Sutter Health

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Sutter Maternity & Surgery Center of Santa Cruz

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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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 Maternity & Surgery Center of Santa Cruz (SMSC), 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.

SMSC 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 2900 Chanticleer Avenue, Santa Cruz, CA 95065, ATTN TO: Community Benefit; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Maternity & Surgery Center of Santa Cruz is affiliated with Sutter Health, a not-for-profit, integrated healthcare system that is committed to delivering innovative, high-quality, equitable patient care and helping to improve the overall health of the communities it serves. 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. Behavioral Health
2. Healthcare Access and Delivery
3. Housing and Homelessness
4. Economic Security
5. Cancer
6. Healthy Lifestyles (Diabetes and Obesity)
7. Community Safety
8. Heart Disease/Heart Attack
9. Unintended Injuries/Accidents

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

2022 Community Health Needs Assessment Summary

To identify and address the critical health needs of the community, in 2021 Sutter Maternity & Surgery Center of Santa Cruz (SMSC) and Dignity Health Dominican Hospital (Dominican) formed an informal collaborative to conduct an extensive, countywide, triennial Community Health Needs Assessment (CHNA) in compliance with current state and federal requirements. Although not required, the benefits of collaborating on the CHNA are multifold, including the leveraging of various sets of knowledge, shared understanding of health needs in our service area, and reduced burden on the community for participation in the assessment. Actionable Insights (AI), LLC, an independent local research firm, was contracted to complete the 2022 – 2024 CHNA on behalf of the collaborative.

SMSC worked together with Dominican and its consultants to fulfill the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over four months in 2021 and culminated in this report.

Dominican and SMSC contracted AI to collect primary qualitative data—through key informant interviews and focus groups—and secondary qualitative and statistical data. Together, AI, SMSC, and Dominican ("the study team") conducted the assessment.

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

Definition of the Community Served by the Hospital

The collaborating hospitals relied on the IRS's definition of the community served by a hospital as "those people living within its hospital service area." A hospital service area comprises all residents in a defined geographic area and does not exclude low-income or underserved populations. SMSC is located in Santa Cruz County and serves the entire county.

In 2020, an estimated 270,861 people resided in Santa Cruz County (an increase of 3% or approximately 8,500 people since 2010).[1] The county occupies 445 square miles of land approximately 35 miles southwest of Silicon Valley, with the Pacific Ocean to the west. This land includes 29 miles of coastline, forming the northern coast of Monterey Bay, and more than 44,000 acres of parks.[2] Nineteen percent of the population in Santa Cruz County is under the age of 18, and 17 percent is 65 years or older. These proportions are similar to California (23 percent are under age 18, and 15 percent are 65 years or older). The median age is 38.5 years old, slightly older than the state median age of 37.0 years.[3]

Almost one in four county residents lives in the city of Santa Cruz, making it the largest local municipality by population.[4] The other incorporated cities are Capitola, Scotts Valley, and Watsonville. Santa Cruz County also includes the following unincorporated towns and areas:[5] Amesti, Aptos, Aptos Hills-Larkin Valley, Ben Lomond, Bonny Doon, Boulder Creek, Brookdale, Corralitos, Davenport, Day Valley, Felton,

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[1] U.S. Census Bureau. (2020). *Decennial Census.*

[2] County of Santa Cruz. (2019). *About Santa Cruz County.*

[3] Age data from U.S. Census Bureau. (2021). *Quickfacts.*

[4] U.S. Census Bureau. (2020). *Quickfacts.*

[5] CA Hometown Locator. (2019). *Santa Cruz County CA cities, towns, & neighborhoods.*

Freedom, Interlaken, La Selva Beach, Live Oak, Lompico, Mount Hermon, Pajaro Dunes, Paradise Park, Pasatiempo, Pleasure Point, Rio Del Mar, Soquel, Twin Lakes, and Zayante.

Santa Cruz County is also relatively diverse ethnically. More than half (54%) of community members are non-Latino white, and four percent are Asian. In comparison, 35 percent of California's population are non-Latino white, and nearly 15 percent are Asian. One third (35%) of residents have Latino heritage, somewhat less than the state proportion (39%).[6] More than one sixth (18%) of Santa Cruz County residents are foreign-born, while in California overall more than one in four (27%) are foreign-born.[7]

Various social determinants, such as income, have significant impact on health outcomes. More than 40 percent of the population live in households with incomes of $100,000 or higher, about one fourth in households with incomes between $50,000 and $100,000, and the rest below $50,000.[8] By comparison, the 2021 Self-Sufficiency Standard for a two-adult family with two school-aged children in Santa Cruz County was $119,792 per year.[9] One source, the Insight Center, named Santa Cruz County the sixth-most expensive California county.[10]

Despite the fact that 42 percent of households in the county earn more than $100,000 per year, estimates show that between 2015 and 2019, 71 percent of county residents lived below 200 percent of the Federal Poverty Level ($24,120 for an individual, $32,480 for two adults, and $49,200 for a family of four). In addition, more than half of Santa Cruz County children received free or reduced-price lunch (53%).[11] Finally, in 2019, approximately one in 10 people (10%) in the community were uninsured.[11]

Housing costs are high; the 2015–2019 median home value was $756,600 and the median rent was $1,717 per month in the county, although housing costs most certainly will have risen by 2022.[12]

Although Santa Cruz County is quite diverse and has substantial resources, significant inequality exists in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality,[13] is higher in certain ZIP Codes compared to others. Certain areas also have poorer access to high speed internet (e.g., ZIP Code 95064), walkable neighborhoods (e.g., ZIP Code 95017), or jobs (e.g., ZIP Code 95076). In this assessment of health needs in Santa Cruz County, we focus particularly on disparities and inequities within the county rather than simply in comparison to California or the nation as a whole.

Significant Health Needs Identified in the 2022 CHNA

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

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[6] U.S. Census Bureau. (2020). *Decennial Census.*

[7] U.S. Census Bureau. (2015-2019). *Quickfacts.*

[8] U.S. Census Bureau. (2019). American Community Survey, One-Year Estimates.

[9] University of Washington. (2021). Self-sufficiency standard calculator. Retrieved from https://selfsufficiencystandard.org/calculator/

[10] Insight Center. (2012). The cost of being Californian: 2021.

[11] United Way of Santa Cruz. (2019). Santa Cruz community assessment project.

[12] According to Zillow.com, the median home price rose to over $1.3M in February 2022.

[13] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of statistical terms*. Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

1. **Behavioral Health:** The community prioritized behavioral health, including mental health and substance use, in both focus groups and all key informant interviews. The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Statistics suggest that youth mental health is an issue: for example, there are rising proportions of students with chronic depression and suicidal ideation. In addition, drug overdose mortality has been rising overall in Santa Cruz County. There are disparities associated with behavioral health, including binge drinking and drug overdose deaths. Poor access to behavioral healthcare poses barriers for Black, Indigenous, and people of color (BIPOC) community members seeking help for behavioral health issues.

2. **Healthcare Access and Delivery:** Nearly all key informants identified healthcare access and delivery as a priority health need. They reported a shortage of healthcare workers and significant levels of burnout in that workforce. Compared to the state, a greater proportion of county residents reported delaying or having difficulty accessing care. Access to dental care was also worse for Santa Cruz County residents versus their counterparts statewide. Access to care was worse for people in the southern part of the county (e.g., Freedom, Watsonville). Experts indicated they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide.

3. **Housing and Homelessness:** Both focus groups and nearly all key informants identified housing and homelessness as a top community priority. Housing costs and other costs of living in Santa Cruz County are extremely high. Certain areas (e.g., Boulder Creek, Watsonville) have high levels of cost-burdened renters. Residential segregation is substantially worse in the county when compared to the state overall. Most feedback about housing from key informants and focus group participants concerned homelessness; the county's homelessness numbers rose in 2020 (the most recent homeless count).

4. **Economic Security:** The community placed a high priority on economic security, including income, education, and food security. The proportion of students eligible for free- and reduced-price meals has been rising in Santa Cruz County. Median household income is lower than the state average for all BIPOC groups, but higher than the state average for whites. COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that the pandemic increased food insecurity. Education generally correlates with income; thus, educational statistics that differ by race/ ethnicity are particularly concerning, such as the county's lower proportion of Latinx residents aged 25+ with at least a high school diploma.

5. **Cancer:** Indicators of concern include rates of breast cancer incidence, prostate cancer incidence and mortality, and cancer screening levels. There are socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes, which the National Cancer Institute attributes to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation.

6. **Healthy Lifestyles (Diabetes and Obesity):** Healthy weight is an issue in Santa Cruz County. The county's BIPOC students are much less likely to be a healthy weight than their peers

statewide. Physical activity, a driver of healthy weight, has been declining among the county's children and youth. As diet is also a driver of healthy weight, it is a problem that expenditures on unhealthy foods and beverages have been rising countywide. The American Diabetes Association has suggested that racism is a root cause for disparities in diabetes outcomes in minority populations.

7. **Community Safety:** Community safety includes violent crime, domestic violence, and other forms of intentional injury. While many community safety statistics are better in Santa Cruz County than the state, rates of domestic violence calls and homicides are rising. Deaths among Latinos in custody in Santa Cruz County are double the state rate. The county's youth feel less safe at school than youth in the state overall. Some experts expressed concern about COVID-related stress contributing to intimate partner violence; it was mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety.

8. **Heart Disease/Heart Attack:** Although statistics for heart disease are generally better in the county than the state, several indicators are trending up (that is, worse): Heart disease and hyperlipidemia are both rising in the county. Parts of the South County area have populations that are doing worse on measures such as high cholesterol prevalence and stroke.

9. **Unintended Injuries/Accidents:** Mortality due to unintended injuries is higher among Santa Cruz County residents than Californians overall. In addition, the bicycle-involved collision rate is higher in the county than the state. Racial inequities in accident rates have been found nationwide and are attributed in part to unequal access to safe transportation.

Process and Criteria to Identify and Prioritize Significant Health Needs

To determine participants' health priorities, key informants and focus group members voted on their community's needs from a list derived from the previous CHNA. AI then tabulated how many focus groups and key informants chose each health need as a priority.

In the fall of 2021, AI synthesized primary qualitative research and secondary and longitudinal data to create a list of health needs for the collaborating hospitals. AI then filtered that list against a set of criteria to identify the significant needs of the community.

These criteria included:

1. Indicator meets the definition of a "health need."
2. At least two data sources were consulted.
3. Must be prioritized by multiple focus groups or key informants, or two or more direct indicators must:
    a. Exhibit documented inequities by race; or
    b. Show worsening trends; or
    c. Fail the benchmark by 5 percent or more.

The CEO of Sutter Maternity & Surgery Center of Santa Cruz (SMSC) invited senior leadership to review the list of identified community health needs and, based on their knowledge and experience working with the community, rank each need in order of importance. The rankings from each senior leader were averaged together to produce SMSC's final list of 2022 prioritized health needs.

2022 – 2024 Implementation Strategy Plan

The Implementation Strategy (IS) describes how SMSC 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 SMSC initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue to focus on the health needs listed below.

Process and Criteria Used to Select Needs

Sutter Health's senior community benefit staff and SMSC 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:[14]

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

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

Description of Health Needs That the Hospital Plans to Address

Access to Care

Healthcare access and delivery, which affects various other community health needs, was identified as a top health need by nearly all key informants.

The proportion of Santa Cruz County residents who reported delaying or having difficulty obtaining care was 20 percent, higher than the state average of 14 percent (and especially high for the county's white

[14] For the purposes of simplicity and clarity in the Implementation Strategy Plan, the following changes were made to the names of the needs: (1) The need "Healthcare Access and Delivery" was renamed "Access to Care." (2) The needs "Housing and Homelessness" and "Economic Security" were merged into one need, "Economic and Housing Stability."

population, at 24%). The proportion of adults who had a routine check-up has been worsening over time (from 71% in 2016 to 66% in 2019) and is particularly low for the county's white (65%) population, as well as for residents of Freedom and Watsonville (65% each). Older adults in those two cities were least likely to receive recommended preventive care (27% for women aged 65+ in Freedom, 25% for men; 25% for women aged 65+ in Watsonville, 24% for men) compared to their peers in other parts of the county (35% for women aged 65+ countywide, 31% for men). Additionally, Black residents of Santa Cruz County were much less likely to have a usual source of healthcare (33%) compared to the state average (87%).

Every interviewee and focus group discussion mentioned a shortage of healthcare workers across the spectrum from primary to specialty care. Key informants and focus group participants indicated there were too few Medi-Cal providers, which they thought was at least partially due to the low Medi-Cal reimbursement rate. In addition, participants said that due to the pandemic, worker burnout is high. It was suggested that staff need more training in trauma-informed care to better serve patients. Participants also indicated a need for the development of career pathways for BIPOC and Spanish-speaking healthcare workers so that county residents can see and be seen by people like themselves. Workers who speak non-Spanish Latin American languages and have Latino American cultural competency are also needed.

Additionally, there was agreement that there are too few facilities in the county, especially for urgent care, and especially in the southern part of the county. Telehealth was reported to have had mixed results, with access harder especially for those without reliable internet access, which tends to disproportionately affect people who are low-income, rural, and/or non-white.[15]

The level of county residents' expenditures on health insurance was also higher ($4,845 per year) than the California average ($4,584), while the average gross premium for Covered California enrollees has been trending up (from $676 in June 2019 to $685 in March 2021) and residents' expenditures have been rising for medical supplies (from $201 in 2019 to $247 in 2021) and prescription and non-prescription medications (from $532 in 2019 to $656 in 2021). Although the proportion of adult county residents with health insurance (92%) is better than California (87%), it does not meet the Healthy People 2030 aspirational goal of 100% insured. The proportion of adults *without* health insurance is higher in Freedom (26%) and Watsonville (28%) than in other parts of the county, and these proportions are generally rising.

The number of dentists per 100,000 people in the county (82) is still lower than the state average (87 per 100,000) but has been rising (from 71 per 100,000 in 2013). This appears to be a greater issue in the southern part of Santa Cruz County; a smaller percentage of adults in southern Santa Cruz County had visited a dentist in the last year (57%) compared to their peers nationwide (67%), and the proportion of older adults with total tooth loss is worse in the southern part of the county (15.4%) than the national average (13.5%).

Finally, although Santa Cruz County generally fares well in maternal and infant health, statistics suggest inequities in access to care. For example, the percentage of pregnant people who received early prenatal care was lower in Watsonville (75%) compared to the rest of the county and the state (over 80%). Additionally, Latinx mothers (19%) were much more likely than white mothers (8%) in Santa Cruz County to receive inadequate prenatal care. Perhaps in part due to these inequities, the infant mortality rate is substantially higher (7.5 per 1,000) in the Watsonville area (ZIP code 95076) than in the county overall. Although no data were available from DataShare Santa Cruz for maternal/infant health by race or class, it

[15] Marshall, B. & Ruane, K. (2021). How broadband access advances systemic equality. *News & Commentary, American Civil Liberties Union (ACLU)*. Retrieved from https://www.aclu.org/news/privacy-technology/how-broadband-access-hinders-systemic-equality-and-deepens-the-digital-divide/

is generally known that social determinants of health such as poverty and racism continue to play a role in maternal and infant health disparities.[16]

Behavioral Health

Behavioral health, which includes mental health and trauma as well as substance use, was prioritized by both focus groups and all key informants.

Mental health statistics were concerning. A greater percentage of adults in Santa Cruz County were likely experiencing serious psychological distress (16%) compared to all Californians (12%), and this figure was growing, especially in ZIP code 95076 (Corralitos, La Selva Beach, Mt. Madonna, Pajaro, Royal Oaks, and Watsonville), where it was seven percent in 2016 and over 12 percent in 2018. Both Latino (14%) and white community members (17%) were more likely to experience this than people of other races/ethnicities in Santa Cruz County. Moreover, a greater proportion of people living in Watsonville had a frequent experience of poor mental health days (more than two weeks per month) (16%) than people in other areas of the county (less than 13%).

Greater proportions of Santa Cruz County adults thought about committing suicide (16%) compared to Californians overall (11%). This statistic was especially high among the county's white (28%) and multiethnic populations (43%). Among the county's students, there have been rising proportions of chronic depression (from 28% in 2017 to 31% in 2019). Perhaps relatedly, the proportion of youth who report having caring relationships with adults has been dropping (for example, 30% of 9th graders reported having a caring relationship with adults in 2013, while only 27% reported this in 2017).

Key informants and focus group participants described stress and anxiety among county residents. They were especially concerned about the isolation experienced by older adults, children, and youth during the pandemic, as well as the effect of the pandemic on the mental health of young adults whose futures are uncertain. Poor access to mental and behavioral healthcare was described as a common issue, with a lack of providers and programs being especially common in the southern part of the county and also in rural parts of the north. Participants expressed the need for residential psychiatric facilities, of which at least one is already underway. While the proportion of adults who both needed and received behavioral healthcare was better among county residents (61%) than the state average (56%), the county's white (52%) and Latino populations (52%) were less likely to receive needed behavioral health help than their peers. There was also discussion of trauma in the county population due to intimate partner violence, generational poverty, and homelessness. Mental illness was mentioned specifically in relation to the homeless population.

Regarding substance use, the rate of opioid prescriptions to Santa Cruz County opioid-naive patients (2.4 per 1,000) was higher than at the state level (1.7). Several overdose death rates were higher in the county than in California overall, including opioid and amphetamine overdose (5.3 per 100,000 vs. 2.8), heroin overdose (5.5 per 100,000 vs. 2.4), and prescription opioid overdose (6.6 per 100,000 vs. 6.1). Opioid overdose was highest in Santa Cruz County among Black (33.7 per 100,000) and white residents (15.3 per 100,000). The county's white community members also had the highest rate of emergency department visits due to heroin overdose (12.2 per 100,000). CHNA participants expressed concern about the rising rates of opioid overdoses, as well as fentanyl and methamphetamine.

[16] Klawetter, S. (2014). Conceptualizing social determinants of maternal and infant health disparities. *Affilia*, 29(2), 131-141.

Liquor store density (13.2 stores per 100,000 people) and the average amount of spending on alcoholic beverages ($1,046 per person per year) are both higher in the county than the state (10.5 stores per 100,000 and $949 per person per year), while alcohol, tobacco, and legal marijuana expenditures have been rising in ZIP code 95076. Adult binge drinking is highest among white (45%), Latino (47%), and multiethnic people (40%) in Santa Cruz County and among residents of Ben Lomond, Boulder Creek, Brookdale, Felton (all 21%), and Lompico (22%).

Economic and Housing Stability

Both focus groups and nearly all key informants identified housing and economic security as top community priorities.

Housing costs in Santa Cruz County are extremely high; more than half (55%) of Santa Cruz County renters are spending more than 30 percent of their income on housing. The proportions of these housing cost-burdened renters are especially high in Boulder Creek (63%), Lompico (63%), Watsonville (67%), and nearby areas. In addition, annual expenses associated with housing are higher for homeowners in the county ($11,618) compared to the state ($11,023). The proportion of overcrowded homes has been generally increasing in Santa Cruz County, reaching nearly seven percent in 2020, as has the total number of people experiencing homelessness (2,256 in 2020). Finally, the percentage of homes with severe housing problems (one or more of overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities) is also slightly higher in the county (27%) than the state (26%).

BIPOC individuals in the U.S. are more likely to live in crowded or substandard conditions and impoverished neighborhoods, in part due to historical red-lining policies and present-day housing discrimination.[17] In Santa Cruz County, residential segregation (white vs. non-white) is substantially worse than in California overall.

Income inequalities by race are substantial in Santa Cruz County, with median household income figures for all BIPOC groups lower than the statewide average ($78,672 annually) while median household income for white Santa Cruz County residents ($100,259 per year) is, on average, nearly 10 percent higher than California overall. Larger proportions of families live below the poverty level in Brookdale (13%), Freedom (14%), and Watsonville (13%) than in other parts of the county (7%). Most BIPOC populations in Santa Cruz County have higher rates of poverty than the county's white (10%) or multiracial populations (9%). Additionally, the proportion of older adults in the county who are living in poverty has been rising (from 7.3% in 2015 to 7.8% in 2020), and is especially high in Boulder Creek (13%) and Brookdale (19%), as well as among the county's Black older adults, wherever they live (40%). Economic precariousness can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

[17] Iton, A., & Ross, R. K. (2017). Understanding how health happens: Your ZIP code is more important than your genetic code. In *Public Health Leadership* (pp. 83–99). Routledge. Retrieved from https://zums.ac.ir//files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84 See also: Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The geography of child opportunity: why neighborhoods matter for equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA. Retrieved from https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf

Although overall and child-specific food insecurity in Santa Cruz County had been dropping before the pandemic[18] (overall, from 14% in 2013 to 11% in 2017; for children, from 23% in 2013 to 17% in 2017), these figures were projected by Feeding America to rise in 2020 due to the pandemic's economic disruption. Additionally, greater and greater percentages of students are becoming eligible for free or reduced-price meals over time (from 37% in 2017 to 46% in 2021). Even more concerning, the proportion of food-insecure children who are likely ineligible for assistance grew substantially between 2018 (16%) and 2019 (27%). Nationwide, food insecurity affects children of color "disproportionately, with Black and Hispanic households reporting rates nearly double that of white households."[19]

Education is a driver of income. The county's rate of high school dropout is higher (12%) than California's rate (9%). Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of the county's Latino inhabitants have at least a high school diploma (64%) compared to all Californians (84%). There are issues with digital (internet) access and access to computing devices in Freedom (75%) and Watsonville (76%) compared to their peers countywide (91%), complicating the ability for students in these areas to complete school, especially during the COVID-19 pandemic when lessons were delivered remotely for many months.

Qualitative data showed that COVID-19 created more economic insecurity for those who lost work and also increased food insecurity. Key informants and focus group participants highlighted the undocumented population as being particularly vulnerable because they are not eligible for public benefits such as unemployment or economic stimulus payments.

Most feedback about housing from key informants and focus group participants centered around homelessness, with concerns expressed about homeless shelters closing and a possible rise in the number of unsheltered people. An expert noted that many individuals experiencing homelessness in Santa Cruz County are employed, suggesting that wages aren't high enough to support the cost of living. Others spoke to the need for tenant protections and mentioned that during the height of the COVID-19 pandemic, landlords may have evicted families with undocumented members because they expected these families would not seek legal protections. Finally, the recent wildfires in the county have stressed many, especially low-income individuals and families who struggle to afford to fix the damage to their homes that FEMA or insurance may not cover.

[18] The measurement methodology changed, and data from 2018 and later should not be compared with data from 2017 and earlier.

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Plan for Addressing Health Needs

Access to Care

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support safety net clinics, including dental clinics[20]
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[21, 22, 23, 24, 25, 26, 27]

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

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Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Reduced emergency department admissions for primary care and improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of emergency department admissions (including demographics if available)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to social services that address housing insecurity, which is a driver of poor healthcare access[28, 29, 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	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

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[31] 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 improved communication about available healthcare services[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.
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 SMSC Number of visits per year to local FQHC

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships with other providers in the county to reduce silos around access to care (e.g., streamlining intake and referral process, universal walk-in policy)[36, 37, 38, 39, 40]

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

Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Improved collaboration and efficiency in healthcare access, reduced wait times for appointments, and improved health equity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of services provided (surgeries, procedures, etc.) Number of SMSC medical volunteers Average wait times for appointments

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[41, 42, 43, 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	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 SMSC (including demographics if available) Number of patient visits per year at local FQHC (including demographics if available)

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[43] 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

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

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support community health worker (promotorx) and/or healthcare navigator programs[32, 33, 34, 47]
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 increase access to screenings, vaccinations, and similar prevention opportunities[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	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.)

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

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Behavioral Health

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increasing mental/behavioral health services for youth and other vulnerable populations[49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60]

[49] 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/

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

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

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

[55] Schouten, K. A., de Niet, G. J., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. (2015). The effectiveness of art therapy in the treatment of traumatized adults: a systematic review on art therapy and trauma. *Trauma, Violence, & Abuse,* 16(2), 220-228. Retrieved from https://psychotraumanet.org/sites/default/files/documents/Schouten-the%20effectiveness%20of%20art%20therapy%20in%20the%20treatment%20of%20traumatized%20adults.pdf

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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
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

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support integrated mental health and substance use services/treatment for co-occurring mental illness and addiction[29, 61]

V., & Unützer, J. (2018). Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review. *The Journal of Rural Health*, 34(1), 48-62.

[58] Quayhagen, M. P., Quayhagen, M., Corbeil, R. R., Hendrix, R. C., Jackson, J. E., Snyder, L., & Bower, D. (2000). Coping with dementia: evaluation of four nonpharmacologic interventions. *International Psychogeriatrics*, 12(2), 249-265. Retrieved from https://www.researchgate.net/profile/Lisa-Snyder-4/publication/12382289_Coping_With_Dementia_Evaluation_of_Four_Nonpharmacologic_Interventions/links/53d3ef1f0cf220632f3ceb59/Coping-With-Dementia-Evaluation-of-Four-Nonpharmacologic-Interventions.pdf. See also Glueckauf, R. L., Ketterson, T. U., Loomis, J. S., & Dages, P. (2004). Online support and education for dementia caregivers: overview, utilization, and initial program evaluation. *Telemedicine Journal & E-Health*, 10(2), 223-232. Retrieved from https://www.researchgate.net/profile/Robert-Glueckauf/publication/8392677_Online_Support_and_Education_for_Dementia_Caregivers_Overview_Utilization_and_Initial_Program_Evaluation/links/599e0f360f7e9b892bb40c7f/Online-Support-and-Education-for-Dementia-Caregivers-Overview-Utilization-and-Initial-Program-Evaluation.pdf

[59] Lieberman, K., Le, H. N., & Perry, D. F. (2014). A systematic review of perinatal depression interventions for adolescent mothers. *Journal of Adolescence*, *37*(8), 1227-1235. See also, Barnet, B., Liu, J., & DeVoe, M. (2008). Double jeopardy: depressive symptoms and rapid subsequent pregnancy in adolescent mothers. *Archives of Pediatrics & Adolescent Medicine*, *162*(3), 246-252.

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

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Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Promote mental/behavioral health among youth and other vulnerable populations
Anticipated Outcomes	Improved access to mental healthcare and substance use services for vulnerable populations, improved coordination of mental/behavioral health services, and improved mental and behavioral health among homeless and vulnerable individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of encounters

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support increasing integration of behavioral health services into existing primary care settings for vulnerable county residents[30, 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)

Economic and Housing Stability

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that expand affordable housing opportunities (rental and ownership), including those on existing residential properties[62, 63]

[62] 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

[63] 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

Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Increased amount of and access to affordable housing
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of affordable housing units in community

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support local homeless prevention organizations and collaboratives that provide temporary housing, financial assistance, career guidance/support, case management, and/or other needed services to homeless community members and other vulnerable individuals[64, 65, 66]
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)

[64] 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

[65] 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

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

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that improve substandard living conditions, including overcrowding[67, 68]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Reduced proportion of overcrowded, sub-standard dwellings and related improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support initiatives to routinize the use of social determinants of health screenings (e.g., ability to afford medications; safe housing; food security) during primary care visits[69, 70]
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

[67] 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

[68] 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.

[69] 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

[70] 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 support programs that combine housing and employment for currently or recently unhoused individuals[71, 72, 73, 74, 75]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	More people earning a living wage
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants Number of participants employed before and after program participation

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs and initiatives for the retention of providers in community/safety net clinic[42, 43, 44]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goals	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	Reduced economic insecurity, more people employed in healthcare settings, and greater diversity among healthcare workers
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of providers by tenure in each clinic Number of loans repaid

[71] 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.

[72] 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.

[73] 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

[74] 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

[75] 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.

Evaluation Plans

As part of SMSC'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.

SMSC 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, SMSC 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 Maternity & Surgery Center of Santa Cruz Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Maternity & Surgery Center of Santa Cruz (SMSC) 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. **Cancer:** This need was of lower priority to the community than the other needs. SMSC addresses this need indirectly through Access to Healthcare strategies.

2. **Community Safety:** This need was of lower priority to the community than the other needs. This topic is outside of SMSC's core competencies. Other organizations in the community are better equipped to address this need.

3. **Healthy Lifestyles (Diabetes and Obesity):** This need was of lower priority to the community than the other needs. SMSC addresses this need indirectly through other strategies and through work with other organizations.

4. **Heart Disease/Heart Attack:** This need was of lower priority to the community than the other needs. SMSC addresses this need indirectly through Access to Healthcare strategies.

5. **Unintended Injuries/Accidents:** This need was of lower priority to the community than the other needs. Prevention of this need is outside of SMSC's core competencies; other organizations in the community are better equipped to address prevention.

Approval by Governing Board

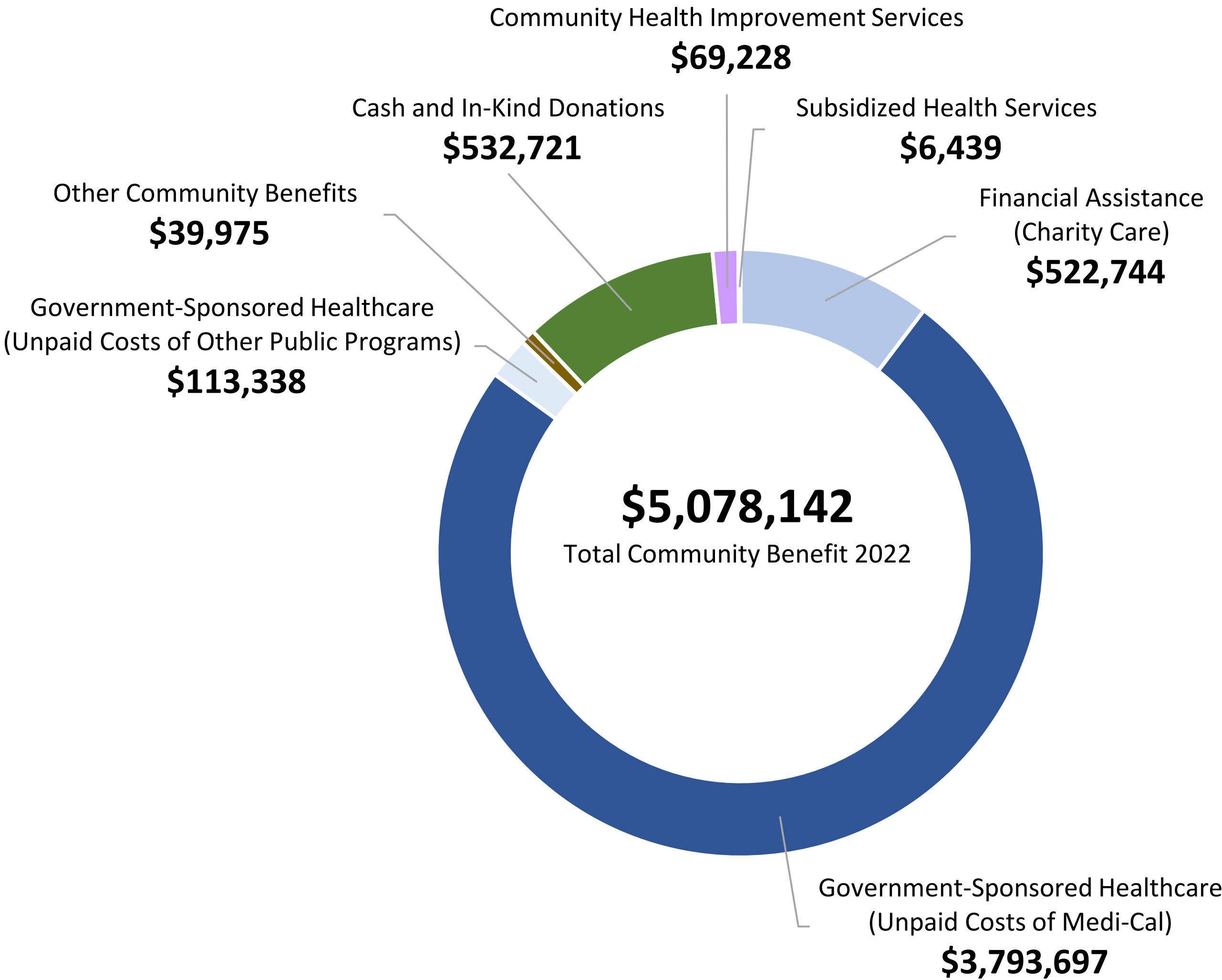
The Community Health Needs Assessment and Implementation Strategy Plan were approved by the Sutter Health Bay Hospitals Board of Directors on October 19, 2022.

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 Maternity & Surgery Center of Santa Cruz 2022 Total Community Benefit & Unpaid Costs of Medicare



2022 unpaid costs of Medicare were $10,305,156