2020 Community Benefit Report

2021 Community Benefit Plan

Stanford HEALTH CARE

STANFORD MEDICINE

ValleyCare

January 25, 2021

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Mr. Dhami:

We are pleased to submit the annual Community Benefit Report for Stanford Health Care – ValleyCare (SHC – VC). This report covers our fiscal year 2020 for the period September 1, 2019–August 31, 2020. Along with the report you will find a Community Benefit Plan for our fiscal year 2021 for the period September 1, 2020–August 31, 2021.

If you have any questions, please contact Denise Bouillerce, Senior Director of Government & Community Relations, Marketing/Public Relations at 925.373.4020 or via email dbouille@stanfordhealthcare.org.

Sincerely,

President and CEO
Stanford Health Care – ValleyCare

Mission Statement

For the benefit of our patients and the community we serve, our mission is

- ***To Care***
- ***To Educate***
- ***To Discover***

Vision Statement

Healing humanity through science and compassion, one patient at a time.

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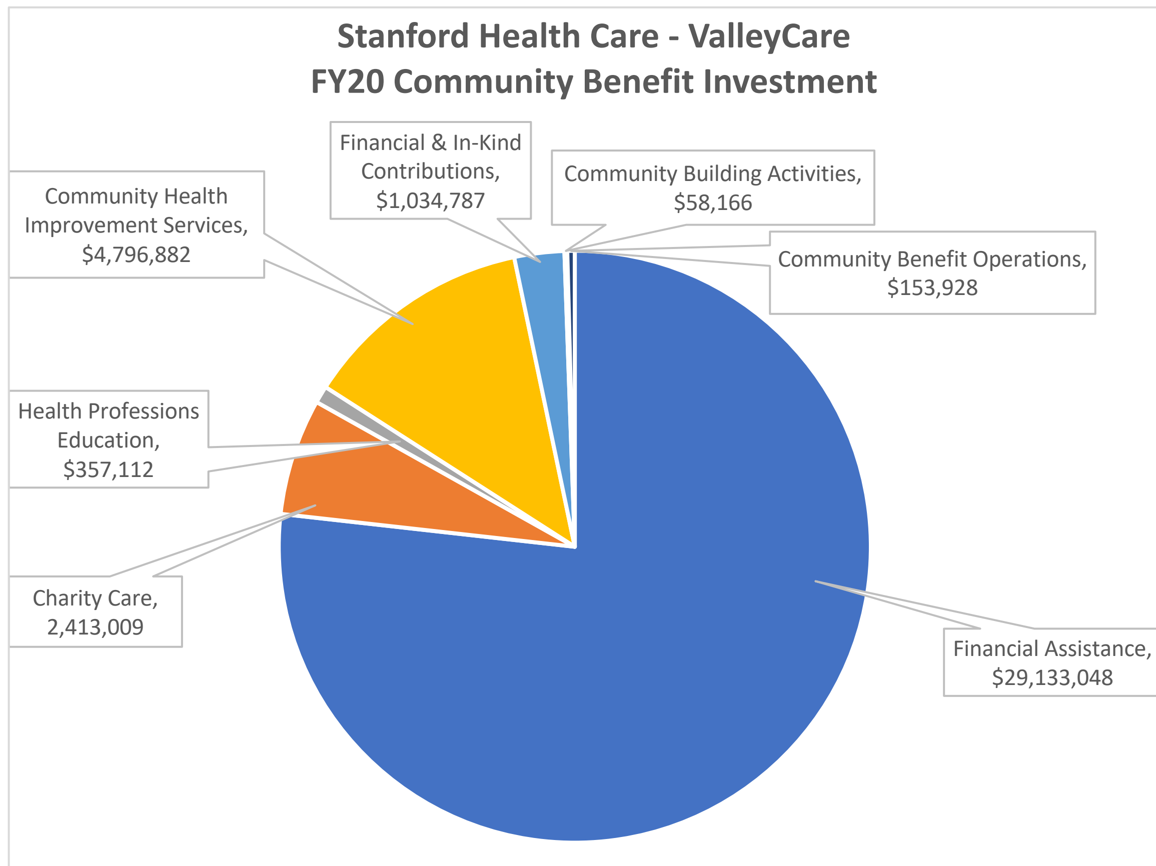
STANFORD HEALTH CARE – VALLEYCARE: FISCAL YEAR 2020 COMMUNITY BENEFIT REPORT

I. INTRODUCTION

Stanford Health Care – ValleyCare (SHC – VC) has been dedicated to providing high-quality, nonprofit health care to the Tri-Valley and surrounding communities since 1961. It seeks to heal humanity through science and compassion one patient at a time. Its mission is to care, to educate and to discover. SHC – VC delivers clinical innovation across its medical facilities. SHC – VC also maintains a strong commitment to the health of its community members and dedicates considerable resources to support its community benefit program.

II. TOTAL QUANTIFIABLE COMMUNITY BENEFIT INVESTMENT FOR FY2020

This report covers fiscal year (FY) 2020 beginning September 1, 2019 and ending August 31, 2020. During this time, SHC – VC invested over **$37 million**[1] in services and activities to improve the health of the communities it serves. In addition to providing details on this investment, this report describes the community benefit planning process and the Community Benefit Plan for FY 2021.



Financial Assistance and Charity Care: $31,546,057

- Uncompensated costs of medical services for patients enrolled in Medi-Cal, out-of-state Medicaid and other means-tested government programs: $29,133,048
- Charity Care: $2,413,009

Health Professions Education: $357,112

- Nurse and allied health professions training

Community Health Improvement Services: $4,796,882

- Community health education programs
- Enrollment assistance for the uninsured
- Programs to support healthy lifestyles for seniors
- Programs to support new mothers
- Health Library
- First aid
- COVID-19 Emergency Response Activities

Financial and In-Kind Contributions: $1,034,787

- Community clinic capacity building and support
- Community health improvement grants
- Donations of medical supplies and food
- Event sponsorships for nonprofit organizations
- Post hospital support - Case management, transportation, clothing

Community Building Activities: $58,166

- Workforce development

Community Benefit Operations: $153,928

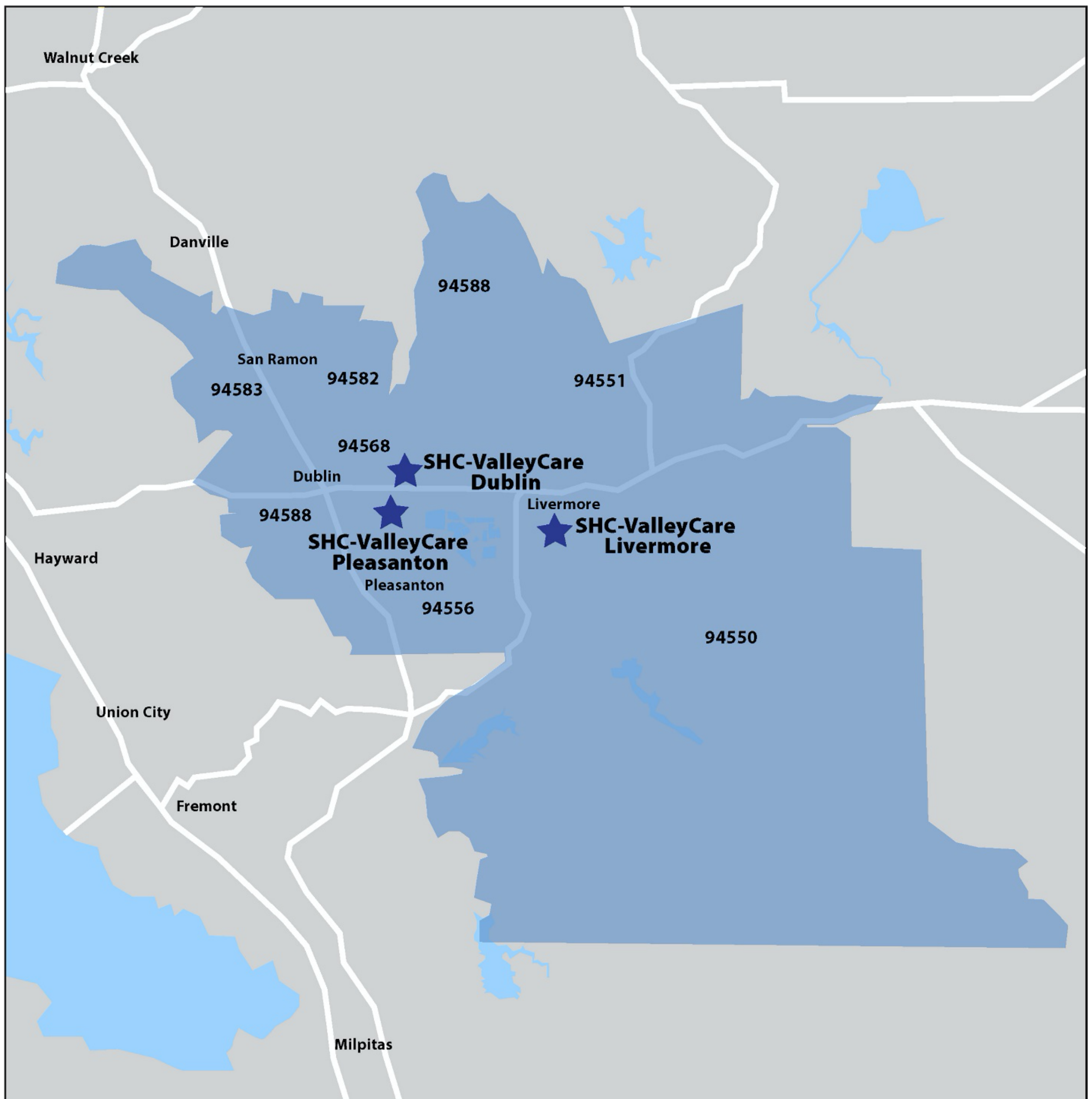
- Community Health Needs Assessment costs
- Dedicated Community Benefit staff
- Reporting and compliance costs

III. Community Served

SHC - VC's primary service area is the Tri-Valley. The Tri-Valley encompasses the suburban cities of Livermore, Pleasanton, Dublin, and San Ramon in the three valleys from which it takes its name: Amador Valley, Livermore Valley, and San Ramon Valley. Livermore, Pleasanton, and Dublin are in Alameda County, and San Ramon is in Contra Costa County. SHC - VC operates facilities in

Pleasanton, Livermore, and Dublin (see Map of the Community Served, next page). The Tri-Valley accounts for the majority of SHC - VC's inpatient discharges. Therefore, for the purposes of its community benefit initiatives and reporting, SHC - VC has identified the Tri-Valley as its target community.

Map of the Community Served



IV. Community Assessment Process and Prioritization of Community Health Needs

As required by California Senate Bill 697[2],community benefit managers from 13 local hospitals in Alameda and Contra Costa counties ("the Hospitals") contracted with Actionable Insights to produce a community health needs assessment in 2019. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs in each hospital area. SHC - VC was an active participant with the Hospitals in this work[3].

Health needs were identified by synthesizing primary qualitative research and secondary data, and filtering those needs against a set of criteria. Needs were then prioritized by SHC - VC's Community Benefit Advisory Group (CBAG), employing the community's prioritization of health needs and additional criteria. The final health needs were selected by the CBAG after reviewing the data, the prioritization process, and current SHC - VC community health initiatives. The CBAG then applied another set of criteria[4] from which three significant health needs were selected:

V. Community Investment to Address Community Health Needs

SHC -VC's annual community investment focuses on improving the health of our community's most vulnerable populations, supporting the health of the broader community, and providing opportunities for health education, research, and training. To accomplish these goals, all community benefit investment addresses the three prioritized community health needs: Health Care Access & Delivery, Behavioral Health, and Healthy Lifestyles (Obesity, Diabetes, Healthy Eating, Active Living).

The tables below describe the programs in which SHC-VC invested in FY20, by prioritized health need, and indicate which foci (vulnerable populations [VP], the broader community [BC], and/or health education, research, and training [ED]) the programs addressed.

A. Health Care Access & Delivery

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Senior Support Program of the Tri-Valley (SSPTV)	Senior Support Program of the Tri-Valley (SSPTV)	SHC – VC funded the provision of free, preventive health screenings and exams to low-income seniors. These screenings generally included blood pressure and diabetes checks, complete foot care, education about medication management, alcohol and drug education, as well as referrals, when appropriate. Some seniors also chose to receive colorectal cancer screenings and/or urine tests for infections and other toxicities. Persons served: 695	X	X	
Tri-Valley Haven	Shelter	For incoming shelter residents, SHC – VC offered TB screening tests and provided initial patient evaluation and follow-up diagnostic testing for any positive TB tests at no charge. 77 tests	X		
Sandra J. Wing Healing Therapies Foundation	Financial Assistance	SHC – VC gave funding to this foundation, which provides cancer patients with financial assistance during their treatment period for complementary healing services, such as acupuncture, acupressure, therapeutic massage, guided/visual imagery, and deep breathing meditation.	X		
HERS Breast Cancer Foundation	Post-Surgical	Helps support women healing from breast cancer by providing post-surgical products and services, regardless of financial status. HERS stands for Hope, Empowerment, Renewal, and Support. SHC – VC provided office space to the foundation free of charge.	X	X	

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Multiple	Tri-Valley Health Initiative	This initiative, in which SHC – VC participates, serves as a gateway to make contact and engage with under-served communities, as well as to provide health screenings, linkages, and health care enrollment opportunities to youth and families in the Tri-Valley. The initiative aims to increase access to health care for youth and families, including culturally-relevant prevention services, and strengthens the continuum of school-linked health supports throughout the Tri-Valley. Also, the initiative provides further opportunity to collaborate with school health officials in the local school districts regarding ongoing health concerns such as asthma and behavioral health.	X		
Multiple	Tri-Valley Anti-Poverty Collaborative	This collective impact initiative to end poverty in the Tri-Valley area involves SHC – VC and partners from government, nonprofits, faith-based organizations, schools, philanthropic organizations, businesses, and individual community residents. The Collaborative supports a program in which struggling residents across the region can achieve a basic standard of living in housing, health care, nourishment, education, and sustainable financial resources.	X		

B. Behavioral Health

Based on SHC – VC’s 2019 Community Health Needs Assessment findings, our interventions to improve behavioral health outcomes in our community include both mental health and substance abuse interventions. For more information about SHC – VC's Community Health Needs Assessment, please visit: https://www.valleycare.com/about-community-benefits.aspx.

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Alameda County Behavioral Health Care Services	Santa Rita Mental Health Assessment, Referral and Drop-In Center	SHC – VC's grant supported the development of a new homeless mentally ill outreach and treatment program which opened in June 2020. The Drop-In Center is located on the grounds of Santa Rita Jail for people with mental illness, co-occurring conditions, and substance use disorders, assisting them with immediate needs as they are released from jail. The Drop-In Center provides a safe, comfortable, non-threatening, temporary stop-over as next options are considered, and provides assistance/connection with: locating both immediate and long-term housing, medication, brief counseling and crisis counseling, referrals to further mental health and/or substance use services, connection to transportation (BART, bus, cab), refreshments and change of clothes. Telephone and/or internet to line up transportation and other post-release necessities. Persons served: 218	X		
Axis Community Health	Behavioral Health Program	The grant from SHC – VC supports a full-time licensed Marriage and Family Therapist (MFT), which increased capacity to serve uninsured Tri-Valley residents at Axis' clinical site. The additional counselor has helped to alleviate the dire need for more mental health services in the community. In addition, wait times for mental health services appointments at the clinic have been reduced. Persons served: 91 patients; 1,041 visits	X		

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Crisis Support Services of Alameda County	Healing Hearts 5K Walk/Run for Suicide Prevention	SHC – VC's funding supported this event, which is focused on raising awareness of the tragedy of suicide, reducing the stigma associated with depression and mental illness, educating the community about available services, supporting local suicide prevention programs, and providing a safe place to heal for those who have lost loved ones to suicide. Persons served: 370		X	

C. Healthy Lifestyles (Obesity, Diabetes, Healthy Eating, Active Living)

Based on SHC – VC's 2019 Community Health Needs Assessment findings, our interventions to improve Healthy Lifestyles (Obesity, Diabetes, Healthy Eating, and Active Living) in our community are focused on prevention, early intervention, and treatment. For more information about SHC - VC's Community Health Needs Assessment, please visit: https://www.valleycare.com/about-community-benefits.aspx.

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Meals on Wheels	Meals	This hot meal program provides local seniors with the nutrition critical to their health and well-being five days a week. Participating homebound seniors were located in Pleasanton, Livermore, Dublin, and Sunol. Some received several meals a day. SHC – VC's kitchen prepared the meals. Persons served: 800 people are served 34,420 meals (more than 90 meals per day, 5 days per week)	X		
Spectrum	Administrative	SHC – VC provided office space to Spectrum, the nonprofit organization in charge of organizing the Meals on Wheels program in the Tri-Valley area.	X		

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
CrossWinds Church Tri-Valley	Operation Cranberry Sauce	SHC – VC provided enough groceries to those in attendance to feed a family of five for a Thanksgiving meal. Each low-income family received one box of groceries that included staples and nonperishable items. In addition, SHC – VC staff provided reusable grocery bags, first aid kits, and nutrition information to event attendees; the nutrition information included healthy recipes, handouts on healthy eating, and healthy eating coloring books for children. Persons served: 830	X		
Culinary Angels	Meals	SHC – VC provided funds to support culinary Angels, a volunteer, donation-based organization that provides nutrient-rich meals and nutrition education to people going through a serious health challenge. Meals are delivered free-of-charge throughout Livermore, Dublin and Pleasanton.	X	X	
CAPE, Inc. (Community Association for Preschool Education)	Nutrition Services	CAPE, Inc.'s primary focus is providing the highest quality Early Childhood Development services that meet the needs of low-income children and their families including health and nutrition. SHC – VC supported CAPE's provision of meals for preschool-aged children by preparing all the meals. Persons served: 150 preschoolers	X		
Open Heart Kitchen	Meals	This local nonprofit organization, which serves free meals to the hungry, stored food and assembled box lunches in space on SHC-VC's Livermore campus free of charge.	X		
LARPD Children's Fair	Nutrition Education	At this free family event for the community, an SHC – VC health educator taught nutrition/healthy eating utilizing a spin wheel with nutrition questions, educational coloring books and had hands-on examples to demonstrate sugar content in foods.		X	

Partner	Program	Program Details and FY20 Impact	VP	BC	ED
Marylin Avenue Elementary School (Livermore)	Physical Education (PE)	SHC – VC funds an instructor to conduct PE classes for Marylin Avenue students during the school week. This project focused on improving scores for state testing, improving student physical health, educating the students on healthy living, and illustrating how to use exercise as a tool to help with focus in the classroom. Twice a week throughout the school year, students in fourth and fifth grades received 75 minutes of physical education. *Due to the COVID-19 pandemic, only mid-year evaluations were able to be completed due to the shelter-in-place and remote learning. 4th grade average results (54 students): • Mile improved from 13:50 to 12:19. 5th grade average results (46 students): • Mile improved from 13:49 to 11:75 minutes. • Curl-ups improved from 14 to 24. • Push-ups improved from 9 to 14. Overall, the students had better focus in class after PE. Most of the kids had an enjoyable experience with PE. Many students who were not physically active before showed a large amount of improvement. Many students were able to bring better problem-solving solutions and teamwork they learned from physical education to the classroom. Persons served: 105 students	X		
Tri-Valley Haven	Food	SHC – VC donated 340 turkeys to the shelter over the Thanksgiving holiday.	X		

VI. Hospital-Based Programs Supporting Community Health Improvement

Program	Program Details and FY20 Impact	VP	BC	ED
COVID-19 Response	Stanford Health Care – ValleyCare remains committed to supporting the broad community needs emerging from the COVID-19 pandemic. Through partnership with federal, state, and local government and public health agencies, other health care providers, and local community-based organizations, during FY20, the COVID-19 response investment totaled over $4M, including: - expanded access to care and community-based COVID-19 testing - participated in COVID-19 clinical trials - provided in-kind community-level emergency management expertise - supported community health improvement activities for patients and the broad community		X	
Supportive Care Programs for Cancer	SHC – VC provides free, non-medical support services to cancer patients, family members, and caregivers regardless of where patients receive treatment. Services provided include support groups, health education classes, seminars, and symposia, exercise and yoga classes, and healing touch supportive care. Persons served: 1,346		X	

Program	Program Details and FY20 Impact	VP	BC	ED
MedData (Patient financial advocacy services)	This program assists low income, uninsured, underinsured and homeless patients in researching their healthcare options. Services, covered by SHC – VC's funding and provided at no cost to the client, included helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers as needed.	X		
High School Regional Occupation Program (ROP)	SHC – VC provided high school Regional Occupation Program (ROP) students with valuable training, helping them to develop practical patient assessment and assistance skills. Students were permitted to observe and shadow health care staff in various areas of the hospital during a typical work day and, when appropriate, assist with simple projects for more hands-on experience. Persons served: 57		X	X
Post-Hospital Support	For patients that have limited or no ability to pay for necessary medical and non-medical services, the Social Work and Case Management department provides funding and resources. Services include transportation, medications and meal assistance. Persons served: 600	X		

Program	Program Details and FY20 Impact	VP	BC	ED
LifeStyleRx Scholarship Program	LifeStyleRx is SHC – VC's 70,000-square-foot wellness center, which provides comprehensive, medical-based, high-quality education and fitness services to all community members. The Scholarship Program provides low-income members of the community the opportunity to achieve their maximum health, fitness, and well-being potential by providing scholarships for membership. Persons served: 13	X		
Health Library	Provides scientifically based health information to assist community members in making more informed decisions about their health and health care. The Health Library is open to the community and reaches out to the local population, as well as to anyone who uses the Internet. The library has an extensive collection of online health and wellness resources, including medical websites and full-text articles. It also includes conventional health and wellness resources. All informational and educational materials are available in English and Spanish. Persons served: approx. 200		X	
Maternal/Child Education	SHC – VC held maternal and child education classes to prepare parents for childbirth. These classes were offered to the community at large and were free to low-income parents. SHC – VC also sponsored a class to help siblings adjust to a new baby as well as Infant Massage classes providing instruction to parents on massage techniques for	X	X	

Program	Program Details and FY20 Impact	VP	BC	ED
	newborns. In addition, SHC – VC provided education for new mothers on the benefits and importance of breastfeeding their infants. The New Moms Support Group supported new mothers by providing programs with guest speakers who focused on breastfeeding as a healthy start to life. The SHC – VC New Mom Wellness Program offered by LifeStyleRx was an effective way for new mothers in the community to increase their fitness and feel better while coping with a new baby. This comprehensive four-week program taught methods for gaining energy, living a healthy lifestyle, and becoming motivated to take care of newly-expanded families. Persons served: 439			
Cardiac Information and Education	SHC – VC provided a wide variety of resources and services to the broader community regarding cardiac information and education, including lectures and infant-CPR training. The latter was also offered free to low-income parents of newborns. Persons served: 274	X	X	

Program	Program Details and FY20 Impact	VP	BC	ED
Diabetes/Obesity Information and Education	For those with diabetes, SHC – VC offered a monthly diabetes support group with occasional guest speakers. SHC – VC also offers education to the Tri-Valley community about healthy eating habits and prevention of pre-diabetes. Persons served: 71		X	
Weight Loss Information and Education	SHC – VC offered bi-weekly support groups for both bariatric weight loss and medical weight management patients from the broader community. Persons served: 97		X	

VII. COMMUNITY-BASED PROGRAMS SUPPORTING COMMUNITY HEALTH IMPROVEMENT

Program	Program Details and FY20 Impact	VP	BC	ED
First Aid	SHC – VC provided medical supplies and first aid to a wide variety of local community events, such as races, festivals, and athletic events including: • First aid station at the Pleasanton Rotary Halloween Spirit Run. Persons served: 500		X	
Career Fairs	SHC – VC provided representation at three career fairs in the Tri-Valley: • Tri Valley ROP Career Fair held at Amador Valley High School in Pleasanton had 2,700 students in attendance. • Granada High School in Livermore had 600 students in attendance. Each career fair was represented by SHC – VC staff in different medical fields. Staff provided guidance and resources for different medical careers and the pathways into those fields. Career fields represented were Physician, Nursing, Occupational Therapy and Physical Therapy. Persons served: 3300		X	X

VIII. HEALTH EDUCATION, RESEARCH, AND TRAINING

Program	Program Details and FY20 Impact	VP	BC	ED
Nursing Education	Student training programs, including Nursing Clinical Experience Registered Nurse Preceptorship			X
Allied Health Professions Education	Student training programs, including Cardiac Rehabilitation Emergency (EMT, Paramedic) Health Administration Physical & Sports Medicine Surgical Technologist			X

STANFORD HEALTH CARE - VALLEYCARE: FISCAL YEAR 2021 COMMUNITY BENEFIT PLAN

I. COMMUNITY BENEFIT PLAN GOALS & STRATEGIES

Stanford Health Care - ValleyCare (SHC – VC) plans to invest its community benefit efforts, including grants, sponsorships, in-kind support, and collaboration/partnership activities, in work that benefits the larger community, including health research, health education and training, serving vulnerable populations, charity care, and unreimbursed Medi-Cal and Medicare. This plan represents the second year of a three-year strategic investment in community health. The plan is based on documented community health needs disclosed in the 2019 Community Health Needs Assessment. These activities provide essential services for those in need in the community. While it is SHC – VC's intent to fulfill the below listed goals and strategies, it is important to note that the country is in the midst of the COVID-19 pandemic. Due to county and state shelter-in-place restrictions and guidelines, there are limitations with activities and events. SHC – VC is unable to predict the timing of when guidelines and restrictions will loosen but will remains flexible and adaptable to supporting the goals and strategies listed below.

For FY21, SHC – VC's goals and strategies for its Community Benefit Plan are as follows:

A. Health Care Access and Delivery

Limited access to health care and compromised health care delivery negatively affect people's quality of life and ability to reach their full potential. Barriers to receiving care include lack of availability, high cost, lack of insurance coverage, and lack of cultural competence on the part of providers. These barriers lead to unmet health needs, delays in receiving appropriate care, and an inability to attain preventive services.

Tri-Valley community members conveyed many concerns about health care access and delivery. Focus group participants and key informants discussed issues related to health insurance access, affordability of care (including deductibles), and the lack of access to specialists (including geriatric care), especially for Medi-Cal patients. Access to behavioral health services was a major concern, particularly the size of the behavioral health workforce, which was deemed insufficient to adequately address demand. Lack of access to oral health services was also identified in the SHC - VC service area. The health care workforce overall was a topic frequently addressed by professionals, who cited low reimbursement rates for clinicians as a barrier to offering services to Medi-Cal patients.

The community also expressed alarm about barriers to access faced by immigrants who are either ineligible for Medi-Cal due to their immigration status or fearful of being deported if they access services for which they are eligible. With regard to health care delivery, the community

identified the need for greater language support, culturally appropriate health care services, and whole-person care. Additionally, experts described the difficulty LGBTQ community members, especially transgender individuals, experience in finding medical professionals sensitive to their needs.

In terms of specialty care, Federally Qualified Health Centers (FQHCs) are the only organizations that receive a higher reimbursement rate for dental services. Statistics show, however, that the ratio of FQHCs to residents is significantly worse in the SHC - VC service area than the state. Further, the percentage of Medicare patients whose diabetes is not well-managed is somewhat worse in the service area than the state. This suggests access and delivery issues with respect to preventive care.

Some access and delivery issues may be associated with inequitable health outcomes. The index of premature death based on ethnicity (i.e., premature death for non-Whites versus Whites) is significantly worse in the SHC - VC service area than the state. More people of “Other”[5] ethnicities are uninsured than any other group locally, followed by Pacific Islanders and Latinx residents. Preventable hospital events were highest for residents of African ancestry, and the rate of diabetes management in the service area is lowest among patients of African ancestry.

Long-Term Goal: Increase the proportion of Tri-Valley residents who have access to appropriate health care services.

Intermediate Goal A.1: Improve access to quality primary and specialty care and preventive health care services for at-risk community members.

Strategies:

Allocate resources to support:

- Participation in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care).
- Provision of Charity Care to ensure low-income individuals obtain needed medical services.

Provide support for efforts such as:

- Providing information and opportunities for students to learn more about health care professions.
- Providing the setting (i.e., hospital) for students, interns, and other health professionals to be trained to provide health care.
- The Resource Center is accessible to all community members free of charge.

- Providing medical supplies, first aid services, and/or athletic training at local community events.
- Providing free TB screenings and imaging services at ValleyCare Urgent Care to incoming residents of local homeless shelters.
- Supporting wellness strategies such as health fairs.
- Educational events and classes open to the public on health topics such as asthma self-management, breast cancer, breastfeeding, CPR, diabetes self-management, and stroke awareness and prevention.

Anticipated Impacts:

- Increased access to health care and health care services.
- Increased health care workforce pipeline.

B. Behavioral Health

More than half of East Bay focus groups and key informants prioritized behavioral health, including mental health and substance use, as a top health need. Depression and stress were the most common issues raised. Community members identified trauma and adverse childhood experiences (ACEs) as drivers of behavioral health problems. A number of participants described the impact of discrimination and institutionalized racism as generational trauma, which has contributed to inequitable health outcomes.

The Mayo Clinic estimates that in 2015, roughly 20% of the adult U.S. population was coping with a mental illness.[6] Mental health (or emotional and psychological well-being, along with the ability to cope with normal, daily life) is key to personal well-being, healthy relationships, and the ability to function in society.[7] Depression and anxiety can affect one's ability for self-care. Likewise, chronic diseases can lead to negative impacts on an individual's mental health.[8]

The use of substances such as alcohol, tobacco, and legal and illegal drugs affects not only the individuals using them, but also their families and communities. Vaping, or inhaling aerosolized nicotine through an electronic smoking device, is an emerging concern, particularly for youth: More than 20% of high school seniors nationwide report vaping in the past month.[9, 10] Nicotine is highly addictive and is known to harm brain development through age 25.[11] Substance use can lead or contribute to other costly social, physical, mental, and public health problems, including domestic violence, child abuse, suicide, car accidents, and HIV/AIDS.[12]

In recent years, advances in research have resulted in a variety of effective evidence-based strategies to treat various addictions. Brain-imaging technology and the development of targeted medications have helped to shift the perspective of the research community with

respect to substance use.[13] Increasingly, substance use is seen as a disorder that can develop into a chronic illness requiring lifelong treatment and monitoring.[13]

Focus group participants and key informants across the East Bay discussed the co-occurrence of mental health and substance use. Data suggest that alcohol is an issue in the SHC - VC service area: The proportion of household expenditures for alcohol is significantly higher here than the state average, as is the rate for excessive alcohol consumption. The ratio of liquor stores per capita is slightly higher in the local area than the state average.

Domestic violence has negative impacts on the mental health of victims and their families.[14] Domestic violence hospitalizations are significantly higher in the local area than the state average.

Long-Term Goal: Improve behavioral health among residents in the Tri-Valley.

Intermediate Goal B.1: Improve mental health and well-being among residents.

Strategies:

Participate in collaboration and partnerships to address mental health in the community such as:

- Partnering with behavioral health services organizations or similar collaborations on efforts to address behavioral health.

Anticipated Impact:

- Increased access to health care and health care services.
- Increased health care workforce pipeline.

Intermediate Goal B.2: Improve residents' access to coordinated mental health care.

Strategies:

Provide support for efforts such as:

- Supporting coordination of behavioral health care and physical health care, such as co-location of services (e.g., Axis Community Health).
- Assessment and referral to behavioral health and social non-medical services for vulnerable reentry populations.
- Screening and referral for behavioral health issues among older adults.

Anticipated Impact:

- Among providers, increased knowledge of the importance of and approaches for routine screening and diagnosis of depression and related disorders.
- Improved clinical and community support for active patient engagement in treatment goal-setting and self-management.
- Improved access to mental health services among community members.

C. Healthy Lifestyles

The community prioritized healthy eating and active living (including access to food and recreation; food insecurity; nutrition, diet, and fitness), diabetes, and obesity as a health need.

Access to Food and Recreation

The U.S. Surgeon General's "Vision for a Healthy and Fit Nation 2010" described how different elements of a community can support residents' healthy lifestyles. The various components of the physical environment, including sidewalks, bike paths, parks, and fitness facilities that are "available, accessible, attractive and safe," all contribute to the extent and type of residents' physical activities.[15] Other community elements that support healthy lifestyles include local stores with fresh produce. Residents are more likely to experience food insecurity in communities where fewer supermarkets exist, grocery stores are farther away, and there are limited transportation/transit options.[16]

The Centers for Disease Control and Prevention (CDC) recommends policies and environments that support behaviors aimed at achieving and maintaining healthy weight in settings such as workplaces, educational institutions, health care facilities, and communities.[17] For example, the availability of healthy and affordable food in retail and cafeteria-style settings allows individuals to make better food choices throughout the day. Otherwise, people may settle for caloric foods of low nutritional value.[18]

Public health experts in Alameda County identified the lack of access to recreation and healthy food in certain areas (or "food deserts") as drivers of poor community health.

With regard to recreation, focus group participants cited a lack of safe public spaces and community centers where residents can engage in recreational activities and exercise. Some neighborhoods have parks, but many of them are not being used because residents fear becoming victims of crime. Some parks lack appropriate exercise equipment; others offer no programs to encourage or teach residents to exercise. Parents specifically mentioned the lack of free exercise and sports programs as a barrier to physical activity for children.

With regard to the food supply, residents described difficulty accessing grocery stores that carry fresh food, the abundance of fast food restaurants, and their dismay with the unhealthy food served at schools and provided by food banks. Local access to healthy food stores is significantly lower than the state average; service area residents have significantly less access to grocery stores and supermarkets than the average California resident. Finally, the ratio of fast food restaurants to residents is higher locally than the state average.

Food Insecurity

Food insecurity is defined as the "lack of consistent access to enough food for an active, healthy life."[19] Hunger and food insecurity are related but distinct concepts; hunger is the physical discomfort related to "prolonged, involuntary lack of food," while food insecurity refers to a "lack of available financial resources for food at the household level."[20, 21] Measurements of various levels of food insecurity, from marginal to low or very low, include anxiety about food insufficiency, household food shortages, reduced "quality, variety, or desirability" of food, diminished nutritive intake, and "disrupted eating patterns."[21] In 2017, approximately one in eight Americans experienced food insecurity, of which more than one third were children.[20]

Individuals who are food-insecure may be more likely to experience various poor health outcomes/health disparities, including obesity. Children who experience food insecurity are also at greater risk for developmental complications and/or delays compared with children who are food-secure. Food insecurity may have a detrimental impact on children's mental health.[16]

Community members specifically mentioned food insecurity, and they often expressed a perception that healthy food is more expensive than fast food and packaged foods. Nearly half (47%) of the population in SHC - VC's service area lives in a Census tract identified as a food desert (meaning a "substantial" share of residents has low access to a supermarket or grocery store); this compares with 27% statewide.

Ethnic disparities in food insecurity are evidenced by the differential statistics regarding SNAP benefits, with Pacific Islander, Native American, and "Other" households accessing those benefits at rates higher than the state average and higher than the rates for other ethnic groups in the service area.

Nutrition, Diet, and Fitness

The benefits of maintaining fitness and a healthy, nutritious diet are commonly known and well-documented, yet most people in the U.S. do not follow the recommended healthy food and exercise guidelines.

The community connected healthy eating and active living to good mental health. However, residents noted that the convenience and relatively low cost of fast food and unhealthy grocery items makes buying and preparing fresh food less likely for busy families. Experts discussed the

fact that few people walk or bike to work because they have long commutes. In fact, workers from the SHC - VC service area have significantly longer commutes than the state average, driving over 60 minutes each way. This can affect the time they have available for physical activity and healthy cooking/eating. (See also Access to Food and Recreation.)

Residents talked about the lack of motivation and time to exercise, the expense of gym memberships and sports or exercise programs, and the inconvenient scheduling of exercise classes. Regarding physical activity, the community identified the increased use of screens (including video games) among youth as a driver of sedentary lifestyles.

The community frequently mentioned the Latinx population as one of particular concern. Latinx youth have the highest levels of physical inactivity in the SHC - VC service area. Specifically, a significantly smaller proportion of children and youth walk or bike to school than the state average. Local children 2 to 13 years old also consume significantly fewer fruits and vegetables than the state average for their age group.

Diabetes

The CDC estimates that 30 million people in the U.S. have diabetes, and that an additional 84 million U.S. adults are pre-diabetic. The more serious health complications of diabetes include heart disease, stroke, kidney failure, adult-onset blindness, and lower-extremity amputations.[22] Nine of 10 diagnosed cases of diabetes are Type 2. Risk factors for Type 2 diabetes include being physically inactive, being overweight, being age 45 or older, having a close family member with Type 2 diabetes, and having pre-diabetes. Additionally, certain ethnic groups (African ancestry, Latinx, Native American, Pacific Islanders, and some Asian groups) are at a higher risk.[22]

The rate of diabetes management in the SHC - VC service area is somewhat lower than the state average—and lowest among patients of African ancestry. Most feedback from the community (focus group participants and key informants) identified the need for more public health education to increase healthy eating and active living, which would help prevent obesity, diabetes, high blood pressure, and other chronic diseases. Culturally appropriate health education may be lacking.

Obesity

Nearly one in five children and nearly two in five adults in the U.S. are obese.[23] Being obese or overweight increases an individual's risk for diabetes, hypertension, stroke, and cardiovascular disease. Obesity can also contribute to poor mental health (anxiety, depression, low self-esteem), stigma, and social isolation. Among children and youth, obesity can also increase the likelihood of bullying.[24] Further, food insecurity and obesity often co-exist because "both are consequences of economic and social disadvantage."[25]

Most focus group and key informant feedback pointed to the need for more community health education to increase healthy eating and active living, which would help prevent obesity and other chronic conditions. Culturally appropriate health education may be lacking, according to participants. Parents specifically discussed having difficulty encouraging their children to engage in healthy eating and active living practices to lose weight.

The proportion of the local adult population that is overweight is significantly higher compared to the state proportion. Locally, obesity is highest among Latinx youth and among African Ancestry adults.

Long-Term Goal: Increase healthy living among children, youth, and adults in the Tri-Valley.

Intermediate Goal C.1: Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area.

Strategies:

Provide support for efforts such as:

- Assisting schools in implementing guidelines for promoting healthy eating and physical activity.
- In-kind support of community health workers for health education, and as outreach, enrollment, and information agents to increase healthy behaviors.
- Strategies to increase fruit and vegetable consumption.
- Programs of education and support for healthy lifestyles across various populations (e.g., older adults, new mothers).

Participate in collaboration and partnerships to promote healthy eating and/or active living such as:

- Health fairs for screening and education.

Anticipated Impact:

- Increased knowledge about healthy behaviors.
- Increased access to physical activity.
- Increased access to healthy foods.
- Increased physical activity.
- Increased consumption of healthy foods.
- Reduced time spent on sedentary activities.

- Reduced consumption of unhealthy foods.
- More policies/practices that support increased physical activity and improved access to healthy foods.

II. EVALUATION PLANS

As part of SHC - VC's ongoing community health improvement efforts, SHC - VC 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.

SHC - VC 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, SHC - VC will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

ENDNOTES

[1] This figure does not include the cost of unreimbursed Medicare.

[2] SB 697: By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

[3] Hospitals: John Muir Health, Kaiser Permanente – Diablo Area (Antioch and Walnut Creek Kaiser Foundation Hospitals), Kaiser Permanente – East Bay Area (Oakland and Richmond Kaiser Foundation Hospitals), Kaiser Permanente – Greater Southern Alameda Area (Fremont and San Leandro Kaiser Foundation Hospitals), St. Rose Hospital, San Ramon Regional Medical Center, Stanford Health Care - ValleyCare, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System.

[4] SHC - VC selection criteria: supported by primary data (community input) and/or secondary data; misses a benchmark (Healthy People 2020 or California state average); is one in which disproportionalities exist (i.e., there are disparities or inequities by ethnicity, income, area of residents, gender, sexual orientation, etc.); is one in which existing community partnerships, programs, assets, or emerging opportunities can be leveraged; is one in which SHC - VC has the required expertise as well as the human and financial resources to make an impact.

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

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