Updated Strategic Plan (draft)
For July 1, 2022-June 30, 2024
**Vision:** Silicon Valley is a healthy community, with no racial health disparities.

**Mission:** To build health equity in Silicon Valley.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>FY23-FY24 Strategies</th>
<th>FY23-24 Milestones</th>
<th>Community Outcomes (5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Nutrition</td>
<td>Implement best practices in trust-based philanthropy, as a leader in local health philanthropy.</td>
<td>Increased general operating support and joint investments with other funders.</td>
<td>THT: 10% increase in # of healthy meals delivered, with food choices for diverse populations.</td>
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<tr>
<td>Chronic Disease Prevention and Management</td>
<td>Increase our role in addressing food insecurity and malnutrition.</td>
<td>Program growth where THT demonstrates excellence and disparities exist.</td>
<td>Food insecurity decreased.</td>
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<td>Supportive Housing</td>
<td>Improve quality of our HIV/AIDS and housing case management services.</td>
<td>Two Health Equity Agenda pilots launched through THT advocacy.</td>
<td>THT: Increased retention of HIV/AIDS Services case management clients (86% in FY20).</td>
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<td>Advocate for local Health Equity Agenda implementation, focused on eliminating health disparities.</td>
<td>Salesforce used agencywide, with staff analyzing data for program improvements.</td>
<td>THT: Collaborative pilot showing improved diabetes outcomes.</td>
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<td>Increase decision making based on data and stakeholder feedback.</td>
<td>“Crucial conversations” training completed. Rise in staff engagement survey scores.</td>
<td>Decreases in: % of adults diagnosed with diabetes.</td>
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<td>Invest in staff: increase professional development, pipeline development, and succession planning.</td>
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<td>% of Medi-Cal members with poorly controlled diabetes.</td>
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As a funder, provider, and advocate, we support the health of residents, recognizing that key drivers such as immigration status, poverty, race, and zip code impact health.

“Crucial conversations” training completed. Rise in staff engagement survey scores.

A 30% decrease in annual inflow of people becoming homeless.
FY23-FY24 Strategic Plan

As a funder, provider, and advocate, we support the health of residents, recognizing that key drivers such as immigration status, poverty, race, and zip code impact health.

With a focus on food and nutrition, chronic disease prevention and management, and supportive housing, we will:

Funder

- Implement best practices in trust-based philanthropy, as a leader in local health philanthropy. We will increase general operating support and joint investments with other funders.

Provider

- Increase our role in addressing food insecurity and malnutrition, and improve quality of our HIV/AIDS and housing case management services. We pursue program growth where THT demonstrates excellence and disparities exist.
  - We strive for:
    - 10% increase in # of healthy meals delivered, with food choices for diverse populations (320K meals in FY22).
    - Increased retention of HIV/AIDS Services case management clients (86% in FY20).
    - Increase in % of clients in permanent supportive housing remaining stably housed (89% in 2022).

Advocate

- Drive collaborative local Health Equity Agenda implementation, focused on eliminating health disparities. We aim to participate in two Health Equity Agenda pilots.
- Lead a collaborative project showing improved diabetes outcomes.

Our work will be data-driven and incorporate communications, development, finance, human resources, and a racial equity lens.
FY23-FY24 Strategic Plan - Longer-Term Outcomes

By the end of 2025—leveraging our roles as a funder, provider, and advocate—the Health Trust will strive for the following community outcomes in Santa Clara County:

- Reduction in food insecurity (7.3% in SCC, 7% in SBC in 2019).
- 70% of residents living with HIV/AIDS are virally suppressed (67% in SCC in 2020).
- A decrease in the % of adults diagnosed with diabetes (8.9% in SCC in 2020).
- A decrease in the % of Medi-Cal members with poorly controlled diabetes (26.5% in SCC in 2021).
- 2020-2025: Community Plan to End Homelessness – A 30% decrease in annual inflow of people becoming homeless (33% in 2021).

June 2022 Sources:
Food insecurity: Feeding America.

HIV/AIDS:
- In 2020 67.4% of all PLWH in the County were virally suppressed, this is, unfortunately, a lower rate than 2018. [https://publichealth.sccgov.org/sites/g/files/exjcpb916/files/documents/STIHIV_AnnualReport_2019_2020.pdf]
- In 2018 70% of all PLWH in the County achieved viral suppression. [https://publichealth.sccgov.org/sites/g/files/exjcpb916/files/hiv-annual-report-2018.PDF]

Diabetes:
- In 2020, of Santa Clara County respondents, 8.9% of adults had ever been diagnosed with diabetes (Source: CHIS).
- In 2021, SCFHP poorly controlled HbA1c levels for Medi-Cal members = 26.52%. (Source: HEDIS data from SCFHP).

Supportive Housing:
HEALTHTrust
Because everyone's health matters.