."[4] 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 coordinated fashion, where individual organizations collaborate with others to build a network of care.

5. **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.

6. **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.

7. **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 disease, including gum disease and tooth decay, are preventable chronic diseases that increase risk of other chronic disease. Oral health issues play a significant role in chronic absenteeism from school for children. Poor oral health status impacts the health of the entire body, especially the heart, digestive, and endocrine systems.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs (SHNs). This began by identifying 12 potential health needs (PHNs). These PHNs were derived from a list of common health needs in previously conducted CHNAs throughout Northern California.[5] Data were analyzed to discover which, if any, of the PHNs were present in Sonoma County and were selected as SHNs. These SHNs 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.

5. 2022 – 2024 Implementation Strategy Plan

The Implementation Strategy (IS) describes how SSRRH plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA) and is aligned with the hospital's charitable mission. The IS describes:

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[4] Robert Wood Johnson Foundation. (2016). *Building a Culture of Health: Sense of Community.* Retrieved from https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html.

[5] Descriptions of each of these PHNs can be found in the 2022 CHNA report, Table 22.

- 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 SSRRH 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 to focus on the health needs listed below.

Process and Criteria Used to Select Needs

SSRRH's senior community benefit staff and SSRRH leadership reviewed the 2022 CHNA report and, based upon the data and findings, selected the needs that the hospital could most appropriately address. The following four health needs were selected:[6]

1. Access to Care
2. Behavioral Health
3. Economic and Housing Stability

Actionable Insights, LLC (AI) provided guidance and expertise for the IS process and conducted research on evidence-based and promising practices for each selected health strategy. AI is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

Description of Health Needs That the Hospital Plans to Address

Access to Care

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. 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

[6] For the purposes of simplicity and clarity in the Implementation Strategy Plan, the following changes were made to the names of the needs: (1) The needs "Access to Quality Primary Care Health Services," "Access to Specialty and Extended Care," and "Access to Dental Care and Preventive Services" were merged and renamed "Access to Care." (2) The need "Access to Basic Needs Such as Housing, Jobs, and Food" was renamed "Economic and Housing Stability." (3) The need "Access to Mental/Behavioral Health and Substance Use Services" was renamed "Behavioral Health."

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.

During CHNA 2022, the community reported that Medi-Cal patients were a particular concern, indicating that these patients are not admitted quickly for the extent of care needs they have, and that lower-income families on Medi-Cal experience a lack of primary care in the county. Community members noted that many patients are treated quickly in the emergency room and then released, only to return multiple times. They also indicated that individuals experiencing homelessness clearly lack access to primary care. Finally, they indicated a lack of access to culturally, linguistically appropriate primary health care services for the Spanish-speaking communities in Sonoma County.

Additionally, respondents noted that access is constrained by healthcare staffing issues. Respite care placement, home health care for older adults, and other forms of specialty care as well as primary care were identified as lacking in the county. Many of the issues described by the community have been shown to generate inequity in health outcomes.

The community offered the following solutions to improve primary care access:

- Increase the living wage for area healthcare providers to improve turnover and the employment pipeline.
- Develop a school health model, e.g., establish federally qualified health centers (FQHCs) at county schools.
- Increase the competency of providers to understand how patient's identities (race, class, ability, income, gender, sexuality, etc.) affect their primary care needs.
- Increase and invest in bilingual providers.
- Expand local FQHC and community clinic capacity to reduce burden on emergency department usage for primary care.

The following statistics (both core indicators and drivers) performed worse in Sonoma County when compared to state averages:

- Stroke Mortality
- Chronic Lower Respiratory Disease Mortality
- Heart Disease Mortality
- Cancer Mortality
- Alzheimer's Disease Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Colorectal Cancer Prevalence
- Lung Cancer Prevalence
- Primary Care Shortage Area
- Specialty Care Providers
- Medically Underserved Area
- Homelessness Rate

Behavioral Health

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.

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."[7] Ensuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community.

The extensive input from the community related to behavioral health included concern about increasingly high rates of substance use and overdose, particularly around methamphetamine and fentanyl use. Additionally, respondents expressed concern about the disproportionately high rates of suicide among Latinx and Black populations. Community members indicated a need for greater access to substance use treatment for all (non-English-speakers were specifically mentioned), more trained behavioral health providers, and improved reimbursement rates for behavioral telehealth. Service providers stated that there are mental/behavioral health services available in the community about which community members are not aware. Additionally, respondents described a connection between substance use and homelessness, discussed in greater depth in the section on Housing & Homelessness.

CHNA participants also expressed significant concern about youth behavioral/mental health, which they felt was poor, as shown by increased suicides among youth, increased school violence in area schools, and increased substance use among youth. Respondents reported that the county has limited mental/behavioral health services available for youth. Participants mentioned the need to address stigma around treatment, and desired an integrated approach to mental/behavioral healthcare services. There was also a focus on the need for services for individuals with severe mental illness who are also experiencing homelessness.

The community offered the following solutions to improve behavioral health:

- Increase mental health mobile units.
- Increase awareness in the community of existing resources, including substance-use treatment services.
- Increase trained behavioral health providers, particularly bilingual and culturally-competent providers.
- Improve access to substance use treatment for all, and particularly for non-English-speakers and individuals experiencing homelessness.
- Improve reimbursement rates for behavioral telehealth.
- Establish additional services specifically for youth (e.g., child psychologists, counselors, and therapists in the schools).

The following mental and behavioral health statistics (both core indicators and drivers) performed worse in Sonoma County when compared to state averages:

- Suicide Mortality
- Poor Mental Health Days
- Frequent Mental Distress

[7] Robert Wood Johnson Foundation. (2016). *Building a Culture of Health: Sense of Community.* Retrieved January 2022 from https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html.

- Poor Physical Health Days
- Frequent Physical Distress
- Excessive Drinking
- Drug Induced Death
- Adult Smoking
- Primary Care Shortage Area
- Mental Health Care Shortage Area
- Medically Underserved Area
- Homelessness Rate

Economic and Housing Stability

Access to stable employment and quality education are vital for survival. Maslow's Hierarchy of Needs[8] 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, including quality affordable housing, adequate employment and income, as well as education, influence individual health as much as health behaviors and access to clinical care.[9]

CHNA participants discussed the need for living-wage employment opportunities. They additionally discussed how the rising cost of living has displaced families and made it difficult to keep educators in the county. They identified significant inequities between those who have economic stability and those who do not, and connected economic instability with housing instability. The community additionally outlined issues in the county around educational attainment, from low student engagement to the rising costs of higher education. The community expressed concern about the dearth of affordable housing and high rates of homelessness in the county. The lack of services available to individuals experiencing homelessness was a special focus of the community, including LGBTQ+ youth, families, the undocumented, mentally ill, and older adults, especially those with dementia. Supportive housing for those with behavioral health challenges was also mentioned.

The community offered the following solutions to improve economic and housing stability:

- Increase investment in affordable early childhood education.
- Increase living-wage employment opportunities.
- Increase wages for educators.
- Increase social safety net for those who are at the margins of financial insecurity, including a universal basic income and other safety net programs.
- Increase interventions for low-income high school students to improve high school graduation and college enrollment rates.
- Increase affordable housing options.
- Increase services for Spanish-speaking/immigrant populations.
- Invest in mental health and drug addiction services.
- Increase diversification of interim and emergency housing options.
- Establish robust eviction diversion programs with full-service case management support.

The following statistics (both core indicators and drivers) performed worse in Sonoma County when compared to state averages:

- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days

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

[9] 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.

- Frequent Physical Distress
- Drug Induced Death
- Limited Access to Healthy Foods
- Food Environment Index
- Medically Underserved Area
- Homelessness Rate

Plan for Addressing Health Needs

ACCESS TO CARE

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support safety net clinics[10]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Increased access to healthcare
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to healthcare among vulnerable populations[11, 12, 13]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members

[10] Knudsen, J., & Chokshi, D. A. (2021). Covid-19 and the Safety Net—Moving from Straining to Sustaining. *New England Journal of Medicine*, 385(24), 2209-2211. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp2114010

[11] Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: a systematic review. *Journal of Health Care for the Poor and Underserved*, 24(2), 499-524. Retrieved from https://muse.jhu.edu/article/508571/pdf

[12] McGuire, J., Gelberg, L., Blue-Howells, J., & Rosenheck, R. A. (2009). Access to primary care for homeless veterans with serious mental illness or substance abuse: a follow-up evaluation of co-located primary care and homeless social services. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(4), 255-264.

[13] Matula, S. R., Beers, J., Errante, J., Grey, D., Hofmann, P. B., & Schecter, W. P. (2009). Operation Access: a proven model for providing volunteer surgical services to the uninsured in the United States. *Journal of the American College of Surgeons*, 209(6), 769-776.

Anticipated Outcomes	Reduced emergency department admissions for primary care, and improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of emergency department admissions (including demographics if available)
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to social services that address housing insecurity, which is a driver of poor healthcare access[14, 15, 16, 17]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Improved quality of life among at-risk/unhoused individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of referrals to social and mental health services

[14] Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A.H., Arya, N., & Hannigan, T. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PloS One*, 15(4), p.e0230896. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230896

[15] Rosenheck, R. A., Resnick, S. G., & Morrissey, J. P. (2003). Closing service system gaps for homeless clients with a dual diagnosis: Integrated teams and interagency cooperation. *Journal of Mental Health Policy and Economics*, 6(2), 77-88. Retrieved from http://www.icmpe.org/test1/journal/issues/v6pdf/6-077_text.pdf

[16] Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, 88(11): 1610-1615. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610

[17] Fitzpatrick-Lewis, D., Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F., & Hwang, S. W. (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health*, 11(1), 638.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to healthcare via better transportation options, mobile clinics, and/or telehealth[18, 19, 20, 21, 22]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Fewer missed appointments/reduced no-show rate
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of telehealth visits (including demographics if available) Number of visits to mobile clinics (including demographics if available)

[18] Flodgren, G., Rachas, A., Farmer, A. J., Inzitari, M., & Shepperd, S. (2015). Interactive telemedicine: effects on professional practice and health care outcomes. *The Cochrane Library.* Retrieved from: https://www.researchgate.net/profile/Gerd_Flodgren/publication/281588584_Interactive_telemedicine_effects_on_professional_practice_and_health_care_outcomes/links/57ac28ec08ae0932c9725445.pdf

[19] Bhatt, J, Bathija, P. (2018). Ensuring Access to Quality Health Care in Vulnerable Communities. *Academic Medicine*, 93: 1271-1275.

[20] Tomer, A., Fishbane, L, Siefer, A., & Callahan, B. (2020). Digital prosperity: How broadband can deliver health and equity to all communities. *Brookings Institute.* Retrieved from https://www.brookings.edu/research/digital-prosperity-how-broadband-can-deliver-health-and-equity-to-all-communities/ See also: Zuo, G. W. (2021). Wired and Hired: Employment Effects of Subsidized Broadband Internet for Low-Income Americans. *American Economic Journal: Economic Policy.* 13(3): 447-82. Retrieved from https://www.aeaweb.org/articles?id=10.1257/pol.20190648

[21] Myers, B., Racht, E., Tan, D., & White, L. (2012). *Mobile integrated healthcare practice: a healthcare delivery strategy to improve access, outcomes, and value.* Retrieved from: http://media.cygnus.com/files/cygnus/document/EMSR/2013/DEC/medtronic-download-12-9_11273203.pdf

[22] Beaudoin, J., Farzin, Y. H., & Lawell, C. Y. C. L. (2015). Public transit investment and sustainable transportation: A review of studies of transit's impact on traffic congestion and air quality. *Research in Transportation Economics*, 52: 15-22.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or partnerships to collaborate with other providers in the county to reduce silos around access to care[23, 24, 25, 26, 27]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Improved collaboration and efficiency in healthcare access, reduced wait times for appointments, and improved health equity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of services provided (surgeries, procedures, etc.) Number of SSRRH medical volunteers Average wait times for appointments

[23] Ginsburg, S. (2008). *Colocating health services: a way to improve coordination of children's health care?* (Vol. 41). New York, NY: Commonwealth Fund. Retrieved from www.commonwealthfund.org/usr_doc/Ginsburg_Colocation_Issue_Brief.pdf

[24] Unützer, J., Harbin, H, Schoenbaum, M., & Druss, B. (2013). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes.* Health Home Information Resources Center. Retrieved from https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. See also: Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 347: f4913.

[25] Brown, R. S., Peikes, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, 31(6): 1156-1166. Retrieved from http://content.healthaffairs.org/content/31/6/1156.full.html

[26] Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care*, 15(6). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/

[27] Mohler, J. M. (2013). Collaboration across clinical silos. *Frontiers of Health Services Management,* 29(4): 36-44.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support workforce development efforts to increase the number of bilingual healthcare workers from the local community[28, 29, 30, 31, 32, 33]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Increase levels of culturally competent, compassionate, and respectful healthcare delivery
Anticipated Outcomes	Greater supply of bilingual primary care providers and increased access to care among underserved community members, especially individuals with limited English proficiency
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of family medicine residents trained Number of patient visits per year at SSRRH (including demographics if available) Number of patient visits per year at local FQHC (including demographics if available)

[28] Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.

[29] Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.

[30] See, for example, Sieck, L., Chatterjee, T., & Birch, A. (2022). Priming the pipeline: inspiring diverse young scholars in the radiologic sciences begins during early childhood education. *Journal of the American College of Radiology*, 19(2), 384-388. Retrieved from https://www.jacr.org/article/S1546-1440(21)00852-8/fulltext

[31] Renner, D. M., Westfall, J. M., Wilroy, L. A., & Ginde, A. A. (2010). The influence of loan repayment on rural healthcare provider recruitment and retention in Colorado. *Rural and Remote Health*, 10(4), 220-233. Retrieved from https://search.informit.org/doi/pdf/10.3316/informit.396789141569821

[32] Humphreys, J., Wakerman, J., Pashen, D., & Buykx, P. (2017). *Retention strategies and incentives for health workers in rural and remote areas: what works?* Retrieved from https://openresearch-repository.anu.edu.au/bitstream/1885/119206/3/international_retention_strategies_research_pdf_10642(1).pdf

[33] Hosek, J., Nataraj, S., Mattock, M. G., & Asch, B. J. (2017). The Role of Special and Incentive Pays in Retaining Military Mental Health Care Providers. *RAND Corporation.* Retrieved from https://apps.dtic.mil/sti/pdfs/AD1085233.pdf

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support community health worker (promotorx) and/or healthcare navigator programs[34, 35, 36, 37]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Increase levels of culturally competent, compassionate, and respectful healthcare delivery
Anticipated Outcomes	Increased access to care among underserved community members, especially low-income individuals and those with limited English proficiency
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of community health workers/healthcare navigators Number of persons enrolled in program(s) (including demographics if available)

[34] Centers for Disease Control and Prevention. (2016). *Addressing chronic disease through community health workers.* Retrieved from www.cdc.gov/dhdsp/docs/chw_brief.pdf

[35] Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human Resources for Health*, 16(1), 39. Retrieved from https://link.springer.com/article/10.1186/s12960-018-0304-x

[36] Whitley, E. M., Everhart, R. M., & Wright, R. A. (2006). Measuring return on investment of outreach by community health workers. *Journal of Health Care for the Poor and Underserved*, 17(1), 6-15. Retrieved from https://chwcentral.org/wp-content/uploads/2014/01/Whitley-Return-on-Investment-CHWs.pdf

[37] Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, 117(S15): 3541-3550. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/cncr.26264/full. See also: Yates, P. (2004). Cancer care coordinators: Realizing the potential for improving the patient journey. *Cancer Forum*, 28(3):128-132. Retrieved from http://eprints.qut.edu.au/1739/1/1739.pdf.

BEHAVIORAL HEALTH

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to increase mental/behavioral health services (including acute mental health and psychiatric services) for youth and other vulnerable populations[38, 39, 40, 41, 42, 43, 44]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants,

[38] Chiesa, A. & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research*, 187(3), 441-453. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20846726 ; also, Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice*, 18(4), 233-252. Retrieved from www.ncbi.nlm.nih.gov/pubmed/22805898 ; see also Zenner, C., Herrnleben-Kurz, S., & Walach, H. (2014). Mindfulness-based interventions in schools—a systematic review and meta-analysis. *Frontiers in Psychology*, 5, 603. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC4075476/

[39] Lopez-Maya, E., Olmstead, R., & Irwin, M. R. (2019). Mindfulness meditation and improvement in depressive symptoms among Spanish-and English speaking adults: A randomized, controlled, comparative efficacy trial. *PloS One*, 14(7), e0219425. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0219425

[40] Firth, J., Torous, J., Nicholas, J., Carney, R., Pratap, A., Rosenbaum, S., & Sarris, J. (2017). The efficacy of smartphone-based mental health interventions for depressive symptoms: A meta-analysis of randomized controlled trials. *World Psychiatry*, 16: 287-298. Retrieved from doi.org/10.1002/wps.20472

[41] Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *International Review of Psychiatry*, 26(4), 467-475. Retrieved from https://www.researchgate.net/profile/Gergoe-Hadlaczky/publication/264867737_Mental_Health_First_Aid_is_an_effective_public_health_intervention_for_improving_knowledge_attitudes_and_behavior_A_meta-analysis/links/55e99d7308ae21d099c2fcc8/Mental-Health-First-Aid-is-an-effective-public-health-intervention-for-improving-knowledge-attitudes-and-behavior-A-meta-analysis.pdf

[42] Suicide Prevention Resource Center. (2012). *QPR Gatekeeper Training for Suicide Prevention.* Retrieved from https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention ; see also Suicide Prevention Resource Center. (2016). *SOS Signs of Suicide Middle School and High School Prevention Programs*. Retrieved from https://www.sprc.org/resources-programs/sos-signs-suicide and see Holm, A. L., Salemonsen, E., & Severinsson, E. (2021). Suicide prevention strategies for older persons—An integrative review of empirical and theoretical papers. *Nursing Open*, 8(5), 2175-2193. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1002/nop2.789

[43] Carr, A. (2000). Evidence-based practice in family therapy and systemic consultation: Child-focused problems. *Journal of Family Therapy*, 22(1), 29-60. Retrieved from https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/1467-6427.00137

[44] Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology*, 58(3), 279. Retrieved from https://www.researchgate.net/profile/Steven-Benish-2/publication/51158332_Culturally_Adapted_Psychotherapy_and_the_Legitimacy_of_Myth_A_Direct-Comparison_Meta-Analysis/links/5d84288f458515cbd19f4721/Culturally-Adapted-Psychotherapy-and-the-Legitimacy-of-Myth-A-Direct-Comparison-Meta-Analysis.pdf See also: Castro, F. G., Barrera Jr, M., & Steiker, L. K. H. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, 6, 213. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4262835/

	sponsorships, and partnerships will be reported at year end.
Goal	Promote mental health and the healthy development of children and families
Anticipated Outcomes	Improved mental health among youth and members of other vulnerable populations
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of encounters

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to increase integration of behavioral health services into existing primary care settings for vulnerable county residents[16, 23, 24]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Promote mental health and the healthy development of children and families
Anticipated Outcomes	Improved access to mental healthcare and substance use services for vulnerable populations and improved mental and behavioral health among homeless and other vulnerable individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available)

ECONOMIC AND HOUSING STABILITY

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that expand affordable housing opportunities (rental and ownership), including those on existing residential properties[45, 46]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health

[45] Hope, H. (2022). *Accessory dwelling units promoted as a strategy to increase affordable housing stock at White House event.* Smart Growth America. Retrieved from https://smartgrowthamerica.org/white-house-adus-event/ See also: California Department of Housing and Community Development. (2021). *Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs).* Retrieved from https://www.hcd.ca.gov/policy-research/accessorydwellingunits.shtml

[46] Benton. A. L. (2014). *Creating a Shared Home: Promising Approaches for Using Shared Housing to Prevent and End Homelessness in Massachusetts.* Retrieved from https://ash.harvard.edu/files/ash/files/3308562.pdf?m=1637364880

Anticipated Outcomes	Increased amount of and access to affordable housing
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of affordable housing units in community
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support local homeless prevention organizations and collaboratives that provide temporary financial assistance, legal support, counseling, case management, and/or other needed services to vulnerable individuals and families at risk of losing their housing[47, 48, 49]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Increased social services to prevent homelessness, and more community members remain independent longer
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants linked to social services (e.g., cash aid, legal support, counseling)

[47] Schapiro, R., Blankenship, K., Rosenberg, A., & Keene, D. (2022). The Effects of Rental Assistance on Housing Stability, Quality, Autonomy, and Affordability. *Housing Policy Debate*, 32(3), 456-472. Retrieved from https://www.nlihc.org/sites/default/files/Effects_of_Rental_Assistance.pdf and see Pfeiffer, D. (2018). Rental housing assistance and health: Evidence from the survey of income and program participation. *Housing Policy Debate*, 28(4), 515-533. Retrieved from http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence_Survey-of-Income-Program-Participation.pdf. See also Liu, L. (2022). *Early Effects of the COVID Emergency Rental Assistance Programs: A Case Study.* Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4095328

[48] Holl, M., Van Den Dries, L., & Wolf, J. R. (2016). Interventions to prevent tenant evictions: a systematic review. *Health & Social Care in the Community*, 24(5), 532-546. Retrieved from https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12257 . See also Cassidy, M. T., & Currie, J. (2022). *The Effects of Legal Representation on Tenant Outcomes in Housing Court: Evidence from New York City's Universal Access Program (No. w29836).* National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w29836/w29836.pdf

[49] Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27(4), 334. See also Santa Clara County. (Undated). *Evidence That Supportive Housing Works*. Retrieved from https://housingtoolkit.sccgov.org/sites/g/files/exjcpb501/files/Evidence%20That%20Supportive%20Housing%20Works.pdf

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that improve substandard living conditions, including overcrowding[50, 51]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Reduced proportion of overcrowded, sub-standard dwellings and related improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served

[50] ChangeLab Solutions. (2015). *Up to Code: Code Enforcement Strategies for Healthy Housing.* Retrieved from https://changelabsolutions.org/sites/default/files/Up-tp-Code_Enforcement_Guide_FINAL-20150527.pdf

[51] See, for example, Kercsmar, C. M., Dearborn, D. G., Schluchter, M., Xue, L., Kirchner, H. L., Sobolewski, J., Greenberg, S. J., Vesper, S. J. & Allan, T. (2006). Reduction in asthma morbidity in children as a result of home remediation aimed at moisture sources. *Environmental Health Perspectives*, 114(10): 1574-1580. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626393/ . See also: Sauni, R., Uitti, J., Jauhiainen, M., Kreiss, K., Sigsgaard, T., & Verbeek, J. H. (2013). Remediating buildings damaged by dampness and mould for preventing or reducing respiratory tract symptoms, infections and asthma. *Evidence-Based Child Health: A Cochrane Review Journal*, 8(3), 944-1000.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support Housing First models that include employment for currently or recently unhoused individuals[52, 53, 54, 55, 56]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	More people earning a living wage
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants Number of participants employed before and after program participation

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs and initiatives for the retention of providers in community/safety net clinic[31, 32, 33]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	Reduced economic insecurity, more people employed in healthcare settings, and greater diversity among healthcare workers

[52] Tsemberis, S., Joseph, H., et al. (2012). Housing First for Severely Mentally Ill Homeless Methadone Patients. *Journal of Addictive Diseases*, (31)3, 270-7. See also Davidson, C., et al. (2014). Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use. *Psychiatric Services*, 65(11), 1318-24.

[53] Poremski, D., Rabouin, D., & Latimer, E. (2017). A randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(2), 217-224.

[54] Bretherton, J., & Pleace, N. (2019). Is work an answer to homelessness?: Evaluating an employment programme for homeless adults. *European Journal of Homelessness*, 59-83. Retrieved from https://eprints.whiterose.ac.uk/145311/1/13_1_A3_Bretherton_v02.pdf

[55] Johnsen, S., & Watts, B. (2014). Homelessness and Poverty: reviewing the links. In Paper presented at the *European Network for Housing Research (ENHR)* conference (Vol. 1, p. 4). Retrieved from https://pure.hw.ac.uk/ws/portalfiles/portal/6831437/ENHRfullpaper_H_P.pdf

[56] See, for example, Listwan, S. J., Cullen, F. T., & Latessa, E. J. (2006). How to prevent prisoners re-entry programs from failing: Insights from evidence-based corrections. *Fed. Probation*, 70, 19. Retrieved from https://www.uc.edu/content/dam/uc/ics/docs/ListwanCullenLatessaHowToPrevent.pdf; see also Duwe, G. (2015). The benefits of keeping idle hands busy: An outcome evaluation of a prisoner reentry employment program. *Crime & Delinquency*, 61(4), 559-586.

Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of providers by tenure in each clinic Number of loans repaid
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that offer employment training to vulnerable populations[56]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	Reduced unemployment, more people earning a living wage
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people trained Number of people employed before and after training
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs shown to increase the pipeline of diverse education and healthcare providers[28, 29, 30]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Reduce barriers to employment/careers that provide community members with a living wage, continue to build healthcare workforce
Anticipated Outcomes	Effective training and education of future healthcare workforce, more people employed in healthcare settings, greater diversity among healthcare workers
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of family medicine residents and allied health program interns and fellows trained (including demographics if available) Number of students participating in pipeline programs (including demographics if available) Number of staff supervising and training students

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support integrated support services on school campuses (e.g., healthy eating, well-being)[57, 58]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage, continue to build healthcare workforce
Anticipated Outcomes	Greater student well-being, effective training and education of future healthcare workforce
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of students served Number of classes/workshops provided Number of referrals to social and mental health services

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increased access to high-quality affordable childcare[59, 60]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	Reduced unemployment, more people earning a living wage
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of childcare slots countywide (by age range if available – infant, toddler, preschool)

[57] Lewallen, T. C., Hunt, H., Potts-Datema, W., Zaza, S., & Giles, W. (2015). The whole school, whole community, whole child model: A new approach for improving educational attainment and healthy development for students. *Journal of School Healt*h, 85(11), 729-739. Retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1111/josh.12310

[58] See for example: Gueldner, B. A., Feuerborn, L. L., & Merrell, K. W. (2020). *Social and emotional learning in the classroom: Promoting mental health and academic success.* New York: Guilford Publications.

[59] Henry, C., Werschkul, M., Rao, M. C., & Lee, C. (2003). *Child Care Subsidies Promote Mothers' Employment and Children's Development.* Institute for Women's Policy Research. Retrieved from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.643.7677&rep=rep1&type=pdf

[60] Bivens, J., Garcia, E., Gould, E., Weiss, E., & Wilson, V. (2016). *It's Time for an Ambitious National Investment in America's Children: Investments in Early Childhood Care and Education Would Have Enormous Benefits for Children, Families, Society, and the Economy*. Economic Policy Institute. Retrieved from: https://files.eric.ed.gov/fulltext/ED568888.pdf

Evaluation Plans

As part of SSRRH's ongoing community health improvement efforts, it partners with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through its triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

SSRRH will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, SSRRH will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report year-end performance on annual metrics, which are synthesized and shared with the public as well as state and federal regulatory bodies.

6. Needs Sutter Santa Rosa Regional Hospital Plans Not to Address

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

1. **Increased Community Connections:** This topic is outside of SSRRH's core competencies (i.e., SSRRH has little expertise in this area) and the hospital feels it cannot make a significant impact on this need through community benefit investment. However, SSRRH merged aspects of this need into "Behavioral Health" and will address community connections through mental health initiatives.

2. **Injury and Disease Prevention and Management:** The community indicated this need as a lower priority than the needs chosen. SSRRH recognizes the importance of injury and disease prevention and management as part of overall healthcare, and the hospital is addressing aspects of this need in "Access to Care."

7. Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board on October 19, 2022.