Sutter Health

Sutter Health
Sutter Delta Medical Center

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

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Introduction

The Implementation Strategy Plan describes how Sutter Delta Medical Center, 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 Delta Medical Center 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 to 2000 Powell Street, 10th Floor, Emeryville, CA 94608, Attention: Sutter Health Bay Area Community Benefit department; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Delta Medical Center 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.](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. Behavioral health
2. Housing and homelessness
3. Economic security
4. Healthcare access and delivery
5. Dismantling structural racism
6. Community and family safety
7. Food security
8. Transportation

The 2022 Community Healthy Needs Assessment conducted by Sutter Delta Medical Center is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

Sutter Delta Medical Center conducted its 2022 Community Health Needs Assessment (CHNA) collaboratively with seven local hospitals in Alameda and Contra Costa Counties, members of the Alameda and Contra Costa Counties Hospital CHNA Group. Contra Costa Health Services was an essential partner in collecting primary and secondary data and prioritizing health needs. The CHNA was completed by Ad Lucem Consulting, a public health consulting firm. The key informant interview data and secondary data charts/tables that were included in the report were provided by ASR, the consultant hired by Kaiser Permanente Alameda and Contra Costa service areas to prepare their 2022 CHNAs. ASR also convened community stakeholders and hospital representatives to review service area data and participate in a health need ranking process.

The Hospitals began the CHNA cycle in 2021, with the goal to collectively gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the summer and fall of 2021 through key informant interviews with local health experts, community leaders, and community organizations, and focus groups with community residents. Secondary data were obtained from multiple sources, including the Kaiser Permanente Community Health Data Platform. Data were collected for Contra Costa County as a whole, as well as for Sutter Delta Medical Center's Service Area – Eastern Contra Costa County. Significant health needs were identified and prioritized in late 2021, described further below.

The 2022 CHNA assessed the health issues and contributing factors with greatest impact among vulnerable populations[1] whose health is disproportionately affected across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas as well as disparities among the county's diverse ethnic populations.

[1] California Department of Health Care Access and Information (2022). HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations. Accessed July 6, 2022 from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf.

The full 2022 Community Health Needs Assessment conducted by Sutter Delta Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

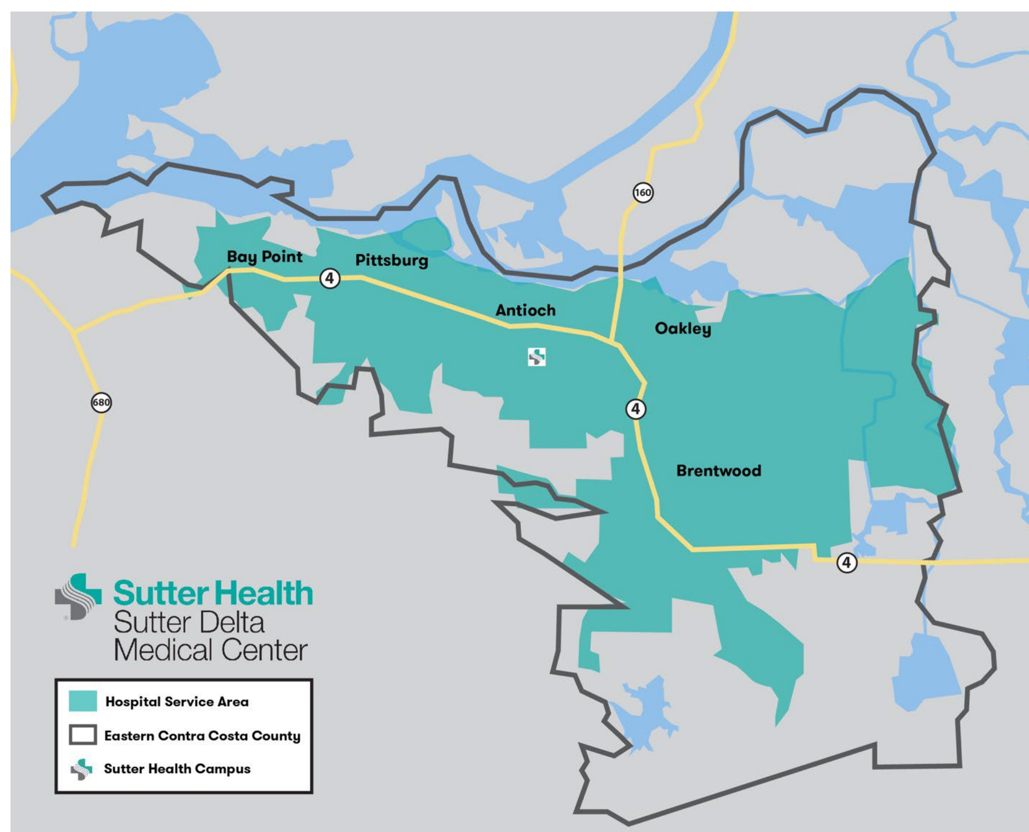
Each hospital participating in the Alameda and Contra Costa Counties Hospital CHNA Group defines its service area to include all individuals residing within a defined geographic area surrounding the hospital. For this collaborative CHNA, Contra Costa County was the overall service area, with each hospital adding additional focus on their specific service area.

The Internal Revenue Service defines the community served as individuals who live within the hospital's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

Sutter Delta Medical Center is located in the city of Antioch in Eastern Contra Costa County. Sutter Delta Medical Center's hospital service area includes six ZIP codes surrounding the hospital and its neighboring communities. As previously noted, the hospital collaborated on the 2022 CHNA with other healthcare facilities serving the Eastern Contra Costa County region. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, including the cities of Antioch, Bay Point, Brentwood, Oakley, and Pittsburg.

The map below (Figure 1) shows the alignment of the Eastern Contra Costa County region with Sutter Delta Medical Center's service area.

Figure 1. Sutter Delta Medical Center Service Area Map, Eastern Contra Costa County



The two cities with the largest populations in Eastern Contra Costa County are Antioch and Pittsburg. Antioch is home to 111,200 people and is a growing city that has become significantly more diverse over

the last few decades.[2] Thirty-seven percent of residents are White followed by Hispanic (Latinx), who make up nearly one third of the population; there is significant representation from Black/African American (21%), Other (17%) and Asian (16%) residents. Antioch's percentage of children living in poverty (26%) is over twice the county's percentage (12%). The city has a higher proportion of seniors in poverty (10%) when compared with the county (6%). The proportion of adults without a high school diploma is slightly higher in Antioch (13%) compared to the county (12%) and the unemployment rate for Antioch (9%) is higher than the county (6%).

Pittsburg is home to 72,569 people.[3] Forty-six percent of Pittsburg's population is Hispanic (Latinx); 37% identify as White and another 25% identify as Other. Pittsburg is also home to Asian (15%), Black/African American (13%), and Multiracial (9%) residents. Pittsburg has a higher percentage of residents living in poverty (12%) compared to the county as a whole (9%), while the percentage of Pittsburg older adults (>65) living in poverty (15%) is more than double the county percentage (6%). The percentage of children in poverty is slightly higher in Pittsburg (13%) than the county (12%). One fifth of Pittsburg residents (20%) do not have a high school diploma compared to 12% for the county. The unemployment rate is higher in Pittsburg (8%), compared to the county (6%).

Significant Health Needs Identified in the 2022 CHNA

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

1. *Behavioral Health.* Behavioral health, which refers to both mental health and substance use, affects a large number of Americans. Anxiety, depression, and suicidal ideation are on the rise, and heightened further due to the COVID-19 pandemic, particularly among Black/African American and Latinx community members. Almost all key informants and over a half of focus group participants identified mental health and behavioral health as a priority health need, noting a linkage to trauma, community safety (over-policing and over-incarceration in communities of color), substance use, economic security challenges, and homelessness. They described inequitable behavioral health services access for patients on Medi-Cal and identified cost, limited number of providers, transportation issues, lack of linguistic/cultural relevance, and social stigma (especially for Latinx communities) as barriers. Behavioral health services for children and adolescents were highlighted as a critical need. The focus group participants described a high prevalence of trauma among undocumented communities in Eastern Contra Costa County, yet also hesitancy in accessing behavioral health services due to fears about Immigration and Customs Enforcement. Both key informants and focus group participants emphasized the critical need for a diverse, bilingual, behavioral health workforce.

2. *Housing and Homelessness.* The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30% of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside. Almost all key informants and over two-thirds of focus group participants identified housing and homelessness as a top priority health need, noting how housing challenges influence health needs by increasing economic and food insecurity and unhealthy behaviors that exacerbate chronic disease and disability. They described how county residents struggle to afford rent, and experience housing instability and crowded households, which sometimes cause mental/behavioral health difficulties and interpersonal issues that may escalate to domestic violence. Focus group participants noted that residents who do not speak English experience discrimination in obtaining housing, and often end up living in unsafe conditions, such as units without heating or air conditioning. These participants

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[2] United States Census Bureau (USCB) (2019). American Community Survey. Demographic Information for Antioch. https://data.census.gov/cedsci/table?q=Antioch%20city%20acs&tid=ACSDP1Y2019.DP05

[3] United States Census Bureau (USCB) (2019). American Community Survey. Demographic Information for Pittsburg. https://data.census.gov/cedsci/table?q=Pittsburg%20city%20acs&tid=ACSDP1Y2019.DP05

also described increases in homelessness in their community in Eastern Contra Costa County and attributed this to the economic impacts of COVID-19.

3. *Economic Security.* People with steady employment are less likely to have an income below the poverty level and more likely to be healthy. Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The establishment of policies that positively influence economic conditions can also improve health. A third of key informants and a third of focus groups participants identified the following barriers to economic security: insufficient vocational training, limited living wage jobs, and lack of clear communication on availability of/registration for existing income/employment supports. They reported that these barriers exacerbate a variety of issues for residents, such as housing, access to healthcare, unhealthy behaviors that promote chronic disease and disability, food insecurity, mental health issues and substance use. Several key informants perceived structural racism as a root cause of economic security disparities experienced by communities of color in Contra Costa County. Both key informants and focus group participants in Eastern Contra Costa County described economic security challenges stemming from limited availability of jobs in the region, which require longer commutes to jobs that pay living wages or offer comprehensive health insurance.

4. *Healthcare Access and Delivery.* Access to comprehensive, quality healthcare has a profound impact on health and quality of life. Components of access to and delivery of care include insurance coverage; adequate numbers of primary and specialty care providers; health care timeliness, quality, and transparency; and cultural competence/cultural humility. A majority of key informants and over half of focus group participants identified healthcare access and delivery as a top priority health need, emphasizing limited services available to Medi-Cal recipients in Contra Costa County, with extremely long wait-times for appointments. They reported that the Medi-Cal system is difficult to navigate, which delays preventive appointments and results in emergency room visits as health issues go untreated. Focus group participants and key informants identified language, racial/ethnic, and cultural barriers, disincentivizing many residents from seeking needed healthcare. Key informants emphasized the challenges of telehealth for some groups who don't have access to computers or internet, or who lack computer literacy skills. A significant healthcare access and delivery issue in Eastern Contra Costa County is the infant mortality rate, which is higher than that of Contra Costa County as a whole (5.1 versus 3.5 per 1,000 live births); for Black/African American infants in Eastern Contra Costa County, the infant mortality rate is higher compared to the total Eastern Contra County population (8.5 per 1,000 live births) and also higher for multiracial infants (7.8 per 1,000 live births).

5. *Dismantling Structural Racism.* Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms. Centuries of racism in this country have had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. Data show that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions. The COVID-19 pandemic, which has disproportionately impacted racial and ethnic minority populations, is another example of these enduring health disparities. A number of key informants and focus group participants described how structural racism results in limited access to healthcare, worse quality of services received, decreased sense of community safety, and higher rates of trauma and mental health disorders for people of color in Contra Costa County compared to White residents. The need for more accurate data collection (disaggregated by race) and implicit bias training for healthcare and social service providers was echoed in several key informant interviews and focus groups. In Eastern Contra Costa County specifically, key informants identified structural racism as the primary driver of poverty in their communities and focus group participants discussed how structural racism contributes to the lack of safety felt by Black/African American residents with respect to their relationships with law enforcement.

6. *Community and Family Safety.* Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to poorer physical and mental health outcomes. Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color, particularly males, is disproportionately affected by juvenile arrests and incarceration related to policing practices. Several key informants and focus group participants stated that community crime/violence is a symptom of trauma and unmet needs. They linked community and family safety issues with housing challenges, accessing healthcare (including behavioral healthcare services), and finding living wage employment. Over-policing and higher rates of incarceration in communities of color in Contra Costa County was an important theme echoed across several key informant interviews and focus groups. Eastern Contra Costa County focus group participants emphasized the lack of safety in relationships between the police and Black/African American residents. This is reflected in the secondary data for the City of Antioch where the use of police force incidents per 100,000 people has increased from 2 in 2018 to 9 in 2019 overall; greater increases were experienced by Black/African American residents, from 4 per 100,000 in 2018 to 21 per 100,000 in 2019.

7. *Food Security.* Food insecurity is the lack of consistent access to enough food for an active, healthy life. Food insecurity encompasses household food shortages; reduced quality, variety, or desirability of food; diminished nutrient intake; disrupted eating patterns; and anxiety about food insufficiency. Black/African American and Latinx households have higher than average rates of food insecurity than other racial/ethnic groups. The COVID-19 pandemic substantially increased food insecurity due to job losses, closure/changes to feeding programs, and increased demand on food banks. Several focus group participants identified how accessing healthier food options is difficult in the county and that stores carrying fresh produce and healthier options are not in walking distance, requiring the use of a car or public transportation. One key informant shared how LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, allies and others), transitional-aged youth (ages 18-24) in the county are particularly struggling with food insecurity due to economic instability and often times lack of familial support. Eastern Contra Costa County focus group participants echoed concerns about the limited availability of nearby stores carrying healthy options. Indeed, there is less access to grocery stores in Eastern Contra Costa County than CA overall (19% of the population with low access versus 12%, respectively). Eastern Contra Costa County key informants and focus group participants perceived how some local, low-income families who could benefit from food banks opt out due to stigma and provided suggestions to address this stigma.

8. *Transportation.* Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing healthcare, and securing food. For households without access to a car, including many low-income individuals and people of color, walking, biking, and using public transportation provide critical links to jobs and essential services. Several key informants and focus group participants described how transportation impacts access to healthcare and a variety of community wellness related activities, including: ability to commute to a living wage job, access to grocery stores selling healthy food, ability to get children to/from school, and access to community events. They noted that cars are residents' preferred transportation mode, with low-income residents, older adults, and individuals with disabilities the least likely to be able to afford/access automobile transportation. Eastern Contra Costa County focus group participants and key informants echoed sentiments regarding poor public transportation options. This is particularly troubling given that the percent of workers driving with long commutes (defined as the percent of population age 16 years and older who drive alone to work with a commute time longer than 60 minutes) is greater in Eastern Contra Costa County than for CA overall (29% versus 11%).

Health Need Identification
Through a comprehensive process combining findings from primary and secondary data, health needs were scored to identify a list of the top eight health needs for the service area. Measures in the Kaiser Permanente Community Health Data Platform, a CHNA data source, were clustered into 16 potential health needs, which formed the backbone of a prioritization tool to identify significant health needs in Contra Costa County.

For secondary data, a score was assigned to each need (4: very high, 3: high, 2: medium, 1: lower, 0: no need) based on how many measures were 20% or more worse than the California overall.

Themes from key informant interviews and other primary data sources were identified, clustered, and assigned scores on a 0-4-point scale, based on the number of times the theme was mentioned. Both the Data Platform and primary data informed scores for geographic, racial/ethnic, and other disparities.

Each data collection method was assigned a weight, based on rigor of the data collection method, timeliness, and ability to describe inequities/disparities. Primary data (key informant interviews and focus groups) were weighted significantly more than the secondary data to prioritize timely input from diverse, underserved communities. Weighted values for each potential need were summed, converted to a percentile score for easy comparison, and then ranked highest to lowest.

Health Need Prioritization
In December 2021, Sutter Delta Medical Center participated in a meeting with key leaders in Contra Costa County to rank top health needs for service areas within the county. Representatives included Contra Costa County Health Services, the Community Clinic Consortium of Contra Costa and Solano Counties, the Contra Costa County Office of Education, The California Endowment, and partner hospitals. Qualitative and quantitative findings for the top eight health needs identified were presented. Representatives considered a set of criteria in prioritizing the list of health needs. The criteria chosen by the health systems before beginning the prioritization process were:

- *Severity:* How severe the health need is (potential to cause death or disability)
- *Magnitude or scale:* The number of people affected by the health need
- *Clear disparities or inequities:* Differences in health outcomes by subgroups (based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others)
- *Community priority:* The community prioritizes the issue over other issues
- *Multiplier effect:* A successful solution to the health need has the potential to solve multiple problems

Representatives affiliated with each service area ranked the top eight health needs according to their interpretation of the criteria. Rankings were then averaged across all representatives to obtain a final rank order of the health needs. Sutter Delta Medical Center then selected the top three health needs to address in its 2022-2024 Implementation Strategy.

2022–2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Delta Medical Center plans to address significant health needs identified in the 2022 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

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

Prioritized Significant Health Needs the Hospital will Address

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Sutter Delta Medical Center initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Behavioral health
2. Housing and homelessness
3. Economic Security

Behavioral Health

Name of program/activity/initiative	Partnerships to Address Behavioral Health
Description	Sutter Delta Medical Center (SDMC) partners with nonprofit organizations and schools to address behavioral health (mental health and/or substance use) in Eastern Contra Costa County. SDMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[4] Below are examples of evidence-supported strategies to address behavioral health: • Focus on childhood and youth, critical ages for preventing mental illness and promoting mental health.[5] Specifically, building continuums of behavioral health supports in school-based, after-school, and family settings are recommended approaches to addressing child and youth mental health.[6] • Enhance access to culturally responsive behavioral health services, which can improve patient/client retention and treatment outcomes.[7] • Support integrated behavioral health services, which is patient-centered care provided by a team of primary care and behavioral health clinicians. A growing evidence base demonstrates improvements in access to care and patient outcomes resulting from integrated behavioral health.[8] • Address individuals' health-related social needs associated with the social determinants of health, which greatly impact physical and

[4] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.

[5] National Academies of Sciences, Engineering, and Medicine. 2020. Children's Mental Health and the Life Course Model: A Virtual Workshop Series: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/25941.

[6] Surgeon General of the United States. Protecting youth mental health: The U.S. Surgeon General's advisory. Retrieved June 10, 2022, from: https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html.

[7] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A treatment improvement protocol: Improving cultural competence. Retrieved August 15, 2019, from https://store.samhsa.gov/system/files/sma14-4849.pdf.

[8] Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Retrieved June 23, 2022, from: https://integrationacademy.ahrq.gov/sites/default/files/2020-06/AHRQ_AcadLitReview.pdf.

	behavioral health and well-being.[9] • Focus on behavioral health workforce development strategies, including provider/staff/student training in evidence-based practices to improve promotion, prevention, and care, and pipeline programs to develop a workforce that is racially/ethnically, culturally, and linguistically diverse, which are essential to behavioral health equity efforts.[10] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents experience improved behavioral health and wellbeing, at all stages of the life-course. The behavioral health workforce is equipped to address the behavioral health needs of residents.
Anticipated Outcomes	Residents experience improved access to affordable, evidence-based, and culturally responsive behavioral health resources and services. Residents increase behavioral health and wellness knowledge and skills. Providers, staff and trainees increase their knowledge of and skills in evidenced-based, culturally responsive, and/or trauma- informed behavioral health resources and services.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics that are used to evaluate efforts to address behavioral health. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # who received mental health services directly from the program # who received substance use services directly from the program # who received case management services directly from the program # of class, workshop, or support group sessions provided by the program # of participants demonstrating increased mental health and wellness knowledge

Housing and Homelessness

Name of program/activity/initiative	Partnerships to Address Housing and Homelessness
Description	Sutter Delta Medical Center (SDMC) partners with nonprofit organizations that address housing and homelessness in Eastern Contra Costa County. SDMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that

[9] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved June 23, 2022, from: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.
[10] Alves-Bradford, J. M., Trinh, N. H., Bath, E., Coombs, A., & Mangurian, C. (2020). Mental health equity in the twenty-first century: Setting the stage. *Psychiatric Clinics*, *43*(3), 415-428.

are closely linked with social, economic, and/or environmental disadvantage.[11] Below are examples of evidence-supported strategies to address housing and homelessness, a social determinant of health:

- Housing First approach, which prioritizes access to permanent (non-time-limited) housing with minimal preconditions, thereby reducing barriers to housing for people experiencing homelessness.[12] Housing First approaches can include improving access to affordable housing, rapid-rehousing, and supportive housing.[13]
- Homelessness prevention, including short-term financial assistance, employment services, and benefits enrollment, to help individuals and families retain housing.[14]
- Rapid re-housing (RRH), which connects individuals and families to permanent housing, housing assistance, and support services.[12] RRH has been found to result in positive housing outcomes for those who do not need ongoing supports.[13]
- Transitional housing for families, which can provide housing and support services up to two years.[15]
- Permanent supportive housing programs (PSH), which provide non time-limited housing and a variety of voluntary support services tailored to individual needs.[16,17] PSH programs have been found to result in increased housing stability among participants.[17]
- Outreach, navigation, and support services for individuals and families currently experiencing homelessness.[18]

Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.

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[11] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.

[12] United States Interagency Council on Homelessness. Home, together: Federal strategic plan to prevent and end homelessness. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.

[13] United States Interagency Council on Homelessness. (2017). The Evidence Behind Approaches that Drive an End to Homelessness. Retrieved July 8, 2022, from https://www.usich.gov/resources/uploads/asset_library/evidence-behind-approaches-that-end-homelessness.pdf.

[14] Shinn, M., & Cohen, R. (2019). Homelessness prevention: A review of the literature. Center for Evidenced-based Solutions to Homelessness. Retrieved July 11, 2022 from: http://www.evidenceonhomelessness.com/wp-content/uploads/2019/02/Homelessness_Prevention_Literature_Synthesis.pdf.

[15] The National Alliance to End Homelessness and U.S. Interagency Council on Homelessness. (2015). Role of Long-Term, Congregate Transitional Housing in Ending Homelessness. Retrieved July 11, 2018 from https://www.usich.gov/tools-for-action/role-of-long-term-congregate-transitional-housing-in-ending-homelessness/.

[16] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved June 23, 2022, from: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

[17] National Academies of Sciences, Engineering, and Medicine 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. Washington, DC: The National Academies Press. https://doi.org/10.17226/25133

[18] United States Interagency Council on Homelessness. (2019). Core Elements of Effective Street Outreach to People Experiencing Homelessness. Retrieved July 12, 2022 from https://www.usich.gov/resources/uploads/asset_library/Core-Components-of-Outreach-2019.pdf

Goals	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well-being.
Anticipated Outcomes	Residents experiencing homelessness or housing instability have access to support services and resources. Residents are placed in permanent housing. Residents retain housing, preventing entry or re-entry into homelessness.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address housing and homelessness. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # of encounters # placed in interim housing through the program (emergency shelter or interim housing) # placed in permanent housing through the program # provided with rental assistance # who retained permanent housing through the program (e.g., via rent/utility assistance) # who received case management services directly from the program # who received mental health services directly from the program # who received substance use services directly from the program # provided with employment services by the program (e.g., job/skills training, resume writing, job placement) # referred out to social services

Economic Security

Name of program/activity/initiative	Partnerships to Address Economic Security
Description	Sutter Delta Medical Center (SDMC) partners with nonprofit organizations that address economic security in Eastern Contra Costa County. SDMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[19] Below are examples of evidence-supported strategies to address economic security, a social determinant of health: • Job training and workforce development programs, particularly those that are occupation-specific, cohort-based, and facilitate access to support services to address barriers to training and

[19] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.

	employment.[20] • Financial coaching for low-to-moderate income households, which has been found to contribute positively to objective financial health indicators and feelings of financial well-being.[21] • Increasing access to high-quality early care and education, which promotes workforce participation for parents, particularly women.[22,23] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents experience improved financial well-being.
Anticipated Outcomes	Residents access job training and placement opportunities, support services to address barriers to training and employment, and/or financial coaching services. Residents experience increased skills and confidence to support employment and/or financial well-being. Residents are placed in/secure stable employment. Residents retain stable employment. Residents achieve financial stability goals.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address housing and homelessness. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # provided with employment services by the program (e.g., job/skills training, resume writing, job placement) # of class, workshop, or support group sessions provided by the program # referred out to social services # and % of participants that graduate from the program # and % of program participants that secure employment # and % of program participants that retain employment (measured within a defined time period)

[20] United States. Department of Labor United States. Department of Commerce; United States. Department of Education; United States. Department of Health and Human Services. (2014). What works in job training: a synthesis of the evidence. Accessed July 14, 2022, from https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/jdt.pdf.
[21] Consumer Financial Protection Bureau. (2016). Financial coaching: A strategy to improve financial well-being. Retrieved July 18, 2022, from https://files.consumerfinance.gov/f/documents/102016_cfpb_Financial_Coaching_Strategy_to_Improve_Financial_Well-Being.pdf.
[22] Powell, A., Thomason, S., & Jacobs, K. (2019). Investing in early care and education: The economic benefits for California. Center for Labor Research and Education, University of California, Berkeley. Retrieved July 18, 2022, from http://laborcenter.berkeley.edu/investing-early-care-education-economic-benefits-california.
[23] United States Department of the Treasury. (2021) The Economics of Child Care Supply in the United States. Retrieved July 27, 2022, from https://home.treasury.gov/system/files/136/The-Economics-of-Childcare-Supply-09-14-final.pdf.

Needs Sutter Delta Medical Center Plans Not to Address

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

- Healthcare access and delivery
- Dismantling structural racism
- Community and family safety
- Food security
- Transportation

Due to the magnitude and scale of health needs and resources available, Sutter Delta Medical Center will focus its strategy on the top three health needs that were identified and prioritized through the 2022 Community Health Needs Assessment process.

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.