Sutter Health

Novato Community Hospital

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

180 Rowland Way, Novato, CA 94945
License #110000375
www.sutterhealth.org

Table of Contents

Introduction

The Implementation Strategy Plan describes how Sutter Health Novato Community Hospital (NCH), 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.

NCH 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 180 Rowland Way, Novato, CA 94945, ATTN TO: Community Benefit; and
- In-person at the hospital's Information Desk.

1. Executive Summary

NCH 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. Access to Functional Needs

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

2. 2022 Community Health Needs Assessment Summary

NCH participates in a collective needs assessment process with other healthcare partners, called the Healthy Marin Partnership (HMP). Members of the HMP include MarinHealth Medical Center, Novato Community Hospital, Marin County Health and Human Services, Marin Community Foundation, and Kaiser Permanente Northern California. The HMP completes a CHNA every three years, which uses primary and secondary data to identify priority issues affecting the health of Marin County residents. Community Health Insights was contracted to conduct the 2022 – 2024 Marin County CHNA on behalf of HMP 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. 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 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 five health needs were identified in the 2022 CHNA, described later in this report. The full 2022 Community Health Needs Assessment conducted by NCH is available at https://www.sutterhealth.org/.

3. Definition of the Community Served by the Hospital

Marin County is the defined service area for NCH. Marin County includes the cities of Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, Tiburon, and

the coastal towns of Stinson Beach, Bolinas, Point Reyes, Inverness, Marshall, and Tomales. The county covers 520 square miles, much of which is preserved as parks, tidelands, and agricultural areas. Among them are the Point Reyes National Seashore, Mount Tamalpais State Park and Game Refuge, and Samuel P. Taylor State Park. A large part of the population lives along the Highway 101 corridor, dividing the county into a more urban environment in the eastern part of the county and a more rural environment along the coast and the western side of the county.

The total population of Marin County was 259,943 in 2019. The majority of the county's population is white (71%), followed by Latinx (16%). The Black population in Marin County (2%) had the lowest life expectancy, highest premature age-adjusted mortality, highest premature death, and highest percent of babies born with low birth weight, compared to any other racial/ethnic group. The Black population in Marin also had a premature age-adjusted death rate and level of premature deaths (YPLL) that was more than twice that of all other groups. Health factor data showed the Latinx population having lower high school completion rates, lower college rates, lower third-grade reading and math levels, a higher percentage of the population living in poverty, and the highest uninsured population in comparison to all other racial and ethnic groups. Data on median household income revealed the lowest median income was among the Black population In Marin County.

The county consists of 30 ZIP codes. Those with the highest poverty levels are 94901 (San Rafael), 94924 (West Marin - Bolinas, Five Brooks, Woodville), 94933 (Lagunitas/Forest Knolls), and 94950 (West Marin - Point Reyes Station). In addition, ZIP codes with median household incomes lower than the state's $75,235 include 94956 (West Marin - Point Reyes Station and Inverness) and 94973 (Woodacre/San Geronimo). Finally, ZIP code 94937 (West Marin - Inverness and Seahaven) has a higher percentage of uninsured people compared to the state's 13 percent. All of these ZIP codes, with the exception of 94933 and 94973, were identified as Communities of Concern, geographic areas within Marin 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 94903 (San Rafael), 94945 and 94947 (both Novato), 94965 (Marin City), 94929 (West Marin - Dillon Beach), 94940 (West Marin - Marshall), and 94971 (West Marin - Valley Ford and Tomales Bay).

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[1] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[2]

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.

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

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

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 well-being for all."[3] 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. **Access to Functional Needs.** Functional needs refers to an individual's access to adequate transportation 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.

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 using 12 potential health needs (PHNs). These PHNs were derived from a list of common health needs in previously conducted CHNAs throughout Northern California. Data were analyzed to discover which, if any, of the PHNs were present in Marin 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 plan describes how NCH 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 NCH 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.

[3] 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.

Process and Criteria to Select Needs

Sutter Health's senior community benefit staff and NCH 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 health needs were selected:[4]

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.

In addition, 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 such as 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 said that the lack of adequate transportation is a major barrier to accessing care. 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 bilingual/bicultural primary care providers.
- Expand local FQHC and community clinic capacity to reduce burden on emergency department usage for primary care.
- Engage young bilingual members of the community to go into healthcare professions to help meet the need for culturally sensitive care.
- Develop a school health model, e.g., establish federally qualified health centers (FQHCs) at county schools.
- Establish a volunteer transportation network to get people to care, similar to that in Sonoma County.

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

---

[4] 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 need "Access to Quality Primary Care Health Services" was renamed "Access to Care." (2) The need "Access to Mental/Behavioral Health and Substance Use Services" was renamed "Behavioral Health." (3) The need "Access to Basic Needs Such as Housing, Jobs, and Food" was renamed "Economic and Housing Stability."

- Alzheimer's Disease Mortality
- Breast Cancer Prevalence
- Cancer Mortality
- Colon Cancer Screening
- Income Inequality
- Influenza and Pneumonia Mortality
- Medically Underserved Area

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."[5] 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, including mortality from overdoses. 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.

CHNA participants also expressed significant concern about youth behavioral/mental health, which they felt was poor, and the limited number of 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 following mental and behavioral health statistics (both core indicators and drivers) performed worse in Marin County when compared to state averages:

- Excessive Drinking
- Medically Underserved Area
- Income Inequality
- Juvenile Arrest Rate
- Suicide Mortality

Economic and Housing Stability

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[6] suggests that only when people have

[5] 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.

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

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.[7]

CHNA participants discussed the need for living-wage employment opportunities. They identified significant inequities between those who have economic stability and those who do not, and connected economic instability with housing instability.

The community expressed concern about the dearth of affordable housing. The lack of services available to individuals experiencing homelessness was a special focus of the community, including families, the undocumented, mentally ill, and older adults, especially those with dementia. Supportive housing for those with behavioral health challenges was also mentioned.

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

- Income Inequality
- Juvenile Arrest 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[8]
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	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[9, 10]

[7] 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.

[8] 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

[9] 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

[10] 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.

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	Improve access to affordable, high-quality healthcare services for vulnerable community members
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[11, 12, 13, 14]
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	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

[11] 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

[12] 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

[13] 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

[14] 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[15, 16, 17, 18, 19]
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	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)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support improved communication about available healthcare services[20, 21, 22, 23]
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	Improve access to affordable, high-quality healthcare services for vulnerable community members

[15] 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

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

[17] 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

[18] 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

[19] 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.

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

[21] 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

[22] 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

[23] Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259-267. Retrieved from http://doh.hpc.go.th/data/HL/HLAsPublicHealthGoalEng.pdf

Anticipated Outcomes	Increased knowledge and use of available healthcare services
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of visits per year to NCH Number of visits per year to local FQHC

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships with other providers in the county to reduce silos around access to care (e.g., streamlining intake and referral process, universal walk-in policy)[24, 25, 26, 27, 28]
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	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 NCH medical volunteers Average wait times for appointments

[24] 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

[25] 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, 2013*(347):f4913.

[26] 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

[27] 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/

[28] 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[29, 30, 31, 32, 33, 34]
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	Increase levels of culturally competent, compassionate, and respectful healthcare delivery
Anticipated Outcomes	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)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support community health worker (promotorx) and/or healthcare navigator programs[20, 21, 22, 26, 35]
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	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

[29] 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.

[30] 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.

[31] 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

[32] 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

[33] 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

[34] 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

[35] 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.

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)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support athletics training at local high schools[36]
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 unintentional injuries in the community
Anticipated Outcomes	Reduced sports-related injuries, including traumatic brain injuries and reduced unintentional injury deaths from sports
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of athletes served Number of games supported

[36] Owoeye, O., VanderWey, M. J., & Pike, I. (2020). Reducing injuries in soccer (football): an umbrella review of best evidence across the epidemiological framework for prevention. *Sports Medicine-Open*, 6(1), 1-8. Retrieved from https://sportsmedicine-open.springeropen.com/articles/10.1186/s40798-020-00274-7. See also: Emery, C. A., Roy, T. O., Whittaker, J. L., Nettel-Aguirre, A., & Van Mechelen, W. (2015). Neuromuscular training injury prevention strategies in youth sport: a systematic review and meta-analysis. *British Journal of Sports Medicine*, 49(13), 865-870. Retrieved from https://www.researchgate.net/profile/Jackie-Whittaker/publication/277311741_Neuromuscular_training_injury_prevention_strategies_in_youth_sport_A_systematic_review_and_meta-analysis/links/5567291308aeccd77737832b/Neuromuscular-training-injury-prevention-strategies-in-youth-sport-A-systematic-review-and-meta-analysis.pdf

BEHAVIORAL HEALTH

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increasing mental/behavioral health services for youth and other vulnerable populations[37, 38, 39, 40, 41, 42, 43]
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	Promote mental health among youth and other vulnerable populations

[37] 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/

[38] 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

[39] 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

[40] 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

[41] 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

[42] 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

[43] 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/

Anticipated Outcomes	Improved mental health among youth and members of other vulnerable populations
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Possible metrics include: Number of people served (including demographics if available)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increasing integration of behavioral health services into existing primary care settings for vulnerable county residents[13, 24, 25]
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	Promote mental health among youth and other vulnerable populations
Anticipated Outcomes	Improved access to mental healthcare and substance use services for vulnerable populations and improved mental and behavioral health among homeless and at-risk 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[44, 45]
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 housing instability among community members in order to support improved health
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, case management, and/or

[44] 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

[45] 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

	other needed services to vulnerable individuals and families at risk of losing their housing[46, 47, 48, 49, 50]
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 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)
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that improve substandard living conditions, including overcrowding[51, 52]

[46] 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

[47] 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

[48] 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

[49] Reif, S., George, P., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Recovery housing: Assessing the evidence. *Psychiatric Services*, *65*(3), 295-300. Retrieved from https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300243

[50] Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, 96(10), 1727-1729. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2005.070839. See also: Jason, L. A., Davis, M. I., & Ferrari, J. R. (2007). The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive behaviors*, *32*(4), 803-818.

[51] 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

[52] 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.

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 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
Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support initiatives to routinize the use of social determinants of health screenings (e.g., ability to afford medications; safe housing; food security) during primary care visits[53, 54]
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 housing instability among community members in order to support improved health
Anticipated Outcomes	Improved health outcomes for those at-risk of and/or experiencing homelessness
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of referrals to social services
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[55, 56, 57, 58, 59]

[53] Andermann, A. (2018). Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public Health Reviews*, 39(1), 1-17. Retrieved from https://link.springer.com/article/10.1186/s40985-018-0094-7

[54] O'Gurek, D. T., & Henke, C. (2018). A practical approach to screening for social determinants of health. *Family Practice Management*, 25(3), 7-12. Retrieved from https://www.aafp.org/pubs/fpm/issues/2018/0500/p7.html?cmpid=em_FPM_20180516 and see American Academy of Family Physicians. (Undated). *Social Needs Screening Tool*. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

[55] 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.

[56] 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.

[57] 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

[58] 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

[59] 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

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
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[32, 33, 34]
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
Anticipated Outcomes	Reduced economic insecurity, more people employed in healthcare settings, and greater diversity among healthcare workers
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of providers by tenure in each clinic Number of loans repaid

Evaluation Plans

As part of NCH'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.

NCH 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, NCH 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 Health Novato Community Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. NCH 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:** NCH merged aspects of this need into the "Mental Health" need and will address community connections through mental health initiatives.

---

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.

2. **Access to Functional Needs:** NCH is better positioned to address this need via initiatives related to healthcare access & delivery and economic & housing stability. Additionally, this need was of lower priority to the community than the needs that NCH selected.

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.