Solano County Community Health Improvement Plan

January 2023

harder + co | community research

SOLANO COUNTY 1850

SOLANO PUBLIC HEALTH

Contents

Executive Summary

The Community Health Improvement Plan (CHIP) is intended to be a long-term, systematic effort to address priority issues that affect community health. This plan builds on the foundational work in the previous Solano County CHIP in 2017 by continuing to focus on upstream drivers of health inequities and deepen work with community partners critical to responding to the unique needs of Solano County residents and engaging community members in efforts to promote equity and achieve the CHIP vision.

Solano Public Health (SPH) and partners used a streamlined process to identify updated needs and to develop a new plan to focus their work moving forward. This began with a Community Health Needs Assessment (CHNA) in 2020 to re-examine health needs across a broad spectrum of indicators related to health determinants and outcomes. A Steering Committee made up of representatives from across Solano County helped prioritize health needs from the CHNA and identified goals, strategies and milestones for the CHIP. Please see the Appendix for a list of members and their organizational affiliations.

The Steering Committee used the following pillars as guiding principles in developing the CHIP:

- **Racism as a public health issue** means SPH understands that racism permeates all aspects of life. Racism is a health outcome and a social determinant of health. The indicators selected to describe health needs are patterned according to race due to systemic and interpersonal racism[1].

- **Social belonging** means that SPH views interpersonal associations, organizational affiliations, and other forms of social recognition as essential for maintaining sound mental and physical health. Social belonging is a health outcome and a social determinant of health[2]. This perspective is especially important for marginalized communities, youth, and older adults.

- **Trauma over the life course**[3] means that SPH recognizes the role of trauma in shaping the psychology and life pathways of individuals exposed to harm.

CHIP Vision

The Healthy Solano Steering Committee worked together to develop the CHIP vision for a healthier community. The resulting vision is:

- A health system that invests in the root causes of health issues, with holistic services that are affordable and available to all.
- A commitment to centering the needs of Black, Indigenous, and People of Color (BIPOC) communities.
- An inclusive and accepting community with a strong educational system, available housing, and reduced poverty.
- A safe and healthy Solano County that has walkable and bike-able communities, clean air, and universal access to healthy food.

[1] SPH recognizes that the presentation of capitalized racial and ethnic groups may make some readers uncomfortable. Racial and ethnic categories are historically contingent, socially constructed, and flawed. For the purpose of this report, we decided to capitalize all racial and ethnic groups for both grammatical clarity and consistency.

[2] Camilla A. Michalski, Lori M. Diemert, John F. Helliwell, Vivek Goel, Laura C. Rosella, Relationship between sense of community belonging and self-rated health across life stages, SSM - Population Health, Volume 12, 2020. (https://www.sciencedirect.com/science/article/pii/S235282732030313X)

[3] Fink DS, Galea S. Life course epidemiology of trauma and related psychopathology in civilian populations. Curr Psychiatry Rep. 2015 May;17(5):31. doi: 10.1007/s11920-015-0566-0. PMID: 25773222; PMCID: PMC4380344.

Trauma is health outcome and a social determinant of health. In particular, the enduring effects of ACEs are a major source of disparities evident across the selected health needs[4].

The goals for the four strategic issues are as follows:

Behavioral Health: Ensure all Solano County residents feel safe, supported, and well in their communities.

Access to Care: Eliminate inequities in access to preventive services and health care across Solano County.

Maternal and Infant Health: Improve the well-being of BIPOC women, infants, children, and families.

Housing Stability: Ensure all Solano County Residents have access to safe, stable, and affordable housing.

To accomplish these goals, everyone in both the public and private sectors — policy makers, business, government agencies, educators, health care professionals, philanthropic organizations, and residents — need to work together. The CHIP includes objectives, strategies, and action steps that focus on health equity, engage a broad array of partners, and promote collaboration and community engagement.

The implementation of the CHIP is driven by the Healthy Solano Collaborative. The group is a representative of the many organizations and individuals who contribute to the health of the public. Upon completion of the plan, the Collaborative will turn the focus to establishing the structure by which the work will be done. Much of the leadership needed for the planning process has come from the staff of Solano Public Health and other county staff. Going forward, the Collaborative will set up decision-making processes and oversee progress toward milestones.

[4] Ace Response. Ace Study, Retrieved from: http://www.aceresponse.org/who_we_are/ACE-Study_43_pg.html on January 20, 2023.

Letter to the Community

Dear Community Members,

We are pleased to present the 2023 Solano County Community Health Improvement Plan. With this plan in place, we continue to advance our vision of a healthier community. The plan includes goals, strategies, and collective action steps we will use as a guide to pursue healthier communities across our four (4) strategic issues: behavioral health, access to care, maternal and infant health and housing stability.

We are particularly proud of the plan's integration of the Bay Area Regional Health Inequities Initiative's (BARHII) recommendations for making equity endemic in Solano County. BARHII's strategies and action steps are woven throughout each element of the plan. This plan also aligns with Healthy People 2030 Overarching Goals and the statewide efforts of CDPH Equity Playbook and Let's Get Healthy California. Additionally, we are proud of the level of engagement from a wide variety of community leaders in the development of the CHIP. The plan integrates the voices of the community gathered as part of the extensive assessment phase and creates a foundation for ongoing engagement with community members to pursue our collective health and equity goals.

The completion of this plan was detoured by the COVID-19 pandemic, as our collective public health system was called upon to address the health and other needs of community members impacted by illness, job loss, and other instabilities. While the CHIP completion comes at a time when the immediacy of the pandemic has curbed, our commitment to equitable responses to public health challenges and authentic community engagement has not waivered. This plan focuses on these lessons learned from COVID-19, and the communities most impacted.

There are numerous other county-wide and community level plans addressing intersecting issues. The value of the CHIP efforts is the diverse perspectives and coordinated efforts across a broadly defined "health of public" system. Our CHIP Steering Committee included entities responsible for developing related county-wide plans. The work done as part of the CHIP not only enhances and informs the efforts of these other groups but ensures there is good coordination and a decrease in duplicated efforts. The CHIP also focuses on breaking down silos in order to better leverage resources including funding to better serve the Solano community.

We want to thank all of the individuals participating in the planning efforts without whom we would not have the diversity of thought and creativity to solve the problems we face as a community. Additionally, we would like to acknowledge the support of the Board of Supervisors, Mayors, City Council Members, and Health & Social Services leadership. Our efforts are enhanced by everyone's commitment to our vision of a healthier community.

Sincerely,

Healthy Solano Collaborative

Steering Committee Members

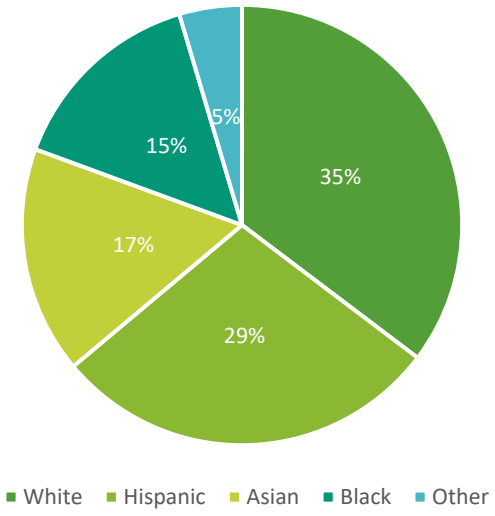
Thank you to all the community representatives who served on the Steering Committee and whose commitment of time, resources, and expert counsel has guided the development of the Community Health Improvement Plan. The Steering Committee met monthly for nearly a year to develop the CHIP. We appreciate everyone's time and engagement in this collaborative process.

Name	Organization
Angel Mackelvie	VOICES
Annette Aalborg	Touro University California
Ashley Banta	Vacaville Solano Services Corporations
Ashley Mahri Cumpas	Solano County Public Health
Christine Smith	NorthBay Health
Debi Sanderson	Kaiser Permanente Vacaville
Denise Kirnig	Innovative Health Solutions
Elaine Clark	Napa/Solano Area Agency on Aging/Solano County ODAS
Gio Miramontes	Innovative Health Solutions
Hans O. Johnson	Solano Public Health/ California Health Medical Reserve Corps
Hannah Cordero Chen	Kaiser Permanente
Hannah O'Leary	Partnership HealthPlan
Heather Henry	Workforce Development Board of Solano County
Heather Sanderson	Fairfield PAL
Jonathan Cook	Solano Pride Center
K Patrice Williams, J.D.	BrandGOV Outreach
Kathryn Power	Partnership HealthPlan
Kwiana Algere	First 5 Solano
Mohamed Jalloh, PharmD, BCPS	Touro University California
Norma Lisenko	Innovative Health Solutions
Dr. Rhonda Renfro	Club Stride, Inc.
Stefanie Garcia	Solano County Public Health
Susan Miller	Child Start, Inc.
Tracy Lacey	Solano County Behavioral Health

Background

Solano County extends from the San Pablo Bay in the west to the heart of the Central Valley in the east and is centrally located between the San Francisco and Sacramento metropolitan regions. Solano is one of the most diverse counties in the country; the city of Vallejo has been named as one of the most diverse cities in the country. The county is home to 435,000 people from a wide variety of cultural backgrounds (Exhibit 1). Roughly 20% of county residents are children and 23% are older adults (Exhibit 2). A recent senior needs assessment projected a significant increase of seniors by 2024. More than one-third of the county's residents speak a language other than English at home. This compares to a rate of just 21% for the United States population[5].

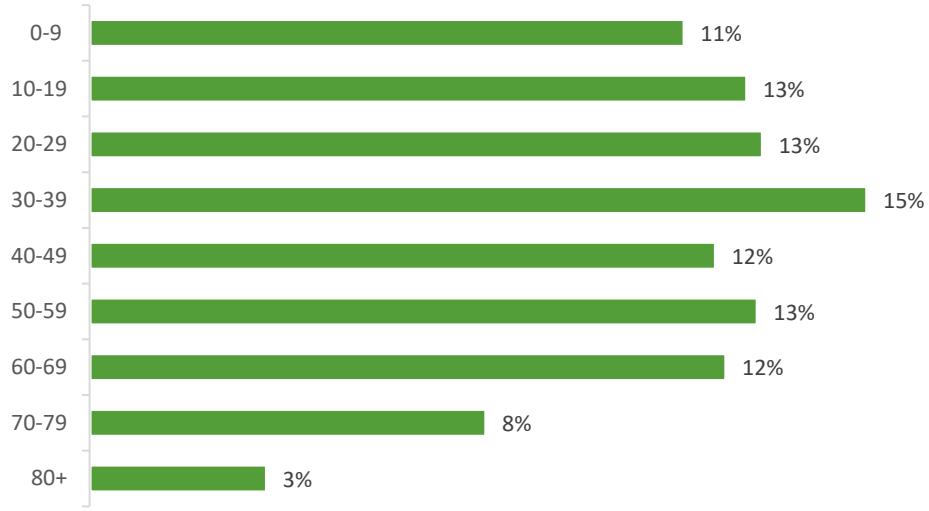
Exhibit 1. Solano County Population: Ethnicity Breakdown



Source: United State Census. Quick Facts: Solano County, https://www.census.gov/quickfacts/fact/table/solanocounty

[5] Solano County Transit Title VI Update Program Report (2020). Accessed from: https://sta.ca.gov/wp-content/uploads/2019/10/Agenda-Item-8.F_2020Title-VI-Draft-V3.pdf on January 20, 2023.

Exhibit 2. Solano County Population: Age Breakdown



Source: United State Census: Age and Sex (2021). https://data.census.gov/table?q=age+solano+county&y=2021&tid=ACSST1Y2021.S0101.

Along with the benefits of such a diverse community, inequities in who benefits from the advantages Solano County offers exist. The Bay Area Regional Health Inequities Initiative (BARHII), in partnership with Solano County, reports many of the ways that Black, Indigenous, and People of Color (BIPOC) in Solano County have faced long standing health inequities, which were exacerbated by the COVID-19 pandemic. For example, BIPOC communities experience disproportionate levels of housing and job insecurity, reduced access to services, and mental health issues. The BARHII report emphasizes the importance of targeted investments to serve BIPOC communities in Solano County in order to advance health equity. Many of the recommendations the report elevates are woven into this plan.

The Community Health Improvement Plan (CHIP) is intended to be a long-term, systematic effort to address priority issues that affect community health. This plan builds on the foundational work in the previous Solano County CHIP in 2017 by continuing to focus on upstream drivers of health inequities and deepen work with community partners critical to responding to the unique needs of Solano County residents and engaging community members in efforts to promote equity and achieve the CHIP vision.

CHIP Vision

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- A commitment to centering the needs of Black, Indigenous, and People of Color (BIPOC) communities.

- An inclusive and accepting community with a strong educational system, available housing, and reduced poverty.

- A safe and healthy Solano County that has walkable and bike-able communities, clean air, and universal access to healthy food.

2017 CHIP

In 2014, Solano Public Health (SPH) began the first round of developing Community Health Improvement Plan (CHIP). That process utilized Mobilizing for Action through Planning & Partnerships (MAPP), an evidence-based process that numerous jurisdictions across the country have used to assess and address the health needs of their communities. The process allowed for the engagement of many and varied partners who contribute to the health of Solano County communities in looking at multiple facets of the community health needs and developing a first-ever community plan to address health needs in a collective way.

The 2017 CHIP focused on five strategic issues. The goals for the strategic issues were as follows:

- **Poverty**
  - o Advance equity through meeting basic needs
  - o Advance equity through system change
- **Homelessness**
  - o Coordinate supportive services for those who are homeless or at risk of being homeless
- **Lack of Affordable Housing**
  - o Research and propose solutions for a full spectrum of housing options
- **Unemployment**
  - o Provide communities with resources and guidance that support the cultivation of interests and skills in youth
  - o Expose people of all ages to opportunities for assessment/education/experience/and skill building for job readiness
- **Inequitable K-12 Education / Barriers to Educational Attainment**
  - o All students acquire the academic & life skills they need to thrive
  - o Adverse Childhood Experiences (ACES) are understood, prioritized and addressed in schools and the community

The 2017 CHIP was the first plan developed for Solano County. This initial plan established an important foundation for community leaders to identify and address priority health needs, and it set the stage for everyone in each community to take part in making Solano County a healthier place. The 2017 plan was also ambitious, focusing on a broad range of social determinants of health. This led to the establishment of individual taskforces focused on each of the strategic priorities.

2017 CHIP Successes

The 2017 CHIP resulted in several new partnerships, programs and efforts to advance health and health equity in Solano County, including:

- The planting of community gardens in every city within Solano County.
- The establishment and implementation of positive policy changes within Solano County for tenant protections.
- The development of a homeless / housing taskforce, which includes community members who are or have been homeless, other key stakeholders, and service providers.
- The distribution of an unemployment resource list across the county to organizations who serve youth & families.
- Engagement from all school districts and other agencies and organizations in efforts to address ACEs.
- The addition of affordable housing as an agenda item for the Board of Supervisors and City Councils at least once per quarter.
- The provision of 10 job skill development workshops to over 40 youth, which resulted in over 40 hours of career development training to the community.
- The development and implementation of the Resilience Solano Strategic Plan: Working to Prevent and Heal Trauma, published February 2019. This plan was developed in partnership with First5 Solano, Solano Kids Thrive, and ACE Connections to address adverse childhood experiences (ACEs).

2023 CHNA and CHIP

The broad framing for this updated plan was to build off momentum of the 2017 CHIP to reflect current priorities. This includes giving a special awareness and commitment to addressing systematic racism and health equity following racially motivated murders and the COVID-19 pandemic. Therefore, SPH undertook a streamlined process to identify updated needs and to develop a new plan to focus their work moving forward. This began with a Community Health Needs Assessment (CHNA) in 2020 to re-examine health needs across a broad spectrum of indicators related to health determinants and outcomes. The 2020 CHNA identified eight (8) priority areas to be considered for this CHIP.

Pillars of the 2023 CHNA and CHIP

SPH chose to use three consistent perspectives to inform the both the CHNA and CHIP processes: racism as a public health issue, social belonging, and trauma endured over the life course.

- **Racism as a public health issue** means SPH understands that racism permeates all aspects of life. Racism is a health outcome and a social determinant of health. The indicators selected to describe health needs are patterned

according to race due to systemic and interpersonal racism[6].

- **Social belonging** means that SPH views interpersonal associations, organizational affiliations, and other forms of social recognition as essential for maintaining sound mental and physical health. Social belonging is a health outcome and a social determinant of health. This perspective is especially important for marginalized communities, youth, and older adults.

- **Trauma over the life course** means that SPH recognizes the role of trauma in shaping the psychology and life pathways of individuals exposed to harm. Trauma is health outcome and a social determinant of health. In particular, the enduring effects of ACEs are a major source of disparities evident across the selected health needs.

These perspectives are interrelated and overlapping. For instance, toxic stress is one consequential thread connecting these impactful health issues: racism can impact both feelings of social belonging (i.e, recognition or exclusion) and experiences of trauma (e.g., violence, discrimination, and ACEs). They served as guiding principles for the Steering Committee in developing the CHIP goals, objectives and strategies.

Overview of 2020 CHNA Findings

Prior to the CHIP process, Solano Public Health collaborated with non-profit hospital partners in the creation of a Community Health Needs Assessment (CHNA)[7], which included hospital service areas spanning Solano and parts of Napa and Yolo counties. The data collection and analysis from that process has been updated to reflect the current health needs of Solano County exclusively. As such, the primary data collection in this CHNA was planned and coordinated with representatives from the Vacaville and Vallejo Kaiser Foundation Hospitals, NorthBay Medical Center, and Sutter Health. Since the hospital service areas spanned county lines, health officials from Napa County also participated and contributed to planning. Additionally, two consulting firms, Harder+Company Community Research (Harder+Company) and Community Health Insights were hired by Kaiser Permanente and Sutter Health respectively to conduct the data collection and analysis. Harder+Company was retained by Solano Public Health for the development of this Solano-specific CHNA. This collaboration is described more fully in the Process section of the report.

The CHNA data collection and analysis process was consistent with the conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII), which focuses attention on measures that intentionally connect social inequities and

[6] SPH recognizes that the presentation of capitalized racial and ethnic groups may make some readers uncomfortable. Racial and ethnic categories are historically contingent, socially constructed, and flawed. For the purpose of this report, we decided to capitalize all racial and ethnic groups for both grammatical clarity and consistency.

[7] The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years.

health. The framework identifies how social determinants ultimately impact disease, injury, and mortality. Therefore, both the selection of secondary data sources and the development of primary data collection tools captured both "upstream" and "downstream" factors influencing health.

Process to identify and prioritize community health needs

For the purposes of the CHNA, Solano Public Health defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data. Health needs were identified through two pathways. First, a health need could be identified through secondary (quantitative) indicators if there was at least one related indicator that was worse than established benchmarks, showed significant evidence of racial/ethnic disparities, or performed worse than a stated external goal. Second, a health need could be identified through primary (qualitative) data if it was a theme in a majority of key informant interviews, group interviews, and focus groups. Following identification, health needs were prioritized via two rounds of in-person ranking by residents, health officials, and community organizational leaders from the Vacaville and Vallejo Kaiser Foundation Hospital service areas and one round of online ranking exclusively by Solano County stakeholders.

Community Involvement in CHNA

A broad range of community members provided input to the CHNA through key informant interviews, group interviews, and focus groups. In total the research team consulted 125 unique individuals with knowledge, information, and expertise relevant to the health needs of the community.

These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, the team gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., race/ethnic minorities and individuals experiencing homelessness).

Summary of Prioritized Significant Health Needs

The eight health needs that emerged as top concerns in Solano County are presented in priority order below. The CHNA Report includes more information including data sources used and more detailed descriptions of each of the health needs, including additional data, interview quotes, and focus group themes.

Economic Security. Intrinsically related to all health issues from housing to behavioral health, economic security is a strong determinant of an individual's health outcomes. Solano County residents encounter many challenges when compared to California residents on the whole, evidenced by food insecurity. Though the unemployment rate in Solano County is less severe in comparison to California as a state, residents face unique disparities and needs particularly in commuting out of the county for employment and diversity in employment opportunities. Residents and service providers identified many challenges related to maintaining economic security, such as unrealistic requirements for government assistance, and the need for better pay to be able to make ends meet.

Housing. Access to safe, secure, and affordable housing is an important social determinant of health. Families and seniors with fewer financial resources are more likely to experience sub-standard housing conditions and the associated risks. One in three Solano County residents is at risk of or experiencing displacement from gentrification. Increases in housing prices across the Bay Area have further intensified racial disparities, making it more difficult for low-income people of color to access neighborhoods with better environmental quality, educational resources and economic opportunities, increasingly placing these neighborhoods out of reach for low-income people of color. At the same time, some areas are becoming newly or further segregated. For example, the number of low-income Black households increased in Fairfield, Suisun City, and Vallejo's eastern neighborhoods. Additionally, lower incomes in the county mean Solano has a higher portion of cost-burdened households than San Francisco. Lower income individuals, African Americans, Latino Americans, Asians and seniors on fixed incomes are particularly cost burdened. Two-in-five residents do not own their homes, which is an indication of lack of access to credit and fair lending. Focus groups revealed that housing barriers are escalating within the community, and there is a lack of affordable options across demographics and ages, with many young people experiencing homelessness. The closure of shelters, which provide a much-needed safety net for many, and diminishing options for low-income families as well as an influx of residents from other regions (e.g., East Bay) have created additional stressors to housing in the community.

Access to Care. Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. It is also one of the key drivers in achieving health equity. Solano County fares worse than the state across important indicators, such as residents recently having a primary care visit and cancer rates. Additionally, racial disparities in accessing care are evident in Solano County. For example, Non-Hispanic Blacks are more burdened for cancer deaths in comparison to

their White, Asian, Hispanic, and Native American/Alaska Native counterparts. Community members, including service providers, provided context on some of the key gaps in accessing services such as: specific barriers for those who are undocumented, long wait times, and unique challenges facing the aging population.

Education. Education includes not only one's means to academic achievement, but also the support and resources to enhance one's educational development, which is connected to longer-term health outcomes. It is also a key driver in achieving both health and economic equity. Solano County fares worse than the state across educational indicators such as reading proficiency, expulsions and suspensions. Racial disparities in educational indicators persist, with Hispanic, Black, Native American/ American Indian, and Pacific Islander or Native Hawaiian adults more likely to have not completed high school. ACEs are one factor that may contribute to attainment and achievement gaps, as punitive relations with the school system are evident in high suspension and expulsion rates. Community members provided context about educational gaps, and specifically mentioned barriers in transportation and the need for children/youth support programs outside of school.

Violence and Injury Prevention. Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of Solano County have higher rates of domestic violence hospitalizations, injury deaths (intentional and unintentional), and violent crimes compared to the state. Nearly half of seniors in the county experienced a fall in the past year; 12% of those required hospitalization. African Americans have nearly double the county rate of misdemeanor arrests, putting them at higher risk for negative health outcomes such as injury and substance use. Interviews and focus groups with local stakeholders identified Adverse Childhood Experiences (ACEs), stress from economic insecurity, and a lack of safe spaces as barriers to improving health. While ACEs have decreased in recent years, the county rate is still higher than the state average. Many of these barriers disproportionally affect low-income individuals and people of color. Restorative justice programs are one approach that community leaders are implementing to address these and other disparities.

Behavioral Health. Behavioral health is the foundation for healthy living, and encompasses mental illness, substance use overdoses (including deaths), suicide deaths and access to service providers for preventive care and treatment. Solano County residents face a range of behavioral health-related challenges, including higher rates of opioid use and suicide ideation compared to the state average. Access to bilingual service providers was a major barrier identified in community focus groups, and a recent report identified Filipino, Latino and

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex (LGBTQQI) residents as underserved groups with regard to mental health needs. Other barriers included early-age use of substances, decreased social connectedness in their communities, and strong peer pressure among youth. ACE's play a large role in shaping Solano County mental health. Compared to the state of California, Solano has a similar rate of "resilient" children; however, one in four 9th graders living in Solano County still report experiencing depression-related feelings.

Healthy Eating and Active Living. Healthy Eating and Active Living (HEAL) relates to Solano County residents' ability to shape their health outcomes through nutrition and physical activity. There is a high rate of adult and youth obesity, especially among minority populations. Community members highlighted the barriers to eating healthy, as well as the high costs and behavioral change needed to live an active lifestyle. Lack of access to healthy food stores and the prevalence of fast-food options stand as an important barrier to health, as highlighted by focus group participants. A healthy lifestyle greatly impacts the rates of chronic conditions like cardiovascular disease, stroke, and cancer, but is not equally attainable for all residents. Partners such as Vibe Solano and CalFresh Healthy Living have programs focused on addressing behavioral changes to promote a healthy lifestyles for youth, families, and seniors.

Maternal and Infant Health. Mothers in Solano County face many barriers related to their own well-being and that of their children. The rate of infant deaths in the county is higher than the California average, and infant mortality disproportionately impacts people of color. Solano County does have a lower teen birth rate than the California average, which can indicate greater chances for economic security and pregnancy preparedness. However, community stakeholders described inconsistencies in reproductive health care such as discrimination against African American residents. Some potential pathways forward related to maternal and infant health include: more work- and community-based childcare options and improved reproductive health services for teens. Solano County service providers noted that over the last ten years, health officials and community providers have made a concerted effort to increase prenatal care. Service providers have observed increased rates over time as a result of these efforts, especially for the Medi-Cal population.

Health need profiles in the CHNA Report include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics). Each health need profile also includes a "spotlight on equity" section which features community member and service provider concerns around inequities in their communities. Examples provided in this section relate to complex and deeply rooted issues and should be considered within a broader system-level context of historical disinvestment as well as discriminatory policies, practices, and discourse.

Impact of COVID-19 Pandemic on Health Needs

The COVID-19 pandemic began in early 2020 just as the final touches of data analysis and report development for the CHNA were wrapping up. Like all public health jurisdictions, Solano County Health & Social Services and their partners focused their work on the pandemic response. Solano County's COVID-19 recovery and response included immediate and cross-cutting strategies, with a focus on equitable recovery from the social, economic, and health effects of the pandemic. Efforts adapted over time based on trends reported in the Solano County COVID-19 dashboard.

The COVID-19 pandemic has further illuminated the inequities and disparities that have existed for people of historically underrepresented groups, such as seniors, LGBTQQI, communities of color, women, and low-income communities. Recent data show that Hispanic, Black, seniors and Indigenous populations are disproportionately affected by COVID-19 and its economic impacts. The process for distilling the eight (8) health priorities into the four addressed specifically in the 2023 CHIP considered emerging data related to the impact of the pandemic; those points are included in the detail for each strategic priority. Additionally, the Steering Committee worked to identify dually focused strategies that could address the challenges faced by a post-pandemic Solano County, and that could highlight lessons learned from the various equity-focused, community-work partnerships and collaboration that were vital to the pandemic response.

Strategic Priorities

Overview of the Process

After completing the CHNA, SPH engaged a Steering Committee. With representatives from across Solano County, this Steering Committee helped prioritize health needs from the CHNA and identified goals, strategies and milestones for the CHIP.

Steering Committee Members participated in monthly meetings between August 2022 and December 2022. The Steering Committee members initially focused on narrowing the eight health needs from the CHNA into three to four strategic priorities. They applied the following criteria to the eight health needs to identify top priority health areas.

Criteria	Definition
Severity	Severity of need as demonstrated in secondary data and interviews, considering factors such as potential to cause death or extreme/lasting harm; data that varies significantly from state benchmarks; and magnitude/scale of the need, where magnitude refers to the number of people affected.
Clear Disparities or Inequities	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
Impact	The ability to create positive change around this issue, including potential for prevention, addressing existing health problems and those that have been magnified by the effects of COVID-19, and the ability to affect several health issues simultaneously.
Feasibility	Actionable strategies exist to make an impact on elements of the health need in the next 3-5 years. This might include opportunities to mobilize community resources, programs, and partnerships to address health needs.

The results of this process are the four strategic issues the 2023 CHIP will address. These are:

Behavioral Health

Access to Care

Maternal and Infant Health

Housing Stability

Once these health needs were prioritized, Steering Committee Members engaged in monthly meetings to identify goals, objectives and strategies for each health need. The Steering Committee shared updates on the plan with the broader Healthy Solano Collaborative and other partners and integrated their feedback into the plan on an ongoing basis.

The Steering Committee recognized that community members routinely provide input for various community needs assessments and have expressed frustration with the duplication of efforts by the County to seek input. Therefore, due to the broad representation of perspectives on the Steering Committee, and a desire to reduce burden on community members as the COVID-19 pandemic continues, the Steering Committee utilized the wealth of information already obtained from communities during the CHNA and via other community-focused data collection efforts, during the development stages of the plan. Toward the end of the process, members of the Solano Public Health team shared a high-level summary of the plan during a health fair to get initial community response to the health priority areas, goals and objectives presented in the plan. The overall response was positive and created an opportunity to outreach to community members and get them involved with next steps of the CHIP and other community health programs. The Healthy Solano Collaborative and other partners are committed to engaging community members in a more robust way as they move forward to implement the elements of the plan.

Alignment with 2017 plan

This revised 2023 plan has some crossover to the 2017 CHIP, including an intentional focus on housing stability, as well as a focus on the social determinants of health. However, the revised strategic issues focus on several upstream needs related to access to behavioral and physical health care supports including an emphasis on the needs of women and infants. These revised priority areas are a reflection of additional community concerns during the COVID-19 pandemic, and a more focused attunement to equitable responses to health needs.

Content of each Priority Area Section

The following sections provide an overview of the needs related to each priority area as well as outline the goals, objectives and strategies to address them. Each section includes the following information relating to each priority area:

- **Goals** outline the fundamental, long-range (five to ten-year) direction that the CHIP is working toward to support improvement in the priority area.
- **Objectives** share the intended results or accomplishments that result from the specified priority long-term goals.
- **Strategies** evidence and/or practice-based efforts to address the goals and objectives for the priority area.
- **Alignment with State and National Objectives** cite strategies from the CDPH Equity Playbook, Healthy People 2030 Goals and California – Let's Get Healthy Priority Areas that align with the priority area.

- **Key Issues** outline feedback from community members and partners on the most important needs related to the priority area.
- **Impacted Populations** outline communities most impacted by the issues outlined in the priority area that should be the focus of strategies and action steps.
- **Supporting Data** highlight data points from the CHNA that were used to inform the development of the priority area.
- **Impact of COVID** highlights data that emerged after the CHNA about ways in which needs in the priority area were exacerbated by the pandemic.

Behavioral Health

Goal: Ensure all Solano County residents feel safe, supported, and well in their communities

Objective 1: Improve the safety and well-being of youth and young adults

Strategies

- Invest in or utilize supportive spaces and programs for youth and families, such as school wellness centers, family resource centers, art youth centers, family justice centers, and afterschool supports. Remove barriers to participation, especially financial.
- Ensure students and youth have access to basic needs to thrive in an educational environment, including housing for college students.
- Ensure students have access to support systems, including mental health services with an emphasis on trauma, healing, anti-racist practices, and stigma reduction. Include language services, and dedicated counselors and educators to support students in navigating and creating future plans

Objective 2: Increase access to culturally and linguistically responsive behavioral health care

Strategies

- Focus on workforce development opportunities, geared towards expanding a bilingual and bicultural workforce.
- Engage community members, community health workers, mental health ambassadors, peers, and trusted messengers.
- Promote and organize ongoing trainings to advance the implementation of the national Culturally and Linguistically Appropriate Services (CLAS) Standards.
- Build capacity among providers and community-based organizations (CBOs) around trauma-informed practices.

Objective 3: Expand connection to community resources

Strategies

- Invest in harm reduction and youth and family violence prevention resources and programs. Integrate workforce development opportunities.
- Increase access to timely community resources, services, and responsive treatment (including harm reduction and medical detox).
- Expand telehealth, mobile, and on-site healthcare and behavioral health services.
- Pilot use of restorative justice approaches to address community violence

Alignment with State and National Objectives

- Examples of CDPH Equity Playbook Alignment
  - School and Childcare (Strategy B)
  - Economic Security (Strategy G)
  - Language Access and Cultural Competency (Strategy B)
  - Community and Stakeholder Engagement (Strategies A, B, and E)
- Healthy People 2030 Overarching Goals
  - Promote healthy development, healthy behaviors, and well-being across all life stages.
- California – Let's Get Healthy Priority Areas: Creating Healthy Communities
  - Creating Healthy Communities – neighborhood safety
  - Living Well – adult depression, suicide
  - Healthy Beginnings – depression related feelings

Key Issues

- Lack of services and providers, especially bilingual providers and those representing diverse communities. Need to enhance efforts to provide culturally responsive and linguistically appropriate services.
- Limited options for accessible and timely services for Medi-Cal members who have mild-to-moderate mental health conditions. The limited options and access to timely services is more prominent for privately insured folks.
- Due to current workforce shortage for behavioral health providers across public and private sectors there are issues related to access to ongoing treatment.
- Accessibility, both in terms of logistic barriers (e.g., location of providers, proximity to residence) and social and cultural barriers (e.g., stigma and distrust of providers).
- Need for more providers that specialize in serving specific groups, including youth, seniors, and LGBTQQI individuals.
- Lack of interventions for mild-to-moderate health challenges and interventions before a mental 'crises'.

Impacted Populations

- Unhoused populations/individuals experiencing homelessness
- Criminal justice system-impact individuals, including children and families of those formerly incarcerated
- Older adults
- Prenatal and postpartum persons
- Low-income individuals
- Youth and families involved with Child Welfare
- Black/African American communities
- Latinx/Hispanic communities
- AAPI communities
- LGBTQQI individuals

Supporting Data

- More than one out of three (33.9%) of Solano County 9th graders reported depression-related feelings (California Healthy Kids Survey 2017-2019).
- Many (55.9%) of Solano County adults who sought treatment for self-identified mental/emotional or alcohol/drug issues in the past year received help, but this was true for just 45.4% percent of Latinx residents and 36.1% percent of those who identify with 2 or more races (Racecounts.org 2022).
- Many individuals ages 18 and older in Solano County (17.1%) indicated they seriously considered suicide, compared to the statewide average of 13.1% (CHIS California Health Interview Survey, 2019-2020).
- Solano County's opioid prescription rate is 394.7 per 1,000 compared to 333.3 per 1,000 in California overall (California Overdose Surveillance Dashboard, 2020).
- Alcohol played a role in over a third (33.5%) of motor vehicle crash deaths in Solano County, compared to over a quarter (28.6%) across the state (NHTSA Fatality Analysis Reporting System, 2014-2018).
- In Solano County, there were 475.7 violent crimes reported per 100,000 compared to 418.1 on average across California (FBI Violent Crime Reports, 2014-2018).
- In Solano County, during calendar year 2022 there were 61 suicide deaths and 62 confirmed overdose deaths (Solano County Sheriff's Office-Coroner's Bureau). *Note: the number of overdose deaths could change pending open Coroner investigations.

Impact of COVID: The pandemic and resulting economic recession have negatively impacted many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. As the pandemic continues, ongoing and necessary public health measures expose many people to situations linked to poor mental health outcomes, such as social isolation and job loss.

Access to Care

Goal: Eliminate inequities in access to preventive services and health care across Solano County

Objective 1: Reduce barriers to care for vulnerable populations

Strategies

- Expand telehealth, mobile, and on-site healthcare and behavioral health services.
- Increase Medi-Cal approved providers and community health navigators.
- Expand rural transportation services (to care).
- Expand appointment times outside of normal business hours such as evenings and weekends.
- Engage with communities to improve outreach and communication about available services.

Objective 2: Increase access to culturally and linguistically responsive care

Strategies

- Focus on workforce development opportunities, geared towards expanding a bilingual and bicultural workforce.
- Invest in systems that address health needs through a lens of diversity, equity, and inclusion (DEI) and trauma informed care.
- Enhance training for providers focused on implicit bias, antiracism, and trauma-informed care.
- Engage community health workers in culturally and linguistically appropriate care.

Objective 3: Improve timely system navigation and coordination

Strategies

- Coordinate and integrate care across hospital systems / providers ('no wrong door' approach).
- Coordinate with local service providers to provide follow-up care and provide warm handoffs.
- Encourage the use of tools to enable health care and service providers to connect and share referrals.
- Provide greater financial support and resources to ensure BIPOC owned small businesses can be effective in supporting community needs.

Alignment with State and National Objectives

- Examples of CDPH Equity Playbook Alignment
  - Economic Security (Strategy H)
  - Cross-Sectoral Collaboration and Health in All Policies (HiAP) (Strategy B)
  - Language Access and Cultural Competency (Strategies A-I)
  - Community and Stakeholder Engagement (Strategies A and B)
- Healthy People 2030 Overarching Goals
  - Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
  - Promote healthy development, healthy behaviors and well-being across all life stages.
- California- Let's Get Healthy Priority Areas:
  - Redesigning the healthcare system
  - Access to primary care providers
  - Access to culturally and linguistically appropriate services

Key issues

- Limited affordable and accessible options, including providers accepting Medi-Cal insurance and specialty care options.
- Long wait times and lack of prompt services.
- Cost, including indirect financial cost of taking time off work, childcare, etc.
- Barriers to access, including transportation, availability of phones/internet to reach providers, and access to childcare.
- Limited experience utilizing telehealth services, particularly for older adults.
- Cultural/linguistic barriers and the lack of appropriate services and providers who can respond accordingly.
- Issues with trust and confidence in the medical profession.

Impacted Populations

- Low-income individuals
- Older adults
- Unhoused populations/individuals experiencing homelessness
- Individuals with Medi-Cal
- Uninsured individuals
- LGBTQQI individuals
- Black/African American communities
- People of color

Supporting Data

- Less than two out of three Latinx residents (65.2%) have a usual source of care, compared to 88.6 percent of white residents (California Health Interview survey, 2019-2020).
- Under half of Black adults (45.1%) visited a primary care clinician at least once in the past year, compared to most white adults (82.1%; California Health Interview Survey, 2020).
- Relatively few Solano County residents are uninsured (4.7%), however the rate is higher for Latinx residents (7.4%) and Native American residents (6.1%; American Community Survey, 2015-2019).
- In six communities across the county, more than a quarter of the population does not live within 0.5 miles of a public transit stop (EPA Smart Location Database 2013 via Solano CHA 2020).
- One out of five children in working families (21%) had a licensed childcare space available to them *(ACS 2019 via Children Now Scorecard).*

Impact of COVID: Since the beginning of the pandemic, visits to primary care providers and outpatient specialists have declined, and many hospitals postponed or cancelled elective procedures as COVID-19 cases increase (and this may be an ongoing trend). The pandemic is likely to have long-term effects on the cost, quality, and access to care in the United States.

Maternal and Infant Health

Goal: Improve the well-being of BIPOC women, infants, children, and families

Objective 1: Expand reproductive health services for BIPOC teens

Strategies

- Create partnerships to bring services provided by County, CBOs and Federally Qualified Health Centers (FQHCs) into schools. Use existing spaces such as school-based wellness centers if possible.
- Provide mobile health clinics with basic services in rural areas.
- Tailor services to be culturally and linguistically responsive.
- Conduct outreach campaigns and education on the importance of reproductive health and on how to navigate the system.

Objective 2: Expand and improve prenatal care options for pregnant BIPOC women

Strategies

- Expand prenatal care options including group prenatal care, patient navigators, doulas, and midwives.
- Access to culturally adapted care which tailors care to patients' norms, beliefs, values, language, and literacy skills.

Objective 3: Improve early outcomes for Black and Latinx infants

Strategies

- Expand access to support programs such as home visiting services, breastfeeding awareness, support and promotion, and postpartum mental health resources.
- Amplify the voices of BIPOC communities, and specifically BIPOC youth, to inform program design and investment decisions, particularly when the decisions impact the lives of these communities.
- Provide education on parental leave and childcare options.
- Invest in BIPOC-led nonprofit organizations to provide services and support capacity building for BIPOC organizations (including general operating support, shared resources, and training opportunities).

Alignment with State and National Objectives

- Examples of CDPH Equity Playbook Alignment
  - Community and Stakeholder Engagement (Strategies A-F)
  - Economic Security (Strategy E)
  - Cross-Sectoral Collaboration and Health in All Policies (HiAP) (Strategies A-D)
- Healthy People 2030 Overarching Goals
  - Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
  - Promote healthy development, healthy behaviors, and well-being across all life stages.
- California- Let's Get Healthy Priority Areas: Healthy Beginnings
  - Infant mortality
  - Child vaccination rates
  - Adverse childhood experiences (ACEs)

Key issues

- Ongoing trauma and stress, and the racial and health inequities that impact maternal health.
- Lack of affordable and accessible care options.
- Untreated health issues, including physical and mental health.
- Inadequate systems of care that support good health-seeking behaviors, including workplace leave policies.
- Social determinants of health, including housing and other economic circumstances.
- Discrimination, racial bias, and the lack of trust.
- Low uptake of COVID-19 and other vaccine uptake.

Impacted Populations

- Black women and parents
- Native American women and parents
- Latinx/Hispanic women and parents
- Teens
- Individuals affected by generational and systemic trauma
- Individuals suffering from abuse
- Substance users

Supporting Data

- In Solano County, while most parents receive adequate prenatal care (68.9%), slightly over half (59.3%) of Pacific Islander parents do *(CDPH MCAH 2017-2019).*
- Over one in ten (11.2%) of infants born to Black mothers are low birthweight, compared to less for Hispanic/Latinx and white women (6% and 5.6% respectively; *CDPH MCAH 2017-2019).*
- Infant mortality rate in the county is 5.3 deaths per 1,000 live births compared to the state average of 4.0 deaths per 1,000 live births (*HRSA Area Resource File, 2020*).
- Infant mortality rate for Black infants (8.2 per 1,000 live births) is over twice that of white infants (4.4 per 1,000 live births) *(California Department of Public Health, 2016-2018).*
- The adolescent birth rate for Hispanic/Latinx and Black teens is 19.9 and 18.4 per 1,000, respectively, and 5.3 per 1,000 white teens. (*California Department of Public Health 2017-2019).*

Impact of COVID: During the pandemic, prenatal care visits decreased. Women were more vulnerable to losing their income due to the pandemic, and working mothers struggled with increased childcare demands.

Housing Stability

Goal: Ensure all Solano County Residents have access to safe, stable, and affordable housing

Objective 1: Expand low-income, affordable, and workforce housing stock

Strategies

- Advocate for investment in direct support (housing development, financial support to low-income renters and homeowners, legal aid, etc.) and policy change efforts (rent stabilization policies), and alternative housing options including housing for youth.

Objective 2: Provide a wide array of support to ensure housing security

Strategies

- Look for ways to deepen trust and connections with CBOs and residents.
- Invest in actions that increase housing security and prevent displacement in BIPOC communities.
- Prioritize strategies to prevent the spread of COVID and other diseases, including those that serve homeless individuals, address overcrowding, and prevent displacement.

Objective 3: Improve access and connection to supportive services for people experiencing homelessness

Strategies

- Engage community navigators who can connect individuals to the service network.
- Emphasize cultural competence in strategy development and execution and use investments to increase community empowerment.
- Utilize the Housing First model, rapid re-housing, and service enriched housing.

Alignment with State and National Objectives

- Examples of CDPH Equity Playbook Alignment
  - Housing Security (Strategies A-D); Homelessness (Strategies A-F)
  - Economic Security (Strategy D)
  - Cross-Sector Collaboration and Health in All Policies (HiAP) (Strategies B and C)
  - Transportation/ Physical Access and Mobility (Strategies A, B, and D)
  - Community and Stakeholder Engagement (Strategies A-F)
  - Language Access and Cultural Competency (Strategies A-I)
- Healthy People 2030 Overarching Goals
  - Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
  - Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
  - Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.
- California- Let's Get Healthy Priority Areas: Creating Healthy Communities
  - Poverty
  - Unemployment

Key issues

- Lack of affordable housing, including supportive transitional housing and the supportive services to maintain housing.
- Limited housing stock, including the poor infrastructure of rental supply and lack of low-income housing options.
- Gentrification.
- Redlining, and other historic and current discriminatory housing practices.
- Loss of income and other economic impacts, especially those as a result of the COVID-19 pandemic.
- Lack of living wage opportunities and pay inequities that exacerbate housing challenges.

Impacted Populations

- Low-income individuals and communities
- Historically marginalized populations
- Single-parent households
- Unhoused populations/individuals experiencing homelessness
- Black/African American communities
- Elderly population
- Substance users

Supporting Data

- More than one in three households in Solano County (37%) are 'cost-burdened', defined as spending 30% or more of their income on housing, and there are geographic disparities across the county (*American Community Survey, 215-2019*).
- The majority of Black and Native American renters in Solano County (62%) are burdened with high housing costs, compared to less than half white renters (48%; *Racecounts.org 2022*).
- Renters in Solano County need to earn $35.84/hour – more than twice the state minimum wage - to afford the average asking rent in Solano County *(California Housing Partnership Affordable Housing Needs Report 2022).*
- 1,179 individuals were counted in the 2019 Point-in-Time count of people experiencing homelessness in the county, among which nearly all (78%) were unsheltered (*Solano County Point in Time Count, 2022*).
- There are significant racial disparities in per capita income, with Black and Latinx residents earning $15,000 and $23,000 less than white residents, respectively (*Racecounts.org 2022*).
  More than one in four Black children (28.1%) and Pacific Islander children (21.9%) in Solano County are impoverished, compared to just 8.3% of white children (*CDPH MCAH 2019*).

Impact of COVID: The same communities of color that have been historically impacted by redlining and poor job prospects have been further disadvantaged during the COVID-19 pandemic. Illness and policies limiting which business and services were open to the public negatively impacted employment and wages - especially for those in the service sector. Many families were unable to pay rent or medical bills, lost wealth, and accrued household debt. This loss of economic security, coupled with the expiration of the national eviction moratorium, and has made many renters' situations even more precarious than before.

Action Plan

To accomplish the goals in the CHIP, everyone in both the public and private sectors — policy makers, business, government agencies, educators, health care professionals, philanthropic organizations, and residents — need to work together. This section outlines collective actions, as well as potential programs and partners, who can address the CHIP goals and objectives.

The Steering Committee focused on action steps that were focused on health equity, engaged a broad array of partners, and promoted collaboration and community engagement. Rather than develop action steps for each priority area separately, the Steering Committee recognized the value in grouping similar strategies from across the priority areas into the following groups:

- Workforce Development;
- Community and Youth Engagement;
- Equity-Driven Investments;
- Trauma and Harm Reduction; and
- Enhanced Access.

Many strategies highlighted in this plan intentionally focus on specific populations such BIPOC individuals and youth. The Steering Committee acknowledges the challenges that other populations encounter. Where possible, action steps also highlight specific steps to improve the health and well-being of many vulnerable populations.

The action plan for each strategy group includes one (1), three (3), and five (5)-year public health system milestones to achieve collective goals, as well as a list of potential partners who are already engaged in similar strategies. It is anticipated that milestones and partners will continue to get updated as the work progresses. Alignment of each strategy with the Priority Areas in this plan is denoted by their respective icons.

Behavioral Health

Access to Care

Maternal and Infant Health

Housing Stability

Workforce Development Strategies			
Focus on workforce development opportunities, geared towards expanding a bilingual and bicultural workforce.			
Promote and organize ongoing trainings to advance the implementation of the national Culturally and Linguistically Appropriate Services (CLAS) Standards.			
Increase Medi-Cal approved providers and community health navigators.			
Engage community health workers in culturally and linguistically appropriate care.			
Tailor services to be culturally and linguistically responsive.			
Expand prenatal care options including group prenatal care, patient navigators, doulas, and midwives.			
Access to culturally adapted care which tailors care to patients' norms, beliefs, values, language, and literacy skills.			
Expand access to support programs such as home visiting services, breastfeeding awareness, support and promotion, and postpartum mental health resources.			

Action Steps

One (1)-year milestones:

1. Encourage internal and external partners to pursue California Growing Resilient and Outstanding Workforce (GROWs) funding (The California Department of Aging Direct Care Workforce Training and Stipends Program: GROW in Home and Community).
2. Identify priority healing-centered career fields that are most in-demand with the fewest barriers to entry.
3. Design and implement a collaborative convening to support career pathways that are lower barrier to entry.
4. Develop a countywide professional development plan focused on advancing the bilingual and bicultural workforce.
5. Build collaboration and coordination with existing education and community partners that are working on workforce development and bridge programs. Some of the components include:
    - Expand training regarding Culturally and Linguistically Appropriate Services (CLAS) Standards to support health and behavioral health providers to implement culturally and linguistically appropriate services.
    - Expand the workforce pipeline to include geriatrics training to care for aging adults.
    - Meet with partners to develop blended occupational and English as a Second Language (ESL) coursework.
    - Promote tax credits, employment subsidies, and other incentives for employers to hire people experiencing homelessness or formerly incarcerated individuals.

Three (3)-year milestones:

1. Create an outreach plan to expand existing partnerships and develop new partnerships between universities and health care providers in order to create new training programs that enhance training programs across the life span.
2. Define pathways towards healing centered careers. This includes:
    - Build awareness of healing-centered careers at the middle school, high school, and community college levels.
    - Create community engagement pathways and connect people to healing centered careers at middle school, high school, community colleges, and higher level academic institutions.
    - Develop or expand existing career pipeline programs such as internship opportunities or formal intern programs.
3. Expand funding to support scholarships or offset costs/barrier reduction for engagement in healing-centered careers (i.e., access to computers, clothing for interviews).
4. Build out peer mentorship opportunities for those with lived experience (potentially paying for people to go back to school).

Five (5)-year milestones:

1. Launch pilot of healing-centered career bridging programs, such as internships or blended occupational and ESL coursework.
2. Develop career pathways sustainability model.
3. Design and implement career pathways collaborative that will guide ongoing development of healing-centered career pathways.
4. Identify potential incentives for healthcare providers and other employers to increase positions.

Potential Partners/Programs

- Workforce Development Board
- Kaiser Permanente can provide funding and partner on career pathways funding or partnering in other ways to create solid pathways from middle school to living wage careers within Solano County.
- Touro University has funding to expand training for community health workers
- Partnership HealthPlan
- Higher education partners to encourage those studying public health to work in local public health jurisdiction
- School Districts and community colleges for career pipelines, Solano County Office of Education (SCOE) youth career development
- PATHS mentorship program (partnership between Kaiser and Touro)
- Education providers, representatives of organizations that employ healing-centered types of jobs, bilingual individuals that have the cultural competence to guide how best to outreach to this population.
- Redwood Community Health Coalition (RCHC) is facilitating the Community Health Worker group in Solano County. There is training, capacity building and support to FQHCs through this group.
- Solano County Behavioral Health's (SCBH), SCOE and other CBO intern programs.
- Empowered Aging and others engaged in CNA Pathways program

Community and Youth Engagement Strategies				
Invest in or utilize supportive spaces and programs for youth and families, such as school wellness centers, family resource centers, art youth centers, family justice centers, and afterschool supports. Remove barriers to participation, especially financial barriers.				
Ensure students and youth have access to basic needs to thrive in an educational environment, including housing for college students.				
Engage community members, community health workers, mental health ambassadors, peers, and trusted messengers.				
Engage with communities to improve outreach and communication about available services.				
Conduct outreach campaigns and education on the importance of reproductive health and on how to navigate the system.				
Amplify the voices of BIPOC communities, and specifically BIPOC youth, to inform program design and investment decisions, particularly when the decisions impact the lives of these communities.				
Provide education on parental leave and childcare options.				
Look for ways to deepen trust and connections with CBOs and residents.				
Engage community navigators who can connect individuals to the service network.				
Emphasize cultural competence in strategy development and execution and use investments to increase community empowerment.				
Advocate for investment in direct support (housing development, financial support to low-income renters and homeowners, legal aid, etc.) and policy change efforts (rent stabilization policies), and alternative housing options including housing for youth.				

Action Steps

One (1)-year milestones:

1. Ensure alignment with workforce strategies and actions to advance youth engagement.
2. Examine opportunities to support and expand the role of community navigators.
3. Leverage existing youth advisory group to amplify BIPOC community voices and develop a youth engagement plan, including creative ways to engage youth via social media and a youth street outreach program.
4. Create a community engagement advisory group to develop a community engagement plan.
5. Enhance connections with CBOs and identify the support they need to participate in CHIP strategies and funding opportunities.
6. Provide training to landlords on various voucher programs (e.g. Section 8) to link them to affordable housing opportunities.

Three (3)-year milestones:

1. Develop partnerships with school wellness centers and child care providers to reach youth and families in the community.
2. Expand formal partnerships with CBOs to collaborate on youth and community outreach.
3. Host “one-stop-shop” community events where community members have access to multiple services (vaccines, health information, health screening, behavioral health screenings, dental screenings) including leveraging the school wellness centers.
4. Develop youth-centered multi-media campaign to address health needs.
5. Enhance supports to CBOs so they can be champions across the public health system. This may include leveraging relationships across the wider nonprofit and funder ecosystem to build trust and strengthen relationships.
6. Expand opportunities to prioritize affordable housing, identify permanent funding sources, support policy and legislative actions.

Five (5)-year milestones:

1. Review progress to date and continue to develop actions to move strategies forward.
2. Develop intergenerational work groups in multiple cities bringing health messaging to schools, social media, senior living areas, community centers, etc.
3. Formally develop a countywide network of CBOs to work together to grow smaller CBOs and build their capacity.
4. Reduce barriers for CBOs that serve communities most impacted by inequities to participate in funding (i.e., grant writing and contracting support).

Potential Partners:

- Workforce Development Board developing resources and an education plan for the parental leave and childcare options if that’s helpful.
- Kaiser Permanente may be able support with having a staff member represent on an advisory board. Also with sponsoring/funding projects and outreach events
- Solano Community College related to the basic needs for the education environment
- Legal Services of Northern California to support connections parental leave resources
- Several organizations may already have youth advisory boards to collaborate with. This includes SCOE, Seneca, Children's Network of Solano, and Fighting Back Partnership
- Solano Pride Center
- FQHCs: For example La Clinica de La Raza promotor@s program in Vallejo focus on the African American Black community
- School districts and SCOE leaders and programs
- CBOs working specifically in this area (Fighting Back Partnership, Club Stride, etc.)
- Organizations such as First 5 and Solano Family and Children’s Services that can connect to child care community
- Other key institutional partners also already working in this area (i.e., Touro University California (TUC) Public Health/Youth in Action and many other TUC efforts, Kaiser Permanent/La Clinica – school clinics).

Equity-Driven Investment Strategies				
Ensure students have access to support systems, including mental health services with an emphasis on trauma, healing, anti-racist practices, and stigma reduction. Include language services, and dedicated counselors and educators to support students in navigating and creating future plans.				
Invest in systems that address health needs through a lens of diversity, equity and inclusion (DEI) and trauma informed care.				
Enhance training for providers focused on implicit bias, antiracism, and trauma-informed care.				
Provide greater financial support and resources to ensure BIPOC owned small businesses can be effective in supporting community needs.				
Invest in BIPOC-led nonprofit organizations to provide services and support capacity building for BIPOC organizations (including general operating support, shared resources, and training opportunities).				
Invest in actions that increase housing security and prevent displacement in BIPOC communities.				
Prioritize strategies to prevent the spread of COVID and other diseases, including those that serve homeless individuals, address overcrowding, and prevent displacement.				

Action Steps

One (1)-year milestones:

1. Increase awareness of BIPOC Led Businesses or Non-Profits by building off of the "Solano Black Business Directory" Facebook Group and/or Solano Cares.
2. Expand availability of free diversity, equity, and inclusion (DEI) training for community members.
3. Build connections to Aging and Disability Resource Center (ADRC) to expand no-wrong door approaches.
4. Identify and/or promote partners who can offer short term rentals or housing options that are willing to offer housing to displaced residents.
5. Strengthen connections to organizations serving housing insecure individuals to bring their voice into planning efforts.

Three (3)-year milestones:

1. Create opportunities for local start-ups to help develop or expand Diversity, Equity, and Inclusion (DEI) related systems/platforms.
2. Expand mini grants for students from communities most impacted by systematic inequities to serve as health promoters.
3. Assess the main issues negatively impacting student success.
4. Continue to build out Age Friendly Designation approved by the Solano County Board of Supervisors (BOS), which helps municipalities focus on all aspects of inclusion.

5. Expand advocacy and policy change trainings for community groups serving those disproportionately impacted by inequities.
6. Strengthen connection with Family Resource Centers, senior centers and churches to promote no-wrong door approach and increase community engagement.
7. Develop housing advocate network.

Five (5)-year milestones:

1. Ask local Start-ups or businesses to participate in an accelerator and donate their own operating support, resources, or internal training to help BIPOC-lead businesses.
2. Engage external training experts or consultants to assess existing implicit bias and antiracism trainings and implement recommended changes.
3. Based on assessment of student needs, expand connections with school- and community-based resources to meet needs.

Potential Partners:

- Kaiser Permanente has supported opening up this training program for free for small businesses. We will be doing this again in 2023.
- Solano Cares.
- Invite Solano Pride Center to participate for the LGBTQQI perspective.
- Continue the partnership established with Trauma Transformed.
- Independent Living Resource Center.
- Family Resource Centers
- Senior Centers
- Churches
- Area Agency on Aging
- Inner City Capital Connections (ICCC) training opportunities for small businesses
- Invite SCBH to share core concepts from the *Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)* MHSA Innovation project, including a systemwide implementation of the CLAS Standards and meaningful community engagement.
- Health and Social Services (H&SS) staff members trained as trainers for Advancing Race Equity as supported through the SPH BARHII project.
- Solano HEALs, continued work with Trauma Transformed and other consultants leading training and dialogue regarding EID, Unite Us Community Network (closed loop referral system)
- Fighting Back Partnership
- PH Program has a TCE grant to build capacity for organizations
- Solano-Napa Small Business Development Center (small business Inclusivity project and culturally competent business advising project)
- The Solano County Racial Equity Action Lab (REAL) Team, a multi-sector collaborative addressing homelessness for BIPOC communities

Trauma and Harm Reduction Strategies
Build capacity among providers and community-based organizations (CBOs) around trauma-informed practices.
Invest in harm reduction and youth and family violence prevention resources and programs. Integrate workforce development opportunities.
Pilot use of restorative justice approaches to address community violence.

Action Steps

One (1)-year milestones:

1. Coordinate with programs addressing substance use, particularly related to opioid/fentanyl use.
2. Advance training to build the capacity of providers and CBOs on the use of trauma-informed practices.
3. Work with SCOE and other partners to identify and expand on school-based programs.
4. Connect with school-based wellness centers and develop a plan to utilize centers as safe places for youth.
5. Create a parent advisory group to identify ways to engage parents.
6. Advance supports for older adults to prevent exploitation.
7. Expand evidence-based classes for seniors on topics such as social engagement, balance improvement, and fall prevention.

Three (3)-year milestones:

1. Expand restorative justice training programs for youth and adults.
2. Expand parent liaison program.
3. Implement creative school-based programs focused on mental health, harm reduction, restorative justice.
4. Create groups or spaces for parents to go to decompress and talk about stresses of being a parent.
5. Host regular events where youth can gather and access needed services.

Five (5)-year milestones:

1. Develop a certificate program for new parents to learn about trauma informed care.
2. Identify other partners to implement harm reduction and restorative justice programs (churches, youth centers, CBOs).
3. Expand school-based programs to churches, youth centers, and CBOs.

Potential Partners:

- Health & Social Services Divisions
- Fighting Back Partnership
- School districts and educational partners integrating restorative justice approaches
- Solano County Behavioral Health and contracted partners

- Napa/Solano Area Agency on Aging
- Drug Safe Solano
- Children's Network
- Family Justice Center
- Syringe exchange at student run free clinics
- Vallejo Together
- Area Agency of Aging
- Innovative Health Solutions
- Forty-seven (47) school sites with school-based wellness centers can become community hubs and provide access to services provided by multi-sector partners such as: mental health support, benefits eligibility, health education, food distribution/pantry, parent support/education, etc.

Enhanced Access Strategies
Increase access to timely community resources, services, and responsive treatment (including harm reduction and medical detox).
Expand telehealth, mobile, and on-site healthcare and behavioral health services.
Expand rural transportation services (to care).
Coordinate and integrate care across hospital systems / providers ('no wrong door' approach).
Coordinate with local service providers to provide follow-up care and provide warm handoffs.
Expand appointment times outside of normal business hours such as evenings and weekends.
Encourage the use of tools to enable health care and service providers to connect and share referrals.
Create partnerships to bring services provided by County, CBOs and Federally Qualified Health Centers (FQHCs) into schools. Use existing spaces such as school-based wellness centers if possible.
Provide mobile health clinics with basic services in rural areas.

Action Steps

One (1)-year milestones:

1. Continue to address gaps in care widened by the COVID-19 pandemic.
2. Expand already successful program such as Everybody Loves Line Dancing project (for seniors) and Food is Free Park It Market events to expand relevant community resources in the community.
3. Research or identify best practices for CBOs and FQHCs to partner with schools.
4. Design an incentive program to encourage medical providers to work with FQHCs.
5. Explore ways to leverage state resources and data including:
    - Integrate information on how to access health resources into CalFresh Healthy Living Program communication.
    - Meet with healthcare providers to discuss using CalAim to expand transportation services.
    - Conduct an assessment to determine which HEDIS/HRSA outcomes can be improved for FQHCs by partnering and volunteering time in school-based wellness centers.
6. Conduct an assessment of all the different transportation resources, gaps in services, and opportunities.
7. Integrate county-approved technology initiatives including Connect Solano, Access to Technology, and Napa/Solano Area Agency on Aging iPad distribution program to increase reach and improve access to socialization opportunities and telehealth.
8. Look for funding options for Telehealth Platforms Partnerships.

Three (3)-year milestones:

1. Strengthen the community health worker program with the FQHCs.
2. Increase CBO capacity to participate and transition to in Californica Advancing and Innovating Medi-Cal (CalAIM) including support on payment reforms.
3. Develop a plan for CBOs, FQHCs and school-based wellness centers to collaborate.
4. Develop a plan to improve transportation options for residents across the county including exploring a partnership with Lyft Health or Uberhealth to expand access to appointments.
5. Identify partners for Telehealth Platforms Partnerships.

Five (5)-year milestones:

1. Continue to strengthen efforts of CBOs and FQHCs providing health services in schools.
2. Expand Telehealth Platforms Partnerships to strengthen telehealth across the county.
3. Implement incentive program to encourage medical providers to work with FQHCs.

Potential Partners:

- Kaiser (mobile clinics)
- FQHCs
- SCBH and contracted partners
- Touro University – SolanoConnex
- SCOE and school districts who are implementing the SBHIP including universal screenings for students
- Forty-seven (47) school sites with school-based wellness centers
- Touro University
- County Public Health and other H&SS Divisions
- Partnership for Health
- Black Infant Health Program
- Area Agency on Aging
- Innovative Health Solutions

Implementation, Evaluation, and Sustained Actions

The implementation of the CHIP will be driven by the Healthy Solano Collaborative. The group is a representative of the many organizations and individuals who contribute to the health of the public. Upon completion of the plan, the Healthy Solano Collaborative will turn the focus to establishing the structure by which the work will be done. Much of the leadership needed for the planning process has come from the staff of Solano Public Health and other county staff. Going forward, the Healthy Solano Collaborative will set up decision-making processes and oversee the establishment of the operational structure for the CHIP taskforces. Both the Collaborative and the taskforces will establish chairs and meeting structures as well as rules of engagement, such as when and how often they will meet and what the standing agenda items will be.

Ongoing evaluation and monitoring of the CHIP will be the responsibility of the Healthy Solano Collaborative. The Healthy Solano Collaborative will meet quarterly to receive updates on the CHIP activities from each significant issue taskforce, align taskforce efforts, and seek input on the process and progress towards outcomes.

Additionally, Solano Public Health is investing in efforts to not only ensure the equitable recovery from the COVID-19 pandemic but also advance the strategies outlined in the CHIP. These efforts are focused on engaging communities that have been disproportionately impacted by COVID-19 and growing trust in the public health system; innovative approaches to best disseminate information to community members ; identifying drivers of trends in disease rates to enhance local epidemiological capacity; intentional engagement strategies to supplement local workforce capacity; and working with small businesses which overwhelmingly employ community members hardest hit by COVID-19 to strengthen health promotion and community outreach efforts.

The CHIP will be reviewed by the Healthy Solano Collaborative once a year and updated after five years.

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