Salinas Valley Memorial Healthcare System Fiscal Years 2021-2023 Implementation Strategy

General Information

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Address of Hospital Organization:	Salinas Valley Memorial Healthcare System 450 East Romie Lane Salinas, CA 93901-4029

Table of Contents

I. About Salinas Valley Memorial Healthcare System

Salinas Valley Memorial Healthcare System (SVMHS) is an integrated network of healthcare programs, services, and facilities that serve thousands of people each year throughout Monterey County and beyond. Opened in 1953, Salinas Valley Memorial Hospital, a public district hospital, is the cornerstone of SVMHS. Licensed for 263 beds, this acute-care hospital features several specializations that enable people to get the advanced care they need without having to travel out of the area. The hospital employs 1,800 people and has a medical staff of 300 board-certified physicians across a range of specialties.

Mission: To provide quality healthcare to our patients and to improve the health and well-being of our community.

Vision: To be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

II. Salinas Valley Memorial Healthcare System's Community

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.

The majority of SVMHS patients come from Monterey County. Thus, for purposes of its community benefit program, SVMHS identifies Monterey County as its target community.

Monterey County comprises 12 cities, eight census-designated places, and large areas of unincorporated rural land. In 2017, over 433,000 people lived there.[a] The ethnic makeup of the county is highly diverse: More than half (58 percent) of the population is of Latinx[b] ethnicity and more than one in five are of "some other race."[c] Nearly 30 percent of residents in Monterey County are foreign-born,[a] and more than 25 percent have difficulty communicating in English.[d]

Income, as a key social determinant, has a significant impact on health outcomes. The median annual household income in Monterey County is about $63,000, which is lower than in neighboring Santa Cruz County ($74,000) and in California overall (about $67,000).[e]

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[a] U.S. Census Bureau. (2019). American Community Survey, 5-Year Estimates, 2013–2017.

[b] The term "Latinx" is employed as a gender-neutral way to refer to Latin American and Hispanic individuals of any race.

[c] "Some other race" or "Other" are U.S. Census categories for ethnicities not specifically called out in data sets.

[d] County of Monterey Board Policy Manual, citing U.S. Census Bureau 2010. Retrieved from https://www.co.monterey.ca.us/home/showdocument?id=69250

[e] U.S. Census Bureau. (2019). American Community Survey, 5-Year Estimates, 2013–2017.

For comparison, the 2018 Self-Sufficiency Standard for a two-adult family with two children in Monterey County was about $75,500.[f] Despite the fact that nearly 30 percent of households in the county earn more than $100,000 per year, almost the same proportion of Monterey County residents live below 150 percent of the federal poverty level.[g] At least one of every seven people in the county is uninsured.[h]

Among county adults age 25 and older, nearly 30 percent do not have a high-school diploma (or equivalent), and fewer than 25 percent have earned a bachelor's degree or higher.[i] Among children and youth, preschool enrollment,[i] student reading proficiency,[j] and students meeting or exceeding grade-level testing standards[k] countywide are all significantly below state benchmarks.

III. Purpose of Implementation Strategy

This Implementation Strategy Report (IS Report) describes SVMHS's planned response to the needs identified through the 2020 CHNA process. It fulfills Section 1.501(r)(3) of the IRS regulations governing nonprofit hospitals. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address. Per these requirements, the following descriptions of the actions (strategies) SVMHS intends to take include the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

For information about SVMHS's 2020 CHNA process and for a copy of the 2020 CHNA report, please visit https://www.svmh.com/documents/content/2020CHNA.pdf.

IV. List of Community Health Needs Identified in the 2020 CHNA

The 2020 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to

[f] The Insight Center for Community Economic Development. (2018). *Self-Sufficiency Standard Tool.* Retrieved November 2019 from https://insightcced.org/2018-family-needs-calculator/

[g] U.S. Census Bureau. (2017). American Community Survey, 5-Year Estimates, 2013–2017.

[h] U.S. Census Bureau. (2019). American Community Survey, 5-Year Estimates, 2013–2017.

[i] U.S. Census Bureau. (2019). American Community Survey, 5-Year Estimates, 2013–2017.

[j] US Department of Education, EDFacts. 2016-2017.

[k] California Department of Education, CAASPP Test Results. 2015-2016.

determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against Healthy People 2020 (HP2020) benchmarks[l] or, if such benchmarks were not available, statewide averages and rates.

To be considered a health need for the purposes of the 2020 CHNA, the need had to meet the definition of a health need,[m] be present in at least two data sources, and either be prioritized by multiple key informants or focus groups or at least three indicators had to miss a benchmark (HP2020 or state average). A total of 10 health needs were identified in the 2020 CHNA. The health need prioritization and selection process is described in Section VI of this report.

2020 COMMUNITY HEALTH NEEDS LIST (IN PRIORITY ORDER; * DENOTES TIE)

Behavioral Health*

1. **Health Care Access and Delivery***
2. **Diabetes and Obesity**
3. **Food and Housing Insecurity**
4. **Cancer***
5. **Maternal/Infant Health***
6. **Built Environment**
7. **Education and Literacy***
8. **Violence Prevention***
9. **Oral/Dental Health**

V. Those Involved in the Implementation Strategy (IS) Development

The SVMHS Executive Management Team selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

[l] Healthy People (www.healthypeople.gov) is an endeavor of the U.S. Department of Health and Human Services, which has provided 10-year national objectives for improving the health of Americans based on scientific data for 30 years. Healthy People sets objectives or targets for improvement for the nation. The most recent objectives are for the year 2020 (HP2020), and they were updated in 2012 to reflect the most accurate population data available.

[m] The definition of a health need is a poor health outcome and its associated health driver(s), or health driver(s) associated with a poor health outcome where the outcome itself has not yet arisen as a need. Further definitions of terms may be found in SVMHS's 2020 CHNA report.

VI. Health Needs that Salinas Valley Memorial Healthcare System Plans to Address

PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In December 2019, the Executive Management Team met to review the information collected for the 2020 CHNA. The purpose of the meeting was to prioritize the identified significant health needs and then select the needs SVMHS would address, which would form the basis for SVMHS's FY2021-2023 community benefit plan and implementation strategies.

After prioritizing the 10 health needs documented in the 2020 CHNA, the Executive Management Team, by consensus, determined that it would merge the health needs of Diabetes and Obesity with Food and Housing Insecurity into a health need called "Healthy Lifestyles." Then, again by consensus, and taking into account the priorities of the community, the Executive Management Team selected the following three health needs:

- **Behavioral Health**
- **Health Care Access and Delivery**
- **Healthy Lifestyles, including:**
  - **Diabetes and Obesity**
  - **Food and Housing Insecurity**

DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM PLANS TO ADDRESS

SVMHS's 2020 CHNA report contains data tables for each health need described below.

BEHAVIORAL HEALTH

Behavioral health, including mental health and substance use, is a high priority in the community: Nearly all focus groups and key informant interviewees in Monterey County prioritized behavioral health as a top health need.

Interview and focus group participants in Monterey County expressed strong concerns about behavioral health in the community, particularly among populations having difficulty accessing consistent, quality care. Youth, undocumented immigrants, and individuals experiencing homelessness were the most often cited as vulnerable. However, they aren't the only ones in need: Participants also noted that health insurance does not always cover behavioral health services.

Community members called out stress and adverse childhood experiences (ACEs) as drivers of behavioral health problems. Participants in most focus groups and interviews linked immigration status with fear-induced stress, suggesting that undocumented people are often hesitant to access services because they're afraid of being identified and deported. Participants in half of the interviews and focus groups perceived that ACEs are increasing; some believe the rise stems from the economic and housing insecurity experienced by many families in the region. Social isolation also emerged as an issue faced by youth and immigrants.

"We have stories of families that are renting hallways to sleep in. … And then, parents not really being able to let their children go to the restroom at night alone because there are other individuals living in the house. So, the potential for abuse goes up, potential for depression, mental illness — all of those things just because of the fact that they're living in such small, confined spaces with … people who are strangers." —Interviewee

Stigmas associated with poor behavioral health came up in almost all discussions with community members. More than one interviewee observed that people coping with behavioral health issues are often met with hostility by both law enforcement and the public. Participants called for efforts to build awareness and empathy that correct misunderstandings and misperceptions around mental health, teach appropriate interaction with people experiencing a behavioral health crisis, and provide training in how to properly respond to mental health emergencies.

Behavioral health statistics for youth in Monterey County underscore the community's concerns: Far fewer school psychologists are available per student countywide than the state benchmark. Among the county's seventh and 11th graders, levels of depression-related feelings and caring relationships with adults at school are both significantly[n] below the state averages. Cyberbullying is also much more prevalent among seventh graders locally than it is among seventh graders across California. Alcohol use among middle- and high-schoolers (seventh, ninth, and 11th graders) is significantly higher in Monterey County than the state average. Regular marijuana use is nearly twice as high among the county's high-schoolers (ninth and 11th graders) as it is among their peers statewide.

Some behavioral health statistics for adults are also worrisome: The percentage of adults affected by ACEs is significantly higher in Monterey County than the state average. The proportion of adults here who lack social or emotional support is significantly higher

[n] In this report, when county statistics are at least 5 percent worse than benchmark (state or Healthy People 2020) statistics, they are considered to be "significantly" worse.

than the state average; social isolation may be a driver of poor mental health. The proportion of adults countywide who have used tobacco is a bit larger than that of all adults in California.

The death rate (age-adjusted) due to drug overdose is slightly higher in Monterey County than the state rate. The county's death rate due to homicide is twice as high as the state's. The rate of domestic violence calls for assistance is slightly higher than the state rate. Slightly fewer mental health providers are available per capita in the county than in California overall. Violence negatively affects the mental health of victims and their loved ones; homicide can also impact the mental health of community members.[o]

Ethnic disparities[p] exist across multiple behavioral health indicators for youth, including: cyberbullying (Native American and African ancestry youth fare worse than their peers); depression-related feelings (the highest proportion of youth experiencing such feelings are of Native American, multiethnic, or African ancestry); and suicidal ideation (Native American, multiethnic, and Asian youth fare worst). Regular marijuana use is highest among multiethnic, African ancestry, and "Other"[q] youth. Latinx, multiethnic, and Native American youth are most likely to have recently used alcohol.

HEALTH CARE ACCESS AND DELIVERY

Interview and focus group participants in Monterey County expressed concern about healthcare access and delivery. The overwhelming consensus was that not enough doctors accept Medi-Cal or Medicaid, and many of those who do no longer see new patients. Many health professionals interviewed for the CHNA described recruiting and retaining healthcare providers as a struggle. Fierce competition among hospitals and clinics (in both the local area and other regions) and the high cost of living, including housing prices, were cited as obstacles.

Interview participants also noted that many residents use hospital Emergency Departments as a source of primary care, particularly for mental health reasons, while those with physical injuries or illnesses avoid seeking care altogether, often because they lack insurance or the ability to afford treatment in a nonemergency setting.

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[o] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. (2019). *Crime and Violence.*

[p] In this report, a disparity is identified when the statistic for at least one ethnic group is significantly worse than the comparable statistic for another ethnic group.

[q] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

"You might forgo some of the important health insurances that you need because that upfront cost, that monthly premium, is just not allowed in your budget. And even though the person rationally knows that they're at greater financial risk, there just isn't enough money to go around to pay all those premiums." —Interviewee

Local statistics support these observations: A significantly smaller proportion of Monterey County residents than Californians as a whole have a usual source for primary care. Compared with state benchmarks, county residents have significantly poorer access to primary care physicians and dentists, and students have substantially poorer access to school nurses. Access to mental health specialists is also slightly worse in the county than the state, as is prenatal care. Countywide, a significantly greater percentage of adults are uninsured than the state average. The county's Latinx adults are much more likely to be uninsured and to lack a consistent source of primary care than their peers of any other ethnicity. The proportion of the Monterey County population that is linguistically isolated[r] is significantly greater than the state average.

Many focus group and interview participants expressed alarm about the barriers to access faced by immigrants who are either ineligible for Medi-Cal due to immigration status or eligible but fear being identified and deported if they access services. Discussions about these barriers included concern about the lack of cultural competency of existing services. (In addition to experiencing fear, community members encounter language barriers and discrimination, such as a lack of understanding about why they're afraid of the government or official organizations and a sense that their health conditions are not being considered as thoroughly as others' due to their minority status.)

HEALTHY LIFESTYLES

Diabetes and Obesity

More than half of interview participants prioritized diabetes and obesity as a health need in Monterey County. Discussions touched on youth fitness, universal diabetes screenings, and better nutrition for all. Some interviewees worried that technology, social media, and unsafe neighborhoods have contributed to youth leading sedentary lifestyles. Others identified a lack of knowledge among parents and guardians, such as how to read Nutrition Facts Labels and prepare healthy meals, as part of the problem.

[r] The term "linguistically isolated" refers to households in which no one 14 years old or older speaks English "very well." U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016.

"Establishing healthy habits early on is just so critical. … I really think that many of our students and their families really have no idea why it's so important not to drink sugary drinks. They think that even Gatorade is really healthy for them." —Interviewee

Interview participants said that issues related to the built environment, such as a lack of safe places to exercise and low access to stores selling healthy food, deter physical activity and good nutrition. Some participants focused on people coping with homelessness, housing insecurity, or overcrowded housing, suggesting that these populations have a harder time maintaining a healthy diet because cooking and storage spaces are often shared or nonexistent, which limits the types of food they can purchase and consume.

Statistics show that adults in Monterey County are significantly less physically active than their counterparts statewide, a trend that's been worsening since 2010. Among youth, Latinx middle schoolers and Native American high schoolers are the least likely students in the county to meet physical fitness standards. Meanwhile, fruit and vegetable consumption among children in Monterey County is significantly lower than the state average.

Diabetes prevalence has been rising in Monterey County since 2014. Obesity rates are significantly higher among children and adults countywide than the state averages. Obesity is most prevalent locally among African ancestry adults.

With regard to related chronic diseases, statistics show that adults in Monterey County are significantly more likely than adults in California overall to have high blood pressure, as well as to lack medication to manage that condition. Among all ethnic groups countywide, Latinxs are the least likely to manage their blood pressure well. Heart disease and stroke disproportionately affect the African ancestry population, whose local death rates for both diseases exceed the state rates.

Food and Housing Insecurity

Food and housing insecurity was identified as a top health need by the Monterey County community. This need covers concerns about economic, food, and housing insecurity.

Interview and focus group participants in Monterey County identified food and housing insecurity as a top priorities. They discussed the high cost of living, the risk of homelessness, and the lack of employment opportunities. Because most of the county's economy revolves around hospitality, tourism, and agriculture, the job prospects are limited, particularly for undocumented youth and young adults, participants said. The local unemployment rate is significantly higher than the state rate, and a much smaller percentage of county residents are employed in white-collar occupations than their peers

statewide. Median household income is significantly lower in the county than the state, and a correspondingly greater proportion of adults over age 25 do not have a high school education. Significant ethnic disparities also exist. For example, the highest proportions of adults without a high school diploma in Monterey County are found among residents of Latinx, Native American, and "Other"[s] ancestry. Residents of Latinx, Native American, and African ancestry account for the greatest proportions of people living in poverty, including children.

Community members frequently linked food and housing insecurity with economic insecurity. When the majority of someone's paycheck goes toward housing costs, little money is left to cover groceries, healthcare, or other critical expenses. Nearly half of interview participants shared stories of people experiencing food insecurity because their rent consumes so much of their household's income. As a result, the physical and mental health of these residents—especially school-aged youth—suffers, they said. (*See also the Behavioral Health description*.) Statistics show that food insecurity among children, and the proportion of students eligible for federal free- or reduced-price lunch, in Monterey County are substantially higher than the state benchmarks.

"When kids in the early morning are really fidgety, they're not focusing, she'll ask them, 'What did you have for breakfast?' And their response is, 'I didn't get a chance,' or, 'We didn't have anything.' " —Interviewee

Focus groups and most interview participants said the lack of affordable child care locally contributes to the economic insecurity of families with younger children. Statistics show that the supply of licensed child care in Monterey County is significantly lower than the state average. Older adults on fixed incomes are also at risk: Life events such as divorce, sudden medical issues or expenditures, and the steadily increasing cost of living can pose a threat to home ownership, financial stability, and more, participants said. Related to income, a significantly smaller proportion of housing units in the county are owner-occupied than the state benchmark. Ethnic disparity exists in home ownership: Whites and Asians are far more likely to own homes in Monterey County than people of Latinx or African ancestry.

Housing, as a social determinant of health, needs to be addressed in order to tackle other health issues in Monterey County, interview participants agreed. Part of the problem is that, with so much of the region devoted to agriculture, cities and builders must compete with commercial entities over land use, some said. This limits the construction of new,

[s] The term "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

potentially affordable housing. Housing costs may also prevent qualified healthcare providers and other professionals from relocating here.

When people don't have access to good-quality housing at reasonable prices, they may be forced to accept housing of poor quality, participants said. Poor housing quality (e.g., evidence of leaks, mold, and pests) is associated with asthma prevalence and asthma-related emergency room visits.[t] Overall asthma prevalence and child and youth asthma Emergency Department visits are both slightly higher in the county than their respective state benchmarks, while the rate of age-adjusted asthma deaths is significantly higher than the state rate. Finally, lead in the home environment is of particular danger to children, whose bodies are still developing and thus more sensitive to toxins.[u] Blood-lead levels for children and youth, respectively, are higher in Monterey County than the state averages.

CHNA participants included overcrowding in their definition of housing insecurity. Stories emerged of several families living in a single-family dwelling, in which each family occupied a bedroom and some even slept in hallways. Shared kitchens (with numerous refrigerators) and bathrooms (with scheduled times per person) often led to poor health conditions. Communicable diseases spread easily in such conditions. Some participants who were healthcare providers reported seeing increases in urinary tract infections among people living in overcrowded households due to limited bathroom access. Others called out their concern for children in these conditions, indicating they may experience higher stress, inadequate sleep, or even physical harm from strangers living in the shared residence. Indeed, statistics show a significantly higher percentage of Monterey County households are crowded, and a correspondingly higher proportion of children live in crowded housing, than the California benchmarks.

The most extreme form of housing insecurity is homelessness. A significantly greater percentage of county students are experiencing homelessness, and a correspondingly higher proportion of these students are unsheltered, than their peers statewide.

VII. Salinas Valley Memorial Healthcare System's Implementation Strategy

SVMHS's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations effected by health disparities. To accomplish this goal, the majority of

[t] Urban Institute. (2017). The Relationship Between Housing and Asthma Among School-Age Children.

[u] California Environmental Health Tracking Program. (2015). *Costs of Environmental Health Conditions in California Children.* Public Health Institute.

SVMHS's community health investment from FY21 – FY23 will improve behavioral health, healthcare access and delivery, and healthy lifestyles through community and hospital-based programs and partnerships.

This plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2020 CHNA process.

1. Behavioral Health

Long-Term Goals:

A. Increase the proportion of people with access to coordinated behavioral healthcare services (mental health and substance use services).
B. Increase ability of community members to have good mental health.
C. Address the systemic/institutional barriers to mental health.

Goal	Strategies	Anticipated Impact
1A.1: Continue/expand access to programs and services that prevent poor mental/behavioral health.	▪ Programs for educating community members in mindfulness-based stress reduction (MBSR) techniques to reduce depression and anxiety, and for stress management.[1] ▪ Support for programs that offer small-group community connections/activities.[2] ▪ Participate in Medi-Cal Managed Care.[3] ▪ Provide Charitable Health Coverage.	◆ Increased knowledge about methods of coping with stress and depression ◆ Improved access to mental healthcare prevention services
1A.2: Expand access to programs and services (including counseling/ therapy) that address stress, depression, and suicidal ideation.	▪ Support teen parenting programs.[4] ▪ Support trauma-informed counseling.[5,6] ▪ Support domestic violence prevention/recovery.[7] ▪ Provide mental health services to Emergency Department patients by a licensed healthcare professional using real-time videoconferencing services transmitted via the Internet.[8] ▪ Support provision of mental/behavioral healthcare to vulnerable individuals.[9]	◆ Increased knowledge among those served about methods of coping with stress and depression ◆ Improved access to social/emotional health programs and services ◆ Increased proportion of those served with effective social/emotional health services ◆ Improved social/emotional health among those served

Goal	Strategies	Anticipated Impact
		◆ Improved coping skills among those served ◆ Healthier relationships for those served
1A.3: Support assessment and referral to mental/behavioral health and social non-medical services for vulnerable populations	▪ Support for mental/behavioral health evaluations and referrals for in-patients at the hospital.[10] ▪ Support for referrals to drug and alcohol programs for in-patients and Emergency Department patients.[11] ▪ Support for local programs that provide appropriate counseling and supportive social services for at-risk and justice-involved youth.[12]	◆ Among providers, increased knowledge of the importance of and approaches for routine screening and diagnosis of depression and related mental and behavioral health disorders. ◆ Improved access to mental/behavioral health services among community members ◆ Improved access to mental/behavioral healthcare and supportive social services among vulnerable populations
1B.1: Support school-based interventions, policies, programs, and approaches to improve school climate and prevent or reduce bullying	▪ Support programming for bullying prevention.[13] ▪ Support school-based violence prevention programs, including group counseling.[14] ▪ Support school-based programs creating opportunities for connection and collaboration among students. ▪ Support schools in the development of policies for Positive Behavior Interventions & Supports programs.[15]	◆ In schools that are served by strategies: ○ Improved school climate ○ Reduced bullying ○ Reduced disciplinary actions (suspensions, expulsions)

Goal	Strategies	Anticipated Impact
		♦ Improved access to mental/behavioral health programs and services for youth ♦ Increased proportion of youth served with effective mental/behavioral health services ♦ Improved mental/behavioral health among youth ♦ Improved coping skills among youth ♦ Healthier relationships for youth
1B.2: Provide access to emotional support groups for community members	▪ Support trauma-informed counseling.[16,17] ▪ Offer support groups for the following topics: cancer survival; multiple sclerosis and other chronic disease survival; traumatic brain injury; grief; breast feeding.[18, 19, 20, 21, 22]	♦ Increased access to mental/behavioral healthcare and support ♦ Improved mental/behavioral health among those served
1B.3: Promote the reduction of stigma related to mental/behavioral health issues	▪ Support provision of mental/behavioral healthcare to vulnerable individuals. [23, 24, 25] ▪ Support mobile clinic community health advocates in referrals for mental/behavioral health improvement programming.[26]	♦ Reduced stigma related to mental/behavioral health issues in the community ♦ Increased proportion of community members accessing mental/behavioral health services, especially: Latinx individuals, low-income individuals, and

Goal	Strategies	Anticipated Impact
		individuals who are experiencing homelessness and/or domestic violence
1C.1: Support integration of mental/behavioral health and physical healthcare, such as co-location of services (e.g. in health settings, schools)	▪ Support coordination of mental/behavioral healthcare and physical healthcare, such as co-location of services.[27, 28] ▪ Support provision of mental/behavioral and physical healthcare to vulnerable individuals.[29] ▪ Continue supporting mobile health clinic, which includes assessment of individuals' mental and behavioral health needs.[30] ▪ Continue support of Cancer Resource Center's programming, which integrates mental health and physical healthcare for individuals with cancer.[31]	◆ Improved coordination of care for underserved populations ◆ Improved access to coordinated care among community members, including access to mental/behavioral healthcare
1C.2: Use existing, trained community health workers for mental health referrals	▪ Continue supporting mobile health clinic, which includes assessment by community health advocates/workers of individuals' mental and behavioral health needs.[32]	◆ Improved access to mental/behavioral healthcare among vulnerable and underserved populations

2. Healthcare Access and Delivery

Long-Term Goals:

A. Improve access to affordable, high quality healthcare services for at-risk community members.

B. Increase access to social non-medical services that support health for low-income and vulnerable populations.

Goal	Strategies	Anticipated Impact
2A.1: Improve community members' access to coordinated medical care.	▪ Support programs for facilitating the exchange of health information.[33] ▪ Support coordination for specialty care.[34]	◆ Improved health outcomes, particularly related to health disparities ◆ Improved access to specialty care
2A.2: Reduce unnecessary ED visits/hospital stays.	▪ Support community health-related education.[35] ▪ Support expanded hours for urgent care clinics.[36, 37] ▪ Provide onsite patient advocates for transition from hospital.[38] ▪ Support for mobile integrated healthcare practice approaches.[39]	◆ Reduced avoidable emergency department and hospital utilization ◆ Improved health outcomes, particularly related to health disparities
2A.3: Increase proportion of population that is adequately insured	▪ Provide financial assistance to reduce health care cost barriers to care for low-income individuals. ▪ Increase health insurance coverage.[40]	◆ Reduced health care cost barriers for vulnerable populations ◆ Improved health insurance rates (% of people with health insurance)

Goal	Strategies	Anticipated Impact
	▪ Provide onsite staff support to assist uninsured and underinsured.[41] ▪ Support organizations or programs assisting with insurance enrollment.[41]	
2A.4: Decrease transportation barriers to accessing healthcare	▪ Expand mobile health clinic/van program.[42] ▪ Support existing older adults transportation program.[43] ▪ Support taxi voucher program.[43] ▪ Support SVMHS physicians serving in community clinics.[44] ▪ Support health care clinics in close geographic proximity to populations of low socioeconomic status.[45] ▪ Support community health advocates home visits.[46] ▪ Community events[47] and flu clinics.[48]	◆ Decrease in healthcare-access transportation barriers ◆ Improved health outcomes, particularly related to health disparities
2A.5: Develop a diverse, well-trained healthcare workforce that provides culturally sensitive healthcare	▪ Support pipeline programs for healthcare careers, including providing training opportunities for medical, nursing, and other health professions students, and scholarships to students seeking clinical or allied health roles.[49, 50, 51] ▪ Support community health advocates programming.[52] ▪ Service learning programs that contribute to health career pathways such as Medical History Museum tours, Medical Adventure Camp, Summer Health Institute, and Scout Health Explorer Post.[49] ▪ Support healthcare programs in higher education.[49, 51] ▪ Support SVMHS employees pursuing advanced degrees.[53]	◆ Increased number of qualified providers in the community focused on community-based practices

Goal	Strategies	Anticipated Impact
2B.1: Increase access to basic needs programming	▪ Support organizations making efforts related to physical health care for the homeless or insufficiently housed by increasing access of individuals at risk of or experiencing homelessness to quality health care services.[54, 55, 56, 57, 58] ▪ Support organizations making efforts related to basic needs, including food, water, shelter, hygiene, and social services for the homeless or insufficiently housed.[59, 60,61] ▪ Support programs that increase access to case management for social services support.[62] ▪ Support programs that improve access to social services to support upstream health influencers (employment, poverty, etc.).[63, 64]	◆ Improved health outcomes for those at-risk of and/or experiencing homelessness ◆ Reduced homelessness ◆ Reduced avoidable emergency department and hospital utilization
2B.2: Increase access to basic skills programming	▪ Support literacy programs in the schools and/or cradle to career programs that include addressing literacy.[65 , 66] ▪ Support programs that improve financial literacy and self-sufficiency among economically insecure community members.[67] ▪ Support programs that provide on-site, on-the-job training for underrepresented people with disabilities.[68, 69] ▪ Support legal rights education, including legal issues for life planning.[70] ▪ Participate in regional economic collaborative.[71]	◆ Increased English literacy ◆ Increased digital literacy ◆ Increased high school graduation/college-going rates ◆ Increased rates of saving ◆ Reduced unemployment rates among individuals with disabilities ◆ Reduction of pay disparities Reduced long-term poverty rates

Goal	Strategies	Anticipated Impact
2B.3: Advocate for health equity for low-income populations	▪ Support organizations conducting community advocacy for low-income populations, especially for farmworkers.[72] ▪ Actively participate in professional association activities that advocate for basic health care rights.[73]	◆ Reduction of pay disparities, especially among farmworkers ◆ Improvement of working conditions, especially for farmworkers ◆ Improved housing conditions, especially for farmworkers ◆ Increased affordable housing, especially for farmworkers

3. Healthy Lifestyles

A. Long-Term Goal: Increase ability of community members to live healthy lifestyles.

Goal	Strategies	Anticipated Impact
3A.1: Increase access to high-quality, affordable, healthy foods for vulnerable populations.	▪ Increase food security screening programs (e.g., by health providers).[74, 75 76, 77, 78] ▪ Increase referrals to food access programs.[79, 80, 81, 82] ▪ Expand capacity of existing food access programs, including those specifically addressing health care-related food access (i.e., food pharmacy, medically tailored meals, meals on wheels, etc.).[83, 84] ▪ Support additional, culturally relevant food access programs.[85, 86, 87] ▪ Provide fresh produce through sponsorship of onsite Farmers' Market.[88] ▪ Subsidize produce purchases through the Fresh Produce Prescription Program.[89] ▪ Decrease transportation barriers to/from existing food access programs.[90, 91, 92, 93]	◆ Reduced proportion of individuals who are food insecure ◆ Improved associated health outcomes ◆ Improved access to healthy food for low-income individuals ◆ Increased proportion of low-income individuals who eat three meals per day ◆ Reduced proportion of individuals experiencing poor health outcomes that are a result of food insecurity
3A.2: Increase access to affordable exercise areas and options	▪ Provide, partner with, or in other ways support other organizations' providing free/low-cost community exercise classes.[94, 95, 96] ▪ Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income / rural communities.[96, 97, 98, 99] ▪ Support traffic safety education.[100] ▪ Support improvements to community safety in outdoor areas:	◆ Improved associated health outcomes ◆ Improved access to exercise for low-income individuals ◆ Increased proportion of low-income individuals who are physically active ◆ Reduced proportion of individuals experiencing poor health outcomes that are a result of physical inactivity

Goal	Strategies	Anticipated Impact
	○ From violence/threats of violence.[101, 102, 103] ○ From traffic accidents.[97, 104, 105]	
3A.3: Increase education related to healthy lifestyles	▪ Participate in health fairs and other opportunities for health screening and education (which include follow-up).[106] ▪ Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors.[107] ▪ Expand access to other health education, including nutrition education and physical activities, education about hygiene and health.[108]	◆ Increased knowledge about healthy behaviors ◆ Improved health outcomes, particularly related to health disparities
3A.4: Increase access to interventions related to healthy lifestyles	▪ Support interventions and practices aimed at reducing recreational, sedentary screen time among community members.[109, 110, 111] ▪ Assist schools in implementing school health policies for promoting healthy eating and physical activity.[112, 113, 114] ▪ Support implementation of healthy food policies in the county.[104, 115]	◆ More policies/practices that support increased physical activity and improved access to healthy foods ◆ Increased knowledge of health impacts of screen time among community members ◆ Reduced screen time among community members ◆ Reduced time spent on sedentary activities by community members ◆ Reduced obesity and overweight among community members ◆ Reduced A1C levels among community members ◆ Reduced blood pressure among community members

Goal	Strategies	Anticipated Impact
3A.5: Reduce barriers to high-quality employment	▪ Increase access to high-quality workforce training.[116] ▪ Increase workforce-related educational attainment and/or job training.[117, 118, 119, 120]	◆ Reduced unemployment rates ◆ Reduced poverty rates ◆ Reduced California Self-Sufficiency Standard disparity ◆ Reduction of pay disparities
3A.6: Reduce barriers affordable housing	▪ Increase quantity of affordable and/or permanent supportive housing.[121, 122] ▪ Address the physical and behavioral health conditions that contribute to housing instability among those at-risk of and/or experiencing homelessness, including mental health and substance use issues.[123, 124]	◆ Reduced homelessness ◆ Increased housing stability ◆ Improved health outcomes
3A.7: Improve basic needs of individuals at risk of or experiencing homelessness	▪ Improve access to affordable and/or permanent supportive housing.[121, 122] ▪ Increase access to programs to house domestic violence survivors.[125] ▪ Improve access to health care for those at-risk of and/or experiencing homelessness.[126, 127, 128, 129] ▪ Improve access to social services to support upstream health influencers.[130, 131, 132]	◆ Increase in social services that are co-located within affordable housing sites ◆ Reduced homelessness ◆ Improved health outcomes for those at-risk of and/or experiencing homelessness

VIII. Evaluation Plans

As part of SVMHS's ongoing community health improvement efforts, SVMHS 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.

SVMHS 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, SVMHS will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report mid-year and year-end performance on annual outcomes metrics, which are shared broadly with the public as well as state and federal regulatory bodies.

IX. Health Needs Salinas Valley Memorial Healthcare System Does Not Plan to Address

The Executive Management team was careful to recommend a set of health needs for SVMHS to address that reflected the priorities of the community and that could make an impact in Monterey County. The remaining health needs did not meet the selection criteria to the same extent as the chosen needs; therefore, SVMHS does not plan to address them at this time.

1. **Cancer**: This need is of lower priority to the community. SVMHS has a Comprehensive Community Cancer Care Program that is accredited by the Commission on Cancer and dedicated to serving cancer patients and their families in Monterey County. Other hospitals are also addressing this need with services available to the community. In addition, SVMHS has the ability to improve cancer health by improving access to healthcare services (one of the selected needs).

2. **Maternal/Infant Health**: This need is of lower priority to the community and is already well-addressed by other community-based organizations, such as First 5 Monterey County, and by the Monterey County Health Department's Maternal, Child, and Adolescent Health Program.

3. **Built Environment**: This need is of lower priority to the community and is being addressed by The Blue Zones Project, of which SVMHS is a key partner. Monterey County's Resource Management Agency is also an active player in improving the built environment.

4. **Education and Literacy**: This need, while of lower priority to the community, is being addressed by other organizations such as the County Office of Education, the public library system, and various Family Resource Centers. Although SVMHS has a relative lack of expertise to address this health need, it has identified certain healthy lifestyles-related strategies (one of the selected needs) that can also support improved education and literacy in the community

5. **Violence Prevention**: Natividad Medical Center has existing expertise and services to address this need, including the Natividad Trauma Center. The need is also being addressed by community organizations such as the Community Alliance for Safety and Peace, Dorothy's Place, Rancho Cielo, and others.

6. **Oral/Dental Health**: This need is of lower priority to the community, and SVMHS has a relative lack of expertise to address this health need.

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