Sutter Health

Sutter Lakeside Hospital

2022–2024 Community Benefit Plan
Responding to the 2022 Community Health Needs Assessment
Submitted to the Department of Health Care Access and Information May 2023

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License #110000094
www.sutterhealth.org

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Note: This community benefit plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

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

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

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

Sutter Lakeside Hospital welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022-2024 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at 5176 Hill Road East, Lakeport, CA 95453, ATTN TO: Community Benefit; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Lakeside Hospital 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. Our 65,000 employees and associated clinicians serve more than 3 million patients in California through our hospitals, primary and specialty care centers, 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 2022 was $899 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 system has implemented charity care policies to help provide access to medically necessary care for eligible patients, regardless of their ability to pay. In 2022, Sutter Health invested $82 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 do not cover the full costs of providing care. In 2022, Sutter Health invested $615 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helps 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 and works to achieve health equity by visiting sutterhealth.org/community-benefit.

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 Care
2. Health Risk Behaviors
3. Mental Health
4. Financial Stability: Employment
5. Financial Stability: Cost of Living
6. Health Conditions
7. Food Security
8. Community Safety
9. Environment and Infrastructure
10. Community Vitality: Civic
11. Housing: Unhoused
12. Housing: Costs
13. Community Vitality: Economic

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

2022 Community Health Needs Assessment Summary

For 2022, the collaborative between Hope Rising, Adventist Health Clear Lake, Lake County Public Health, and Sutter Lakeside Hospital conducted the CHNA. This process involved input from community focus groups and key informant interviews representing broad interests of the community served by two hospitals and collaborative organizations. Input was gathered from: local public health officials, community-based organizations, medical providers, students, parents and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community.

In addition to focus groups and interviews, an online survey of barriers to health was conducted with a sample of registered voters in the community. Secondary statistical data were also collected. Primary and

secondary data collection took place over the course of approximately nine months, from July 2021 to spring 2022. Adventist Health System staff and consultants identified the community's significant health needs by combining the top five community health needs from each of the four CHNA data sources. The data were shared with a local Steering Committee over the course of three meetings (data collection planning, data review and needs prioritization) taking place between October 2021 – March 2022. The local Steering Committee was responsible for confirming the list of identified significant health needs and prioritizing the needs for the new CHNA.

A total of 13 health needs were identified in the 2022 CHNA, described later in this report. The full 2022 Community Health Needs Assessment conducted by Sutter Lakeside Hospital is available at https://www.sutterhealth.org/.

Definition of the Community Served by the Hospital

Near America's oldest lake and the recreational and outdoor activities it supports, our hospital serves a scenic, rural community with a total population of 69,918. Surrounded by mountainous terrain, Lake County is divided by two main cities with Clearlake on the south shore and Lakeport on the north shore.

Despite having a large population over age 65 (22.94%), the community is vibrant with art galleries, festivals, local events and small businesses. Of the total population, 21.09% are Hispanic/LatinX.

The median household income for the community we serve is $50,811, and 68.05% of income is spent on housing and transportation. In this community 23.94% of children live in poverty, compared to 16.80% in California and 17.48% in the country. 7.83% of students are unhoused, compared to 4.25% in the state and 2.77% in the country.

Certain zip codes represent Sutter Health Lakeside and Adventist Health Clearlake's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the County of Lake CHNA service area. The County of Lake CHNA service area has a total population of 69,918 (based on the 2020 Decennial Census). The largest city in the service area is the City of Clearlake, with a population of 15,250. The service area is comprised of the following ZIP codes: 95451, 95443, 95435, 95464, 95493, 95426, 95423, 95485, 95457, 95461, 95469, 95458, 95453, 95422, 95467.

Significant Health Needs Identified in the 2022 CHNA

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

1. **Access to Care:** Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation, and access through mobile health options can help them find the care they need. In the community: There are just 66 primary care providers per 100,000 population in our Lake County service area, compared to 103 primary care providers per 100,000 population in the United States. 78% of residents in this community live in an area affected by a Health Professional Shortage Area —which is more than three times higher than the rate for all of California. Community members reported limited healthcare access leads patients to turn to emergency rooms for basic services. Residents recently voiced concerns about not receiving adequate care, requesting an accessible urgent care center. They shared concerns around the lack of treatment opportunities in the county, including residential treatment programs. There is frustration due to health care providers training locally and then moving on.

2. **Health Risk Behaviors:** Each day, decisions are made that impact lives – directly and indirectly. These manners range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of a behavior that can be a life threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, offer the opportunity to change direction and live a healthier life. In the community: Today, residents in our Lake County service area experience substance use disorder at a much higher

rate than the rest of the state. Kids of all ages can easily access unhealthy foods such as soda, donuts and chips, and smoking rates are well over the state average. Additionally, statistics show that nearly 15% of infants born in this community have low birth weights, setting the stage for future – and very real – health concerns.

3. **Mental Health:** Mental health includes our psychological, social, and emotional well-being. It affects how we think, feel, and act, and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults, and families feeling alone and helpless. In the community: According to a recent survey, 44% of people surveyed selected mental health as a top concern. Another troubling fact is the rate of deaths by suicide is much higher in our Lake County community (26.3 per 100,000 population) than in California (10.5 per 100,000 population) and in the United States (13.8 per 100,000 population).

4. **Financial Stability: Employment:** The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Access to gainful employment at a living wage is crucial for an individual's well-being and health. Over time, a lack of financial means impacts health and physical, emotional, and social well-being. In the community: Median incomes are much lower than the rest of California, and a high percentage of residents in the Lake County CHNA service area live in poverty (21.05% compared to 13.42% across the U.S.). Focus group members also saw the high cost of living and limited employment options as drivers of financial instability.

5. **Financial Stability: Cost of Living:** Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families from securing the care and resources they need. In the community: Median incomes are much lower than the rest of California, and community residents identified problems in paying for food, healthcare, transportation, and housing. Seventy-nine percent of surveyed residents identified the cost of living as a health need.

6. **Health Conditions:** Obesity, heart disease, cancer and diabetes – examples of chronic diseases – are the leading causes of death and disability in the United States. Often, it's our opportunities and choices that lead to some of these serious diseases. Opportunities for education, consistent care and motivation to make healthier choices helps to improve our quality of life. In the community: This region has higher heart disease and diabetes prevalence and cancer mortality rates than the rest of the state. No urgent care is currently available, and residents noted that long travel times to see specialists make it hard to get the medical care they need.

7. **Food Security:** Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase preferred affordable healthy foods, cook and store them. Today, that is a goal and a challenge, as costs increase, and access to finding affordable healthy options is limited. In the community: In the Lake County service area, 74% of school-age children qualify for free and reduced-price school meals, and the rate of people in poverty is very high (21.05%). Residents expressed concerns about the limited availability of reasonably priced, healthy foods.

8. **Community Safety:** Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes, safe people, and safe children. In the community: The violent crime rate in the Lake County CHNA service area surpasses state and federal rates to a noteworthy degree, 536 crimes/100,000 population in the region compared to 418/100,000 in California and 386/100,000 in the U.S.

9. **Environment & Infrastructure:** Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking requires safe sidewalks and roads. In a digital

world where access to high-speed internet provides opportunities to attend school, work, go to a doctor, and conduct daily tasks, high-speed internet access is also an infrastructure necessity. In the community: Key Informants noted a lack of access to safe parks and public spaces, an infrastructure designed primarily for cars, limited sidewalks, and poor-quality roads as major built environment issues.

10. **Community Vitality: Civic:** A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences: this is the definition of community vitality. In the community: The difficulties attracting new businesses to the area, insufficient high-speed internet access, the relatively low level of education across the population, and lack of overall community development were called out as problems by key informants.

11. **Housing: Unhoused:** When families and individuals do not have access to affordable housing, they often end up living in homelessness. Homelessness can take many forms in our community, including temporary, long-term, sleeping in a vehicle, staying with friends or family, sleeping on the streets or in an encampment, staying in a shelter, and other formal or informal arrangements. However, all types of homelessness and housing instability impact people's health and well-being, both in the immediate and in the long-term. Stable housing is a key to health and happiness. In the community: Multiple drivers towards homelessness were noted by focus group participants, including limited employment opportunities and the very high cost of living. A lack of community connection and a history of personal trauma were also seen as contributing factors. It was noted that there are not enough housing units, and the cost is prohibitive for many. Homelessness was viewed as a health need by 53% of the surveyed residents in the area.

12. **Housing: Costs:** The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions. In the community: Forty-eight percent of residents indicated that lack of affordable housing was a health problem in their community. Focus group and key informant interviewees noted the high cost of housing, limited housing stock, and an influx of house buyers from urban areas as some of the causes.

13. **Community Vitality: Economic:** Economic stability is crucial not just for individual survival and well-being but for the health of the entire region. A thriving community needs thriving businesses and a strong local economy. In the community: Difficulty recruiting professionals due to low salaries and limited housing options was noted by key informants. Overall, the difficulty of promoting economic development in local towns was also seen as a problem.

Process and Criteria to Identify and Prioritize Significant Health Needs

Adventist Health System staff and consultants identified the community's significant health needs by combining the top five community health needs from each of the four CHNA data sources. The local Steering Committee was responsible for confirming the list of identified significant health needs and prioritizing the needs for the new CHNA. To facilitate this process, a series of meetings was held in each community to 1) present the results of the CHNA data collection process, and 2) prioritize the identified needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the findings of the primary and secondary data analysis to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a 90-minute data presentation of these results, highlighting the top 5 or so needs for each data source, and the supporting data that led to their inclusion. A conversation about the findings was a part of these data reviews, but the determination of priority needs

was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the priority needs selection. At the end of the meeting the Steering Committee was provided with prioritization tools, data slides, and a full secondary data report to review prior to the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership, and to complete a brief poll a few days prior to the prioritization meeting to identify the three to five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee.

The prioritization meetings were designed to build consensus around the community health needs identified by the steering committee members. Facilitated by Adventist Health System staff, the meetings relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded when three to five community health needs were agreed upon for inclusion in the final CHNA report.

2022–2024 Implementation Strategy Plan

The Implementation Strategy (IS) describes how Sutter Lakeside Hospital 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:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Sutter Lakeside Hospital initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation or 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 to Select Needs

Sutter Health's senior community benefit staff and Sutter Lakeside Hospital 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:

1. Access to Care
2. Health Risk Behaviors
3. Mental Health

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

Health care should be accessible to people of all ages, at all walks of life. Currently, that vision remains out of reach. The data speaks volumes:

- There are just 66 primary care providers per 100,000 population in our Lake County service area, compared to 103 primary care providers per 100,000 population in the United States.
- 78% of residents in this community live in an area affected by a Health Professional Shortage Area—which is more than three times higher than the rate for all of California.

- Community members reported limited healthcare access leads patients to turn to emergency rooms for basic services.

Residents recently voiced concerns about not receiving adequate care, with a request for an accessible urgent care center. They shared concerns around the lack of treatment opportunities in the county, including residential treatment programs. There is frustration due to health care providers training locally, and then moving on.

The challenges are many. But quality, affordable care is at the core of healthy lives and communities.

Community Voices:
- Community members raised concerns around receiving adequate and timely treatment.
- People shared that traveling long distances to appointments takes up an entire day, resulting in losing time from work, which affects wages and family time.
- There's a concern around the lack of treatment opportunities in the county, including limited at-home support and long-term residential treatment programs.
- People are frustrated with health professionals who are here to intern and practice, then leave as soon as they have the opportunity.
- Residents noted they really need an urgent care center since everyone goes to the ER, which results in a huge wait and medical bill.

Health Risk Behaviors

How is it possible that today, residents in our Lake County service area experience substance use disorder at a much higher rate than the rest of the state … kids of all ages can easily access unhealthy foods such as soda, donuts and chips … smoking rates are well over the state average… and nearly 15% of infants born in this community have low birth weights, setting the stage for future – and very real – health concerns.

Communities hold the potential for creating opportunities for all. Over time collective, community-driven changes will give way to a healthier environment, healthier activity, healthier attitudes and life-changing engagement.

Community Voices:
- The community is seen as the poorest and unhealthiest county in California by some residents.
- There is a worry that kids are picking easy and unhealthy items to eat like chips, soda, donuts, and energy drinks.
- Excessive screen time is seen as a problem for many kids.
- Several residents said that marijuana and over-the-counter medicines are a problem. Parents
- expressed needing education about different drugs to know what to look for, sharing concerns that even things like Tylenol can be misused.
- There is a belief that there are high rates of suicides, alcohol and drug abuse in this community.
- Kids not eating healthy in school and families not eating together is viewed as a problem.

Mental Health

Mental health is undeniably complex, with a wide variety of reactions and responses, from engaging in treatment to fear to avoidance. Families cannot understand what is happening to their loved one, they don't know how to help, and too often accessing needed services is difficult.

The concerns and challenges that come with mental health can lead to an increase in domestic violence, anxiety, depression, hopelessness and substance abuse. According to a recent survey, 44 % of people surveyed selected mental health as a top concern. Another troubling fact is the rate of deaths by suicide is much higher in our Lake County community (26.3 per 100,000 population) than in California (10.5 per 100,000 population) and in the United States (13.8 per 100,000 population). These few realities alone can make one wonder how to bring beautiful health back to this beautiful place.

Community Voices:
- There is a perceived increase in domestic violence in the area.

- There is a worry that community members are self-medicating to address mental health problems.
- Due to COVID-19, people have become isolated. Just the isolation has added to the depression
- and anxiety, and not knowing where to go to seek help has compounded that issue, in the eyes
- of some community members.
- Some shared thoughts that the difficulty in accessing mental health services has increased the severity of this problem.
- There is stigma attached to receiving mental health services, compounding the problem for some.
- Substance abuse, especially when coupled with mental health problems, is seen as leading to long-term health problems for many in this area.

Plan for Addressing Health Needs

ACCESS TO CARE

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support safety net clinics[1]
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[2, 3]
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)

[1] 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

[2] 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

[3] 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.

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[4, 5, 6, 7]
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

[4] 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

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[6] 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

[7] 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[8, 9, 10, 11, 12]
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) Annual no-show rate at SLH

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support improved communication about available healthcare services[13, 14, 15, 16]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.

[8] 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

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

[10] 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

[11] 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

[12] 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.

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

[14] 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

[15] 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

[16] 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

Goals	Improve access to affordable, high-quality healthcare services for vulnerable community members
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 SLH Number of visits per year to local FQHC

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, including incentives like loan forgiveness[17, 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.
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 SLH (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, especially in tribal areas[13, 14, 15, 23]

[17] 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.

[18] 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.

[19] 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

[20] 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

[21] 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

[22] 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

[23] 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

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
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 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[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	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 investigate means for the establishment of an urgent care center in the county
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, reduced emergency department admissions, and improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of emergency department admissions (including demographics if available)

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.

[24] 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

[25] 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

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to increase access to screenings, vaccinations, and similar prevention opportunities[26]
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 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 (screenings, vaccinations, etc.)

HEALTH RISK BEHAVIORS

Healthy Eating, Active Living

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support free/low-cost community-based fitness classes[27, 28, 29]
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 physical activity among community members
Anticipated Outcomes	Increased access to free/low-cost opportunities for physical activities
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of participants (including demographics if available)

[26] Bryan, J. M., Deveraux, J. M., York, M. L., & Schoh, R. J. (1991). How effective are health fairs? Quantitative evaluation of a community health fair. *American Journal of Health Promotion*. Retrieved from https://psycnet.apa.org/record/1992-17401-001; see also Seo, D. C. (2011). Lessons learned from a black and minority health fair's 15-month follow-up counseling. *Journal of the National Medical Association*, 103(9-10), 897-906. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0027968415304454

[27] Han, B., Cohen, D. A., Derose, K. P., Marsh, T., Williamson, S., & Loy, S. (2015). Effectiveness of a free exercise program in a neighborhood park. *Preventive Medicine Reports*, 2, 255-258. Retrieved from https://www.sciencedirect.com/science/article/pii/S2211335515000352

[28] Isaacs, A.J., Critchley, J.A., Tai, S.S., Buckingham, K., Westley, D., Harridge, S.D.R., Smith, C. and Gottlieb, J.M., 2007. Exercise Evaluation Randomised Trial (EXERT): a randomised trial comparing GP referral for leisure centre-based exercise, community-based walking and advice only. *Health Technology Assessment*, 11(10). Retrieved from https://pdfs.semanticscholar.org/6fff/260f1d647336a3e81cec01d466e3991d9ca5.pdf

[29] Kahn, E.B., Ramsey, L.T., Brownson, R.C., Heath, G.W., Howze, E.H., Powell, K.E., Stone, E.J., Rajab, M.W., & Corso, P. (2002). The effectiveness of interventions to increase physical activity: a systematic review. *American Journal of Preventive Medicine*, 22(4): 73-107. Retrieved from https://www.thecommunityguide.org/sites/default/files/publications/pa-ajpm-evrev.pdf

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support schools in implementing guidelines for promoting physical activity[30, 31]
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 physical activity among youth and families
Anticipated Outcomes	Increased physical activity among youth and adults and improved physical fitness among students in schools served
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of participants (including demographics if available)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support strategies to increase access to fruits and vegetables[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.
Goals	Reduce food insecurity and increase healthy food access for low-income community members
Anticipated Outcomes	Increased access to healthy food options and reduced food insecurity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of participants (including demographics if available) Amount of produce provided (pieces or weight)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support schools in implementing guidelines for promoting healthy eating[32, 33, 34, 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.

[30] Centers for Disease Control and Prevention. (2011). *School Health Guidelines to Promote Healthy Eating and Physical Activity.* MMWR 2011; 60 (No. RR-5):1-76. Retrieved from www.cdc.gov/mmwr/pdf/rr/rr6005.pdf

[31] The Community Guide. (2019). *Physical Activity: Enhanced School-Based Physical Education.* Retrieved from https://www.thecommunityguide.org/findings/physical-activity-enhanced-school-based-physical-education

[32] Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables.* Atlanta: U.S. Department of Health and Human Services. Retrieved from www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf

[33] Public Health Law & Policy and the California WIC Association. (2009). *Changes in the WIC Food Packages: A Toolkit for Partnering with Neighborhood Stores.* Retrieved from https://alliancetoendhunger.org/wp-content/uploads/2018/03/WIC_Toolkit.pdf

[34] The Community Guide. (2019). *Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools.* Retrieved from https://www.thecommunityguide.org/findings/obesity-multicomponent-interventions-increase-availability-healthier-foods-and-beverages

[35] The Community Guide. (2019). *Obesity: Meal or Fruit and Vegetable Snack Interventions to Increase Healthier Foods and Beverages Provided by Schools.* Retrieved from https://www.thecommunityguide.org/findings/obesity-meal-fruit-vegetable-snack-interventions-increase-healthier-foods-beverages-schools

Goals	Reduce food insecurity and increase healthy food access for low-income community members
Anticipated Outcomes	Increased access to healthy food options and reduced food insecurity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of participants (including demographics if available) Amount of produce provided (pieces or weight)

Substance Use/Behavioral Health

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[6, 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.
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)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support prescription drug misuse prevention education, guidelines, and public messaging[38]
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 behavioral health among youth and other vulnerable populations
Anticipated Outcomes	Improved behavioral health among youth and other vulnerable populations
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of individuals reached (including demographics if available) Countywide statistics on drug overdoses (by age group, if available)

[36] 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

[37] 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.

[38] Twombly, E. C., & Holtz, K. D. (2008). Teens and the misuse of prescription drugs: Evidence-based recommendations to curb a growing societal problem. *The Journal of Primary Prevention*, 29(6), 503-516.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support substance use prevention/intervention initiatives with evidence of effectiveness, such as the Adolescent Community Reinforcement Approach (ACRA)[39], Seven Challenges (for high-risk youth)[40], and various forms of family behavioral health therapy with evidence of effectiveness[41]
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 behavioral health among youth and families
Anticipated Outcomes	Improved behavioral health among youth and families
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of individuals reached (including demographics if available) Countywide statistics on drug use (by age group, if available)

Social Determinants of Health (Drivers of Health Risk Behaviors)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increased access to affordable childcare[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	Reduce barriers to employment/careers that provide community members with a living wage.
Anticipated Outcomes	More people earning a living wage, reduced economic insecurity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of childcare slots countywide (by age range if available – infant, toddler, preschool)

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

[39] The California Evidence-Based Clearinghouse for Child Welfare. (2018). *Adolescent Community Reinforcement Approach (ACRA).* Retrieved from https://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/

[40] The California Evidence-Based Clearinghouse for Child Welfare. (2019). *The Seven Challenges.* Retrieved from https://www.cebc4cw.org/program/the-seven-challenges/

[41] The California Evidence-Based Clearinghouse for Child Welfare. (2019). *Substance Abuse Treatment (Adolescent).* Retrieved from https://www.cebc4cw.org/topic/substance-abuse-treatment-adolescent/

[42] 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

[43] 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

	other needed services to vulnerable individuals and families at risk of losing their housing[44, 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.
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 expand affordable housing opportunities (rental and ownership), including those on existing residential properties[47, 48]
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

[44] 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

[45] 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

[46] 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

[47] 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

[48] 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

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that improve substandard living conditions, including overcrowding[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	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 Housing First models that include employment for currently or recently unhoused individuals[51, 52, 53, 54, 55]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.

[49] 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

[50] 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.

[51] 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.

[52] 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.

[53] 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

[54] 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

[55] 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.

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

MENTAL HEALTH

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support parenting education classes, including early childhood education for vulnerable families[56, 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.
Goals	Promote the healthy development of children in Communities of Concern while preventing adverse childhood experiences
Anticipated Outcomes	Improved quality of life for children and families and reduced adverse childhood experiences, including abuse/neglect
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of classes/workshops provided Number of people served (including demographics if available) Number of encounters

[56] Bellazaire, A. (2018, August). *Preventing and mitigating the effects of adverse childhood experiences*. Denver, CO: National Conference of State Legislatures. Retrieved from https://teamwv.org/wp-content/uploads/2017/11/2018-conference-of-state-legislator-report-on-mitigating-effects-of-ACES-retreived-9-13-18.pdf

[57] Fortson, B.L., Klevens, J., Merrick, M.T., Gilbert, L.K., & Alexander, S.P. (2016). *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention: Atlanta, GA. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Technical-Package.pdf

[58] Center on the Developing Child. (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. Retrieved from www.developingchild.harvard.edu.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increasing mental/behavioral health services for youth and other vulnerable populations[59, 60, 61, 62, 63, 64, 65]
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 mental health among youth and members of other vulnerable populations

[59] 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/

[60] 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

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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 increasing integration of behavioral health services into existing primary care settings for vulnerable county residents[6, 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.
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)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to investigate home visiting programs to improve mental/behavioral health among vulnerable populations
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 mental/behavioral healthcare delivery and improve mental/behavioral health
Anticipated Outcomes	Increased access to mental/behavioral healthcare and improved mental/behavioral health among vulnerable populations
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of home visits made (including zip codes, if available)

Evaluation Plans

As part of Sutter Lakeside Hospital'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.

Sutter Lakeside Hospital 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, Sutter Lakeside Hospital 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.

Needs Sutter Lakeside Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Lakeside Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits.

The implementation strategy 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. **Community Safety:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need.

2. **Community Vitality: Civic:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need.

3. **Community Vitality: Economic:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need. However, several components of this need are indirectly addressed through the needs selected.

4. **Environment & Infrastructure:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need.

5. **Financial Stability: Cost of Living:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need. However, several components of this need are indirectly addressed through the needs selected.

6. **Financial Stability: Employment:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need. However, several components of this need are indirectly addressed through the needs selected.

7. **Food Security:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need.

8. **Health Conditions:** Sutter Lakeside Hospital is addressing this need indirectly through the other needs selected.

9. **Housing: Costs:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need.

10. **Housing: Unhoused:** This topic is outside of Sutter Lakeside Hospital's core competencies and the hospital feels it cannot make a significant impact on this need. Additionally, other community programs are working on this need and are better positioned to impact the need. However, several components of this need are indirectly addressed through the needs selected.

Approval by Governing Board

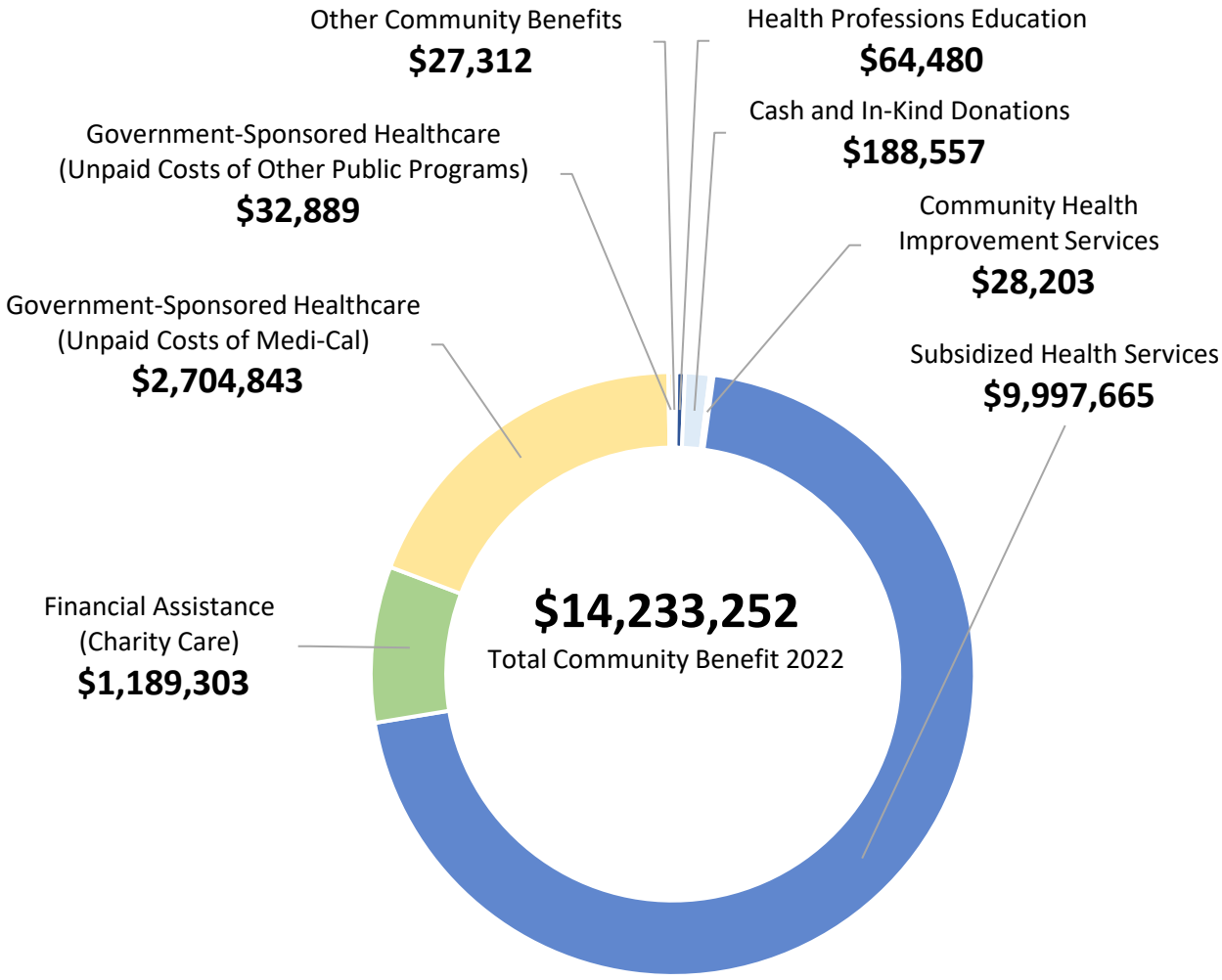
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board of Directors on October 19, 2022.

Appendix: 2022 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

Sutter Lakeside Hospital
2022 Total Community Benefit
& Unpaid Costs of Medicare



There were no unpaid costs of Medicare in 2022