2024-2029

SLO County

Community Health Improvement Plan

April 2024

Prepared by

About SLO Health Counts

SLO Health Counts is a collaborative of community members, nonprofits, government agencies, cities, schools, and other leaders in SLO County working together toward the shared goal of a healthy, thriving community.

Our work builds on a strong history of community engagement in support of health and wellness in San Luis Obispo County. In 1999, a collaborative of individual agencies and public and private organizations called ACTION for Healthy Communities committed to improving the overall quality of life in San Luis Obispo County. That work spanned the course of two decades and championed the understanding that many of the issues affecting quality of life in SLO County could not be changed by just one agency.

In 2007, the Obesity Prevention Task Force (later Healthy Eating Active Living San Luis Obispo or HEAL SLO) also emerged as a collaborative addressing the growing obesity epidemic. In 2018, HEAL SLO updated its mission and structure to address health with a broader scope, working on issues as diverse as food security and land use planning, bringing a wide range of leaders to the table in discussions about health in SLO County.

The work of SLO Health Counts builds on these efforts, engaging many of the same organizations and leaders who were critical to this earlier work advocating for health.

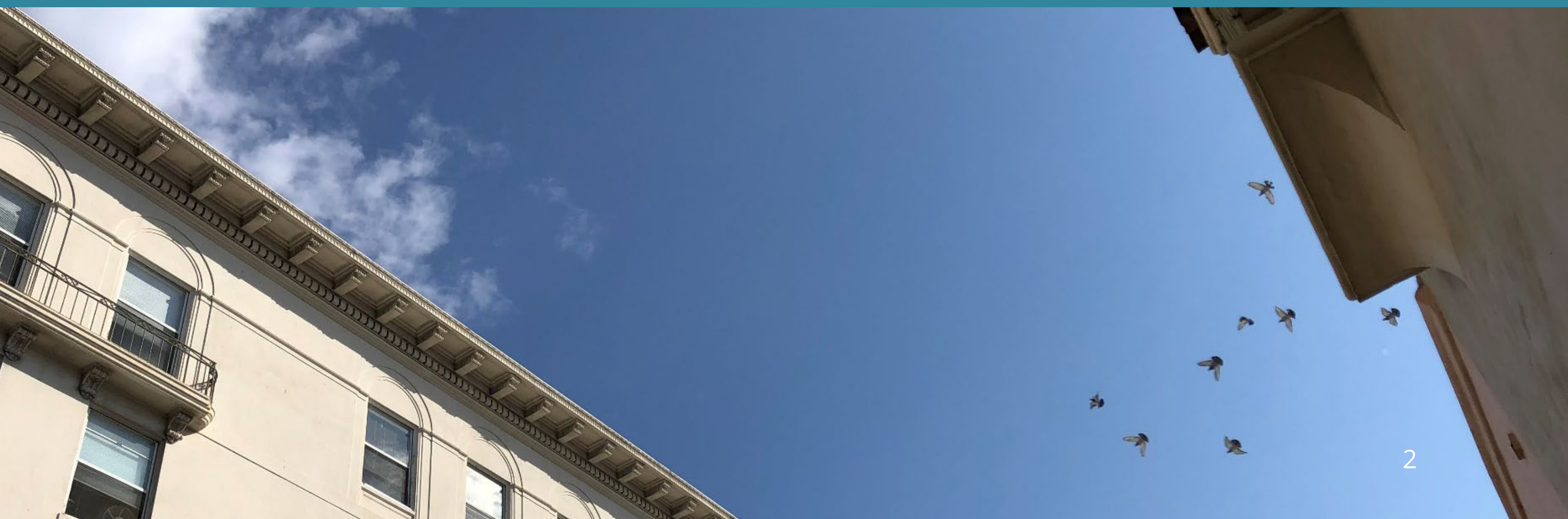
To learn more, please visit www.SLOHealthCounts.org.

Vision

A healthy, equitable, and thriving community.

Mission

SLO Health Counts is a community-wide initiative that works to equitably improve health for those who live, learn, work, and play in San Luis Obispo County.



Acknowledgements

Listed in Alphabetical Order by Organization

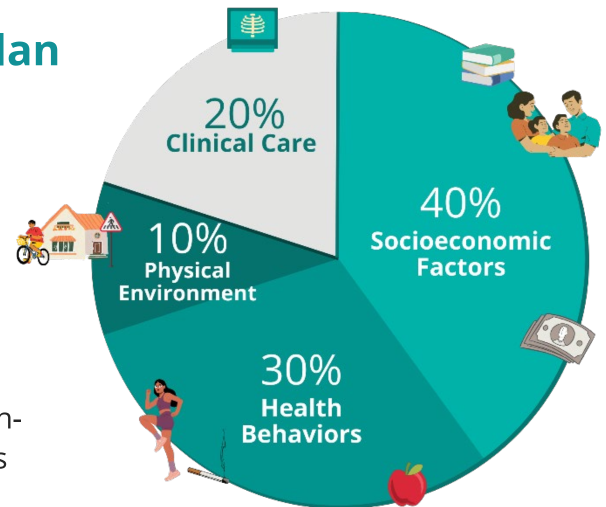
SLO Health Counts acknowledges and thanks the many community partners whose representatives contributed their ideas, expertise and energy to develop this plan.

We also thank the nearly 4,000 surveyed residents who shared their views on what makes it easier or harder to be healthy in our communities. Their experiences are a key driver of this plan.

- Aydin Nazmi
Cal Poly
- Courtney Kienow
Cal Poly
- Biz Steinberg
CAPSLO
- Melinda Sokolowski
CAPSLO
- Ron Yukelson
Carmel & Naccasha LLP
- Gabriela Labraña
CenCal Health
- Jordan Turetsky
CenCal Health
- Marina Owen
CenCal Health
- John Khan-Variba
CHC
- Joel Diringer
Diringer and Associates
- Yessenia Echevarria
Congressman Salud Carbajal's Office
- Jim Brescia
County Office of Education
- Sheldon Smith
County Office of Education
- Laurel Weir
County of SLO Department of Social Services
- Elizabeth Merson
County of SLO Public Health Department
- Jill Stearns
Cuesta Community College
- Jean Raymond
Dignity Health
- Patrick Caster
Dignity Health
- Wendy Wendt
First 5 SLO County
- Ed Waage
Pismo Beach City Council
- Erica Stewart
SLO City Council
- Jim Dantona
SLO Chamber
- James Worthley
SLOCOG
- Francisco Ramirez
SLO Legal Assistance Foundation
- Mark Lisa
Tenet Health
- Barry Johnson
Transitions Mental Health Association
- Jill Bolster-White
Transitions Mental Health Association
- Chelsea Ruiz
UndocuSupport
- Lynn Enns
Wilshire Health & Community Services

These partners were instrumental in the development of this plan, but it will take the work of many more to ensure its success. To lend your support to this effort, visit www.slohealthcounts.org/priorities.

Purpose of a Community Health Plan



Many of our greatest health issues are preventable and it is within our power as a community to create environments that make it easier for all of us to live healthier lives. Research is clear that nearly every health risk we face—from infectious disease to accidental injury and chronic conditions such as cancer and heart disease—is shaped by the environment where we live, learn, work, and play. A coordinated and strategic approach to creating health-supporting environments means better opportunities for everyone in our community to live healthier lives.

This is where a community health improvement plan comes in. A community health improvement plan acts as a roadmap for how the Public Health Department and community partners will work together to counter these preventable health hazards, at their very start, and improve community well-being over the long term. It assesses the community's health needs and collaboratively develops targeted interventions to prevent or address those challenges.

This community health improvement plan takes a holistic approach to health, moving beyond healthcare as the key ingredient to good health and examining other key drivers of health in SLO County—the role of environment, housing, education, economic opportunity, language and literacy, family supports, transportation, food security, and more.

The power of a community health improvement plan is in its collaborative and coordinated approach. SLO County is home to a vast and diverse range of dedicated individuals and organizations working to create a healthy and vibrant future for our community. The work ahead is significant but, by working together, we can effectively leverage resources and create the greatest collective impact.

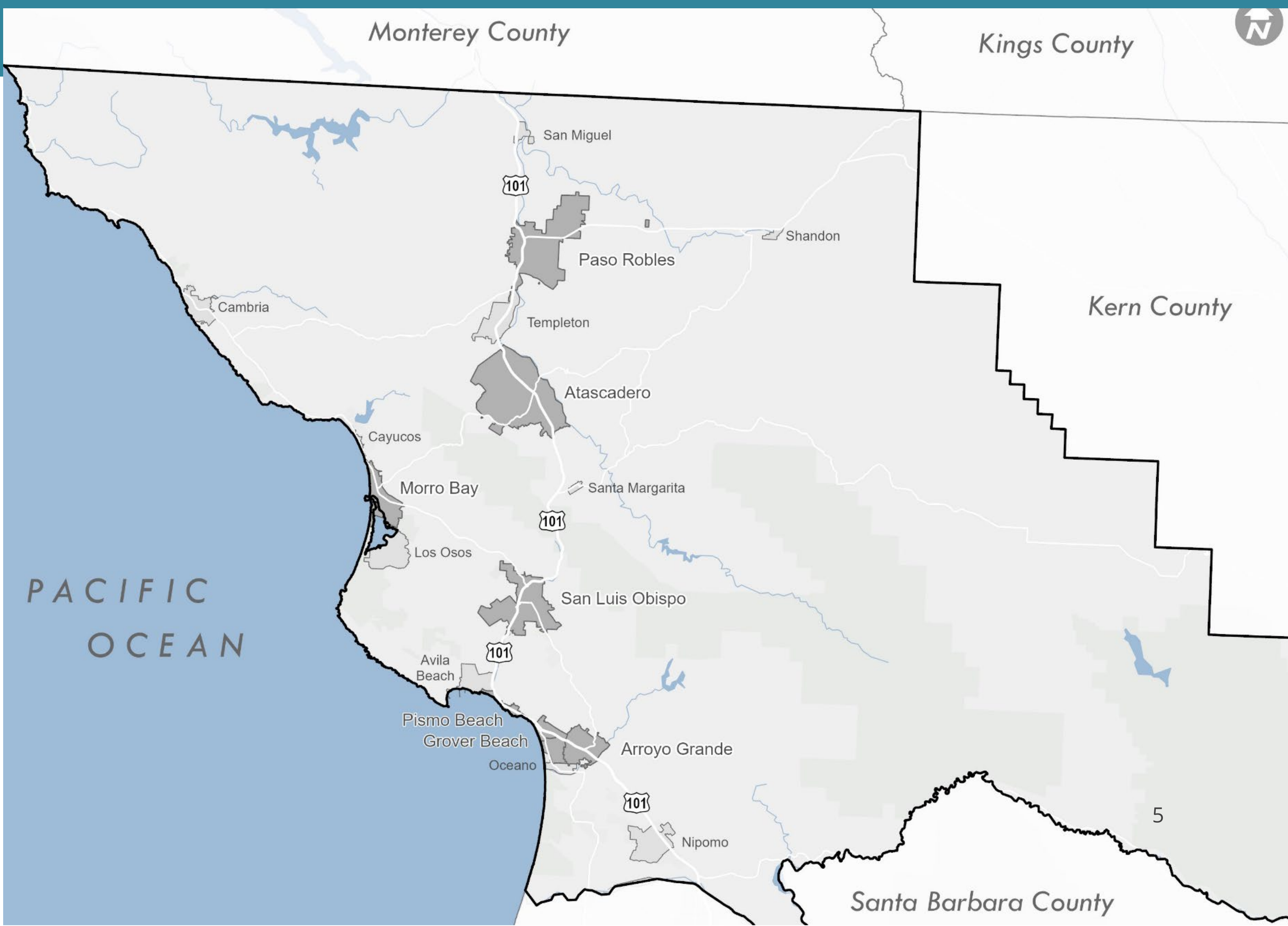
Source: Adapted from the BARHII Framework.

Community Served

San Luis Obispo County is located along the Pacific Coast, approximately 200 miles north of Los Angeles and 235 miles south of San Francisco. It is one of California's 58 counties and is considered part of the Central Coast region of California.

San Luis Obispo County is home to approximately 280,000 people, spread across seven cities and 14 community service districts. The majority of residents live along the coast or along the corridor of Highway 101. The eastern region of the county is sparsely populated with vast areas of agricultural and undeveloped government lands between small, unincorporated towns. Key industries in the county include tourism, education, energy, agriculture and government.

The majority of residents in SLO County identify as White, followed by Hispanic or Latino. The County is also home to an older population, with a greater share of those aged 65 years and older than the state as a whole, and a smaller percentage of those 18 years and younger. The county population includes a greater share of high school graduates than the state overall.



How this Plan was Developed

From July 2023 to April 2024, a dedicated Community Health Improvement workgroup of SLO Health Counts gathered feedback on what makes a healthy, thriving community. That process included data collection and interpretation; identification, prioritization, and selection of health needs; and the creation of this final report.

In developing the plan, the workgroup followed the nationally recognized University of Kansas Community Tool Box, a framework focused on building healthier communities through first understanding local community assets and needs, then working alongside key partners to develop a vision, mission and action plan.

Methods Used to Identify Needs

Community Input

The workgroup leaned heavily on the 2023 Community Health Assessment and the primary data collected from nearly 4,000 surveyed residents in a community survey administered from February – March 2023 in Spanish and English. Respondents answered 55 questions related to the top health needs in the community, perceptions of their overall health, and access to health and community services.

To supplement this data, Public Health staff conducted additional stakeholder interviews from November 2022 – April 2023 with key informants representing people of color, Spanish-speaking and Mixteco-speakers, those living with mental illness and substance use disorders, and people experiencing homelessness.

TIMELINE

July 2023
Community Health Assessment (CHA) is finalized

July 2023
CHIP workgroup is formed

August 2023
New SLOHealthCounts.org website and online assessment launched

Aug-Sept 2023
Workgroup reviews CHA and special topics presentations

October 2023
3-hour facilitated prioritization exercise to identify top 3 priorities

November 2023
Discussion and voting on goals under each priority

December 2023
Meetings with subject matter experts to define activities

April 2024
Plan finalized

The workgroup reviewed and discussed several other partner reports, including the findings of focus groups for Spanish-speaking and Mixteco-speaking residents conducted by the local organization UndocuSupport.

Secondary Data

The County of San Luis Obispo Public Health Department provided secondary data on leading causes of death, as well as disease and injury trends over time and compared to other California counties. Data on social determinants of health, like income and education, as well as mental health, substance use, and access to care were also included. This data can be accessed at www.slohealthcounts.org.

Methods Used to Prioritize Needs

The following criteria were then used by workgroup members in planning sessions to prioritize the list of health needs:

- Impacts a large number or high percentage of people
- Consequences of not acting are severe
- Health disparities or inequities exist
- Good chance of improvement if addressed
- Community support exists, including political will
- Multi-disciplinary collaborative opportunities exist
- Feasible given local resources
- Ability to measure impact

Several priority areas rose to the surface in the review of surveys, focus groups and stakeholder discussions. These were brought to a 3-hour facilitated session in October 2023 where workgroup members identified priorities. The group met again in November 2023 to detail goals for each. The SLO Health Counts Leadership Council met in November 2023 to provide feedback on the chosen priorities and goals outlined. In December 2023, workgroup members engaged additional subject matter experts to further outline the activities under each.

The results of these deliberations are detailed in the work plans on the following pages. Each activity details the organizations that have taken responsibility for the action. Teams will use these work plans to track and monitor progress toward each of the goals at a more detailed level and will provide updates on SLOHealthCounts.org annually.

These annual reports will document the progress of the proposed strategies, any changes in priorities or the strategies to address them, additional resources and community assets needed, and any challenges that groups faced in achieving their selected goals.

For more information or to lend your support to this effort, visit www.slohealthcounts.org/priorities.

Our Priorities

Healthy Neighborhoods

Socially cohesive, vibrant neighborhoods allow people to connect with each other, safely walk and bike, access healthy food and other goods and services, and enjoy parks and open space.

Community members and partners consistently noted insufficient affordable housing as a key health issue for SLO County – affecting everything from household budgets to workforce recruitment. Additionally, they identified access to safe community spaces, like parks, and the bike and pedestrian networks to connect them, as a key issue. The CHIP workgroup noted, for this priority area in particular, a place-based approach was necessary to understand and address the specific and unique needs of certain communities.

Access to Care

Meaningful access to care includes infrastructure that allows for healthcare and services to be accessed in a way that is affordable, culturally and linguistically appropriate, and available to all who need it.

Community members responded that improving access to health care was the top health issue that must be addressed to improve the quality of life in our community in the 2023 SLO County Community Health Survey. This topic consistently came up in focus group discussions, stakeholder interviews, and in open-ended survey responses. The CHIP workgroup noted that special attention must be given to key communities and groups who had less access to care, such as lower-income community members and those living in rural areas. Partners noted that bolstering the healthcare workforce was also critical.

Mental Health & Substance Use

Thriving and resilient communities include opportunities for people to be supported throughout their lifetimes, with socio-emotional supports that facilitate optimal mental health throughout the life course and accessible treatment for mental health challenges and substance use.

Mental health was ranked the #2 health issue that must be addressed to improve the quality of life in our community, with community members and service providers noting social isolation and persistent sad or hopeless feelings among teens, LGBTQ+ people, new parents, and older adults. In addition, opioid abuse and the proliferation of fentanyl were reported as concerns.

Guiding Principles for our Work

Health Across the Lifespan

While many of our most acute illnesses happen later in life, we encounter many of the factors that contribute to or prevent those diseases far earlier in life. For that reason, we take a life course approach when exploring the health needs of SLO County residents. A life course approach considers one's experiences throughout the lifespan, including key developmental phases, as well as housing, income, and access to healthy food, all of which play critical roles in a person's opportunities to be healthy throughout life.

Health Equity

For many of its residents, SLO County provides an ideal place to live, learn, work, and play—and an ideal place to lead a healthy lifestyle. But for others, it can be a difficult place to achieve or maintain health. This is particularly true for low-income individuals, people of color, and rural populations, with life expectancy varying by as much as 14 years across different parts of SLO County. To effectively protect and promote the health of all residents, we must recognize the scale of these disparities and work to meaningfully address the factors that lead to them.

Community Engagement

Residents and partners with deep roots in their community are experts on the strategies that will be most successful there. This is why community engagement is at the core of this effort. Effective community engagement results in more relevant ideas, a deeper understanding of the important issues, more widespread support and ownership, and, ultimately, more meaningful and effective decisions.

Place-Based Strategies

People who live in neighborhoods or places that make the healthy choice the easy choice live longer, healthier lives. Members of the collaborative recognize that SLO County's unique geography poses unique challenges and opportunities when it comes to these opportunities for health, which are shaped by service distribution, transportation, community investment, and more. Because of this, while the work group looked at health for the county as a whole, it also employed a place-based approach to understand and address specific needs for certain communities in SLO County.

Priority Populations

SLO Health Counts recognizes that different populations in SLO County have different opportunities for health. Because of this, implementing this plan and the activities it outlines will require focus on the unique needs of the population groups that call SLO County home.

Hispanic and Latino Populations

Hispanic and Latino populations are the fastest growing communities of color in the U.S. Hispanic and Latino people experience disparities in health and access to care and are 3 times more likely to be uninsured than their Non-Hispanic White counterparts. Furthermore, Hispanic and Latino people who are immigrants, refugees, undocumented, in poverty, disabled, or limited in English proficiency are even more likely to face health inequities due to the marginalization they experience.

LGBTQ+

LGBTQ+ is an inclusive term encompassing a diverse range of gender identities and sexual orientations, including but not limited to Lesbian, Gay, Bisexual, Transgender, Questioning or Queer. Members of the LGBTQ+ population encounter barriers to healthcare, including discrimination, stigma, and lack of culturally competent care. This community also faces higher rates of mental health concerns and smoking and substance abuse. Creating inclusive and supportive healthcare environments, along with policies that protect against discrimination, is crucial in reducing health disparities among LGBTQ+ individuals.

Low-Income Individuals

Income provides access to resources that promote good health, such as good schools, health care, healthy food, and safe neighborhoods. Having sufficient income can also help individuals avoid health hazards like air pollution and subpar housing conditions. As a result, people with lower income are more vulnerable to a variety of health hazards

compared to those making a sufficient living wage. This can lead to a higher prevalence of conditions like obesity, diabetes, and cardiovascular diseases. Addressing health disparities in this group requires a comprehensive approach that focuses on the social determinants of health.

Older Adults (65+ years old)

Older adults are defined as individuals aged 65 years and older. Older adults may face unique challenges that affect their health outcomes, such as limited access to healthcare services, social isolation, and age-related chronic conditions. Socioeconomic factors, including limited income and education level, can further exacerbate disparities. Addressing the health needs of older adults requires accessible health and social services, age-friendly environments, and opportunities for social connection.

People who speak languages other than English

Nearly one in five SLO County residents speaks a language other than English in their household. Spanish is the most common, and growing numbers of indigenous residents in SLO County speak Mixteco languages, which are non-written and include 81 variants. These populations may have a limited or no understanding of Spanish. People who speak languages other than English are at greater risk of linguistic isolation and face barriers to navigating health and social systems. Addressing disparities in this group will require communication and outreach strategies that put language access front and center.

Rural Communities

Rural communities are geographic areas with lower population density. Individuals living in rural areas may encounter difficulties accessing healthcare, leading to delayed or inadequate medical care. Limited availability of healthcare providers, transportation challenges, and difficulty accessing nutritious food also contribute to disparities. Rural residents are more likely to be older adults, in poverty, in fair or poor health, and to have chronic health conditions.

Strategies for Improving Health

SLO Health Counts works across disciplines to create a SLO County that is healthy, equitable and thriving. To do this, the collaborative uses a range of strategies to improve the health of our community.

Capacity Building

Provide technical assistance and support to organizations and agencies.

Communication

Regularly engage the community in decision-making processes, share information and opportunities to get involved, and educate about the role of priority areas in our health.

Funding

Release funding opportunities centered on community health priorities and apply for grant funds that bring additional support into the community.

Partnerships

Build relationships with community members and other agencies to share decision making and sustain meaningful participation.

Planning & Community Implementation

Participate in city and community planning and help implement healthy design standards that bring optimal opportunities for health to schools, workplaces, and communities.

Policy

Provide evidence-based policy tools to change the places where people live, learn, work, and play to improve health outcomes and advance health equity.

Research

Mobilize data, research, and evaluation to inform interventions. Create toolkits and publications with the latest research and emerging best practices.

Healthy Neighborhoods

Healthy Neighborhoods

Goal: Promote healthy, connected communities.

Collaboration partners

Public Health Department (PHD), SLOCOG (1.1, 1.3-1.7), Healthy Communities Work Group (1.1), SLO County Parks (1.1, 1.3, 1.6), Food Systems Coalition (1.2, 1.4), Caltrans (1.3), First 5 SLO County (1.4), UndocuSupport (1.4), Adult Services Policy Council (1.4), 805 La Voz (1.4), Mujeres de Acción (1.4), Safe Routes to School Taskforce (1.7). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities.*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Increase investment in healthy, connected communities through bike and pedestrian improvements, enhanced food access, and free, safe community spaces.	# grants supported	SLOCOG, Healthy Communities Work Group, PHD	Tracking sheet	0	5 grants supported (2028)	Annual
1.1 Using a place-based approach, conduct a needs assessment to understand high-priority communities and their built environment needs (e.g. complete streets, food access, park access).	Assessment	SLOCOG, Healthy Communities Work Group, SLO County Parks, PHD	---	0	1 assessment (2024)	Annual
1.2 Assess current food environments and map out food retailers/service providers, poverty status, ethnicity, and unhealthy food density.	Assessment and map	PHD, Food Systems Coalition	---	0	1 assessment and map (2024)	Annual
1.3 Assess environments for physical activity and map opportunities (e.g. parks, sidewalks, bike paths) in priority cities and communities.	Assessment and map	SLOCOG, Caltrans, SLO County Parks, PHD	---	0	1 assessment and map (2025)	Annual

1.4 Identify existing community assets, like schools, nonprofits and coalitions, and work with them to understand their feasibility as multigenerational, multicultural, and multilingual centers of complete communities (e.g. community resource centers, climate resilience center, community schools).	Outreach / formal or informal agreements	First 5, UndocuSupport, 805 La Voz, Mujeres de Acción	---	0 agreements, 0 presentations (2023)	3 agreements + 5 presentations (2028)	Annual
1.5 Assist cities and local governments adopting or enhancing built environment policies (e.g. Complete or Livable Streets Policies).	# formalized policies	Healthy Communities Work Group, PHD	Personal correspondence	0	3 formalized policies (2028)	Annual
1.6 Share opportunities for and provide technical assistance to grants for parks and free, community spaces for those with limited options.	# grants supported	Healthy Communities Work Group, SLO County Parks, PHD	Tracking sheet	0	5 grants supported (2028)	Annual
1.7 Share opportunities for and provide technical assistance to grants for bike and pedestrian infrastructure or programming in high-priority communities, including Safe Routes to School (SRTS).	# grants supported	Healthy Communities Work Group, Safe Routes to School Taskforce, PHD	Safe Routes to School Prioritization tool	0	5 grants supported (2028)	Annual

Healthy Neighborhoods

Goal: Improve access to affordable, attainable, safe and supportive housing.

Collaboration partners

Healthy Communities Work Group, Public Health Department (PHD). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities.*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Support the development of very low income, low income, and moderate housing units throughout SLO County, with a goal of staying on track annually with regional housing targets (RHNA).	% of housing units permitted annually in SLO County by RHNA income category	Healthy Communities Work Group	CA Regional Housing Needs Allocation (RHNA) For 6th Cycle, ending 12/31/28 HCD; SLOCOG	**% Attained:** V Low 6% Low 22% Mod 24% A Mod 33% (2023) Year 3 of 8	**% Attained:** V Low 100% Low 100% Mod 100% A Mod 100% (2028)	Annual
1.1 Submit comment letters when new housing developments come before government bodies (planning commissions, city council meetings etc.)	# of letters submitted	Healthy Communities Work Group	Tracking sheet	6 letters of support (2022)	8 letters of support each year (2028)	Annual
1.2 Develop an inventory of housing stability and health best practices and policies to build on the work of local housing policy makers.	inventory	Healthy Communities Work Group	---	0	1 inventory of housing best practices	Annual
1.3 Utilize the Healthy Communities Project Checklist for assessing housing-related development projects from a healthy community's perspective.	# of project reviews	Healthy Communities Work Group	Workgroup records	6 projects reviewed with project checklist (2022)	8 projects reviewed with project checklist each year (2028)	Annual

1.4 Participate in partnership and policy conversations around housing (e.g. REACH housing advisory group, Home Builders Association of the Central Coast, SLOCOG RTP process)	Participation records	PHD	Participation records	0	3 new meetings each year	Annual

Healthy Neighborhoods

Goal: Ensure climate resilient communities.

Collaboration partners

Public Health Department (PHD). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities.*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Increase community resilience by understanding, and preparing for, the impacts of climate change.	Assessment	PHD	---	0	1 assessment (2025)	Once
1.1 Conduct needs assessment to identify most pressing needs in SLO County around climate change.	Assessment	PHD	---	0	1 assessment (2025)	Once
1.2 Increase investment in community resilience of those most disproportionately impacted by climate change through implementing strategies prioritized by community stakeholders.	Strategy implemented	PHD	---	0	1 strategy (2028)	Once

Access to Care

Access to Care

Goal: Recruit and retain providers in the Central Coast.

Collaboration partners

SLO Healthcare Workforce Partnership, Center for Family Strengthening's Promotores Collaborative (1.2). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities.*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Develop local pipeline(s) & training programs for Physical, Behavioral, and Oral Health.	workforce projections	SLO Healthcare Workforce Partnership	SLO Workforce Development Board	Current Employment: (2022) CNA 634 LVN 496 RN 1,820	Additional Workforce Needed: (2027) CNA +480 LVN +204 RN +533	Annual
1.1 Gather current data from businesses and conduct a market assessment of local healthcare positions (number and type of positions needed).	assessment	SLO Healthcare Workforce Partnership	---	0	1 assessment (2024)	Annual
1.2 Identify educational/training/ professional development opportunities to build the capacity of support staff, including community support (CHW/P) and Enhanced Care Management roles.	list	Promotores Collaborative, SLO Healthcare Workforce Partnership	---	0	1 list (2024)	Annual
1.3 Partner with Cal Poly, Cuesta, Allan Hancock, A. T. Still University, local residency programs, and/or other educational organizations to expand existing, and build new pathways, for career development.	# of new educational opportunities/ program slots	SLO Healthcare Workforce Partnership, local educational institutions and residency programs	---	TBD	TBD	Annual

Objective 2: Retain local healthcare workforce and identify funding/investment opportunities.	# of new funding sources	SLO Healthcare Workforce Partnership	tracking sheet	0	4 new funding sources identified (2028)	Annual
2.1 Design and implement a survey to health-related employers/employees to identify challenges to retention (permanent vs. contracted positions).	survey	SLO Healthcare Workforce Partnership	---	0	1 survey (2024)	Annual
2.2 Advocate for changes to SLO County's rural designation for Medicare reimbursement rates and to increase Medi-Cal reimbursement rates in general.	# of advocacy meetings with decision makers/legislators	SLO Healthcare Workforce Partnership, partnership member organizations, local elected leaders	---	0	TBD	Annual
2.3 Research and find funding sources to support local healthcare workforce development activities.	# of funding sources identified	SLO Healthcare Workforce Partnership	---	0	TBD	Annual

Access to Care

Goal: Expand services in remote areas and to hard-to-reach populations.

Collaboration partners

Public Health Department (PHD), PHD Health Equity Program (1.4), SLO County Parks (1.4, 1.5), Care Coordination Coalition (1.5), UndocuSupport (1.5), Adult Services Policy Council (1.5). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Increase healthcare visits performed in remote areas of the county by 20% (e.g. through mobile or pop-up clinics, resource fairs).	# visits	PHD	Tracking sheet	TBD	TBD	Annual
1.1 Create list of current organizations that use mobile and pop-up clinics, and the locations, frequencies and services provided.	list/map	PHD	Tracking sheet	0	1 list/map (2024)	Annual
1.2 Based on identified gaps, research the locations, staffing and services needed in expanded mobile operations.	assessment	PHD	---	0	1 assessment (2024)	Annual
1.3 Investigate partnerships, funding opportunities and alternative staffing (e.g. community health workers, promotores) approaches to meet the demand.	# available staff	PHD	---	TBD	TBD	Annual
1.4 Create training suite that helps inform providers on the cultural and linguistic needs of their target population.	training	PHD Health Equity Program	---	0	1 training suite (2026)	Annual
1.5 Create and utilize a system of closed-loop referrals for other needed supports and programs (e.g. housing, mental health, transportation) that is culturally, linguistically, and generationally appropriate.	# agencies participating in referral system	PHD	---	10 agencies (2023)	20 agencies (2028)	Annual

Mental Health & Substance Use

Mental Health and Substance Use

Goal: Improve social and emotional supports over the life course.

Collaboration partners
CenCal, Public Health Department (PHD), Behavioral Health Department (BHD), First 5, Parent Connection (1.2, 1.6), Child and Family Wellness Collaborative (1.2, 1.6), Transitions-Mental Health Association (TMHA) (1.5, 1.6, 2.4), Suicide Prevention Council (3.1, 3.3), Adult Services Policy Council (3.2, 3.3), PHD Healthy Aging Services (3.2), Department of Social Services (DSS) (3.2, 3.3), SLO County Parks (3.2), Opioid Safety Coalition (4.2, 4.3, 4.4), EMSA (4.3). *The work of this plan is just getting started. To lend your support to this effort, visit www.slohealthcounts.org/priorities.*

	Performance Measures	Lead	Data Source	Data Baseline	Improvement Target	Reporting Frequency
Objective 1: Increase percent of parents who are screened and connected to mental health supports.	CenCal postpartum depression screening %	CenCal, BHD, PHD	Healthcare Effectiveness Data and Information Set (HEDIS®)	41% (2023)	62% (2025)	Annual
1.1 Conduct analysis to identify the sub-populations in most need of focus, including stratification by race, age, region, sex, gender identity, sexual orientation, language, and homeless status.	comprehensive report	CenCal, PHD	---	0	1 report	Annual
1.2 Conduct gap analysis of parenting resources by region and socioeconomic status.	gap analysis	First 5, Parent Connection, Child and Family Wellness Collaborative	---	0	1 analysis	Annual

1.3 Use analysis to inform initiatives such as expanding access to community-based training and information on preventive mental health strategies and resources for families, community members, and providers.	completed initiatives	CenCal, BHD, PHD	---	0	TBD	Annual
1.4 Adopt postpartum toolkit with mental health resources and other supports for new parents.	adopted toolkit	CenCal, PHD	---	0	1 toolkit	Annual
1.5 Assess and expand the availability of information and referral websites/access lines to make navigation of existing mental health services easier for the public.	review of referral websites available	TMHA, BHD	---	0	1 review	Annual
1.6 Expand and build upon parent education & support for parents of children of any age.	development or funding of expanded programming	Parent Connection, Child and Family Wellness Collaborative, TMHA	---	0	TBD	Annual
1.7 Expand and strengthen the Services Affirming Family Empowerment (SAFE) program[1] to ensure access and an active program presence in all key geographic regions of the County and for children of any age.	program assessment	BHD	---	0	1 assessment	Annual

[1] Services Enhancing Family Empowerment (SAFE) is a team-based collaboration involving the Behavioral Health Department, Department of Social Services, Probation, County Office of Education, CAPSLO, and others. SAFE is focused on reducing the number of children who require out-of-home care (foster, group homes, or hospitalization), reducing recidivism among probation-involved youth, and improving school attendance.

Objective 2: Increase percent of teens who are screened and connected to mental health supports.	CenCal adolescent depression screening %	CenCal, BHD, PHD	Healthcare Effectiveness Data and Information Set (HEDIS®)	31% (2023)	46% (By 12/31/25)	Annual
2.1 Conduct analysis to identify the CenCal sub-populations in most need of focus, including stratification by race, age, region, sex, gender identity, sexual orientation, language and homeless status.	comprehensive report	CenCal, PHD	HEDIS®, CA Healthy Kids Survey, Behavioral Health data	0	1 report	Annual
2.2 Use analysis to inform initiatives such as expanding access to community-based training and information on preventive mental health strategies and resources for families, community members, and providers.	new provider resources produced	CenCal, BHD, PHD	---	0	TBD	Annual
2.3 Work closely with providers and partners in public health and education to impart a consistent set of messages and informational campaigns on understanding and addressing critical teen issues, such as youth mental health access, the impact of social media on mental health, and suicide.	adopted toolkit	CenCal, BHD, PHD	---	0	1 toolkit	Annual
2.4 Support the continued expansion of school-based wellness centers in the County that provide mental health services to school-age children and youth.	feasibility assessment	TMHA, BHD	---	0	1 assessment	Annual

2.5 Assess and expand the availability of information and referral websites to make navigation of existing mental health services easier for the public.	website review	TMHA, BHD	---	0	1 review	Annual
Objective 3: Reduce older adult suicide deaths by 15%.	Suicide death rates	Public Health	Vital Records	45.8 deaths per 100,000 (85+ years, 2018-2022)	38.9 deaths per 100,000 (85+ years, by 12/31/25)	Annual
3.1 Conduct analysis to identify older adult sub-populations in most need of focus, including stratification by race, age, sex and, if possible, region.	comprehensive report	PHD, Suicide Prevention Council	Vital Records	0	1 report	Annual
3.2 Collaborate with Local Aging and Disability Action Plan workgroup to conduct assessment on older adult programming availability across the county.	assessment	DSS, Adult Services Policy Council, PHD Healthy Aging Services, BHD	---	0	1 assessment	Annual
3.3 Use analysis to inform initiatives such as the creation of communication toolkits, provider education on the importance of screening older adults, or programming to reduce isolation.	new resources produced	PHD, BHD, Suicide Prevention Council, Adult Services Policy Council	---	0	TBD	Annual

3.4 Establish a task force focused on assessing the behavioral health needs specific to aging and older adults (60+ years old); conduct a gaps analysis to discern adaptation of community services and supports for this growing county population.	taskforce initiated	BHD	---	0	6 meetings held (2026)	Annual
Objective 4: Reduce drug-related deaths by 20%.	# of drug-related deaths	PHD, Opioid Safety Coalition	Vital Records	105 drug-related deaths (2022)	84 drug-related deaths (2025)	Annual
4.1 Analyze current data around drug-related deaths (e.g. age, sex, county location, toxicology) and, in particular, emerging trends in opioid overdose deaths.	Assessment	PHD	---	0 (2023)	1 analysis (2024)	Annual
4.2 Expand awareness and education for providers and hospitals about medication-assisted treatment (MAT), including medication for alcohol use disorder, tobacco use disorder, and opioid use disorder, and substance use disorder (SUD) treatment options.	# of new messages	Opioid Safety Coalition (provider collaborative), BHD, PHD	---	0	3 new messages (2025)	Annual
4.3 Pilot project where ambulances deliver buprenorphine in the field when responding to an overdose-related call.	adopted procedure	Opioid Safety Coalition, BHD, PHD EMSA	---	0	1 procedure for buprenorphine administration (2028)	Annual
4.4 Work closely with partners in public health and education to impart a consistent set of messages and informational campaigns on understanding and addressing substance use.	# presentations	Opioid Safety Coalition, BHD, PHD	---	0	2 presentations (per year)	Annual