2022 Community Health Needs Assessment

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El Camino Health

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[1] El Camino Hospital is the legal and funding entity for El Camino Health's community benefit program. The community benefit requirement applies to 501(c)(3) tax-exempt hospitals.

The 2022 Community Health Needs Assessment report was prepared by the research firm Actionable Insights, LLC:

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1. EXECUTIVE SUMMARY

BACKGROUND

The Community Health Needs Assessment (CHNA) is designed as a tool for guiding policy, advocacy, and program-planning efforts. For hospitals, it also supports the development of community benefit plans mandated by California State Senate Bill 697, and it meets the IRS requirements for Community Health Needs Assessment and Implementation Strategies mandated by the 2010 Affordable Care Act. The CHNA report is available to the public for review and comment.

The Internal Revenue Service (IRS) requires the CHNA report to describe how the assessment was conducted (including the community served, who was involved and the process and methods used) and which significant health needs were identified and selected as a result. Gathering input from the community and experts in public health, clinical care, and others is central to the IRS mandate.

To identify and address the critical health needs of the community, the Santa Clara County Community Benefit Hospital Coalition (CBHC) formed in 1995. The CBHC brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, El Camino Health collaborated with the CBHC to conduct an extensive CHNA.

In 2021, four of the remaining nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[2] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA builds upon the earlier assessments conducted by these entities, distills new qualitative and quantitative research, prioritizes local health needs, identifies areas for improvement, and lists Santa Clara County's assets and resources related to identified health needs. Using all of this information, El Camino Health will develop strategies to address critical health needs and to improve the health and well-being of community members.

PROCESS AND METHODS

The members of the CHNA collaborative began the 2022 CHNA process in January 2021. The collective goal for the assessment was to gather community feedback and existing data about local health needs to inform how each member hospital selects specific issues to address through Community Benefit in its service area. The hospital members engaged Actionable Insights, a local consulting firm with expertise in community health needs assessments.

Between March and May 2021, community feedback was gathered through interviews with seven local experts and discussions with seven focus groups. Prior to each interview, experts were asked to complete a short online survey, in which they were asked to identify the health

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[2] The four entities are El Camino Health, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

needs they felt were the most pressing among the people they serve. Interviewees could choose up to three needs from the list presented to them, which had been identified in one or both counties in 2019, or could write in needs that were not on the combined 2019 list. During the interviews, for each need they chose, experts were asked the following four questions:

- How do you see this need playing out in the community?
- Which populations are experiencing inequities with respect to this need?
- How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?
- What is needed (including models/best practices) to better address this need?

AI sent a similar pre-survey to focus group participants, and asked focus groups the same questions during discussion (modified appropriately for each audience). Focus group discussions centered on the needs that had received the most votes from prospective participants in the online pre-survey.The focus groups comprised local residents and people who serve them. Participants included professionals in the fields representing low-income, minority, and/or medically underserved populations in the community. A total of 66 professionals and four safety net clinic patients participated in various focus groups.

Secondary data were obtained from a variety of sources, including the public Community Health Data Platform sponsored by Kaiser Permanente and the Santa Clara County Public Health Departments. The benchmarks used for comparison were California state averages and rates. These data are described in the summary descriptions of the health needs in Section 6.

Health needs described in this report are either a poor health outcome and its health driver(s), or a health driver associated with a poor health outcome. El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which were filtered using the following criteria (see diagram on following page):

1. Must fit the definition of a "health need." *(See Definitions box, opposite.)*
   and

2. Is suggested or confirmed by at least two sources (i.e. more than one source of secondary and/or primary data).
   and

3. Must be prioritized by at least one-third of focus groups or key informants,
   or

4. Two or more direct indicators must fail the benchmark by 5 percent or more,
   or

5. Two or more direct indicators must exhibit documented inequities by race.

DEFINITIONS

Health condition: A disease, impairment, or other state of physical or mental health that contributes to a poor health outcome.

Health driver: A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes. May be a social determinant of health.

Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

Health need: A poor health outcome and its health driver, or a health driver associated with a poor health outcome.

Health outcome: The measurable impact — morbidity (quality of life) and mortality (death) — of a disease within a community.

Health Needs Identification Criteria
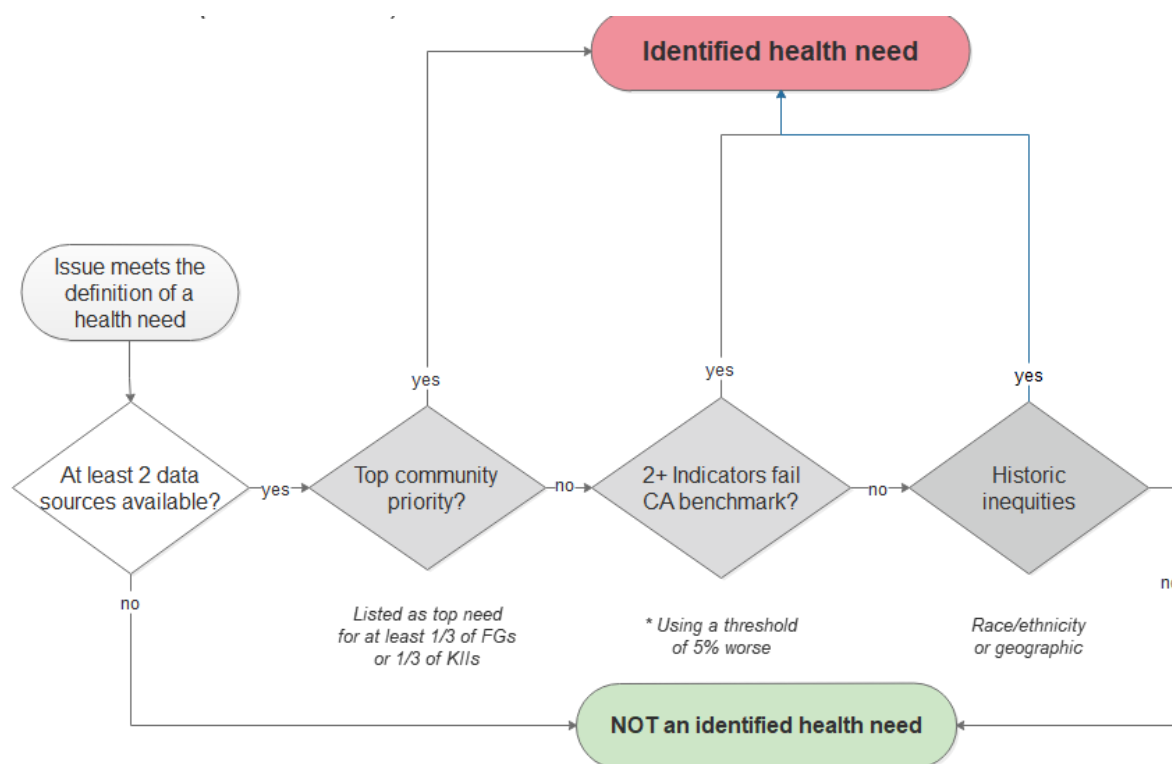
HEALTH NEEDS

The 2022 community health needs are presented below, in priority order. Rates are per 100,000 unless otherwise specified.

Health Need	Justification
Economic Stability (including Education and Food Security)	- Nearly all focus groups and almost three-quarters of key informants identified economic stability as a top community priority. - Income inequality in Silicon Valley is 1.5 times higher than at the state level. - While 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion rises to 58% among Santa Clara County households. - Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards. - In seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty).

Health Need	Justification
	- Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. - Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work. - Infant child care (age 0-2) cost $20,746 per year in Santa Clara County, compared to $17,384 on average statewide. Pre-K child care (age 3-5) cost $15,315 in Santa Clara County versus $12,168 on average in California overall. - Geographic disparities and inequities: - The 94040 and 94043 zip code areas of Mountain View have a higher level of income inequality (both 0.5 on the Gini index) than either the county or the state overall (both 0.4 on the Gini index).[3] - In addition, the East San José area experiences higher levels of Neighborhood Deprivation[4] (0.6) compared to the rest of the county (-0.2) and California as a whole (0.0). - While the index that maps geographic access to job opportunities for the county (50, on a scale of 0 to 100) is similar to California overall (48), jobs proximity index metrics for East San Jose (2) and the 94040 zip code in Mountain View (10) are much worse. - The median household income in East San José ($79,602) is substantially lower than even the state median ($82,053), let alone the county median household income ($129,210). - The proportion of adults who do not have at least a high school diploma is much higher (East San José, 31%; 94040 in Mountain View, approximately 28%) than the state average (18%). - The elementary school proficiency index, which measures the academic performance of 4th-graders, is

[3] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms.* Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

[4] The Neighborhood Deprivation Need Rating is comprised of 13 key measures across the dimensions of wealth and income, education, occupation, and housing conditions. All four East San José zip codes have the worst scores in the county. Rating scale ranges from -3.5 (best) to 3.5 (worst).

Health Need	Justification

	significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4).
	  ○ In East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).
	● Racial/ethnic disparities and inequities:
	  ○ Smaller proportions of Santa Clara County Black (45%), Pacific Islander (38%), and Latinx (46%) 11th-graders met or exceeded grade-level English-language arts standards compared to California 11th-graders overall (57%).
	  ○ Much smaller proportions of the county's Black (32%), Pacific Islander (34%), and Latinx (38%) high school graduates completed college-preparatory courses compared to high school graduates statewide (47%).

Behavioral Health (including mental health, trauma, and substance use)	● Behavioral health ranked high as a health need, being prioritized by all focus groups and more than half of key informants. ● Many experts spoke of depression, anxiety, trauma, and grief among all populations as an effect of the pandemic and reported an increased demand for services; however, children and adolescents were of particular concern. ● Students in Santa Clara County have lower access to psychologists at school (1,199:1) compared to students statewide (1,041:1, a 15% difference). ● The county's youth self-harm injury hospitalization rate (32.7 per 100,000 age 0-17) is significantly higher than the state's rate (22.4 per 100,000). ● Experts noted the lack of mental health providers (348.0 per 100,000 people in the county vs. 352.3 per 100,000 at the state level) and addiction services overall, especially in non-English languages. ● Key informants and focus group attendees described youth isolation and lack of interaction with peers due to the pandemic as preventing normal adolescent development. ● CHNA participants suggested that many students were anxious about returning to school, in part because of the chance of infection. ● Experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that

Health Need	Justification

	seemed to occur beginning about three months into the pandemic.
	● Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected.
	● Experts said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.
	● Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment.
	● Some noted that many hospitals no longer provide mental health services and there are very few inpatient psychiatric beds for acute/high needs.
	● It was stated that services for people without health insurance can be expensive and difficult to access.
	● Racial/ethnic disparities and inequities:
	  ○ Drug overdose deaths among Santa Clara County's Black population occur at nearly twice the rate (25.0 per 100,000 people) as for all Californians (14.0 per 100,000).
	  ○ Self-harm injury hospitalizations are much higher for the county's white youth (66.3 per 100,000 age 0-17) and Latinx youth (31.9 per 100,000) than for all California youth (22.4 per 100,000).
	  ○ The county's white suicide rate for all ages (13 per 100,000 people) remains persistently higher than the state rate (11 per 100,000 people).
	  ○ Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) were substantially higher for Black (23.0 per 1,000) and Latinx (9.3 per 1,000) Santa Clara County youth than for California youth overall (4.1 per 1,000).
	  ○ African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic.

Housing & Homelessness	● More than half of focus groups and one key informant identified housing and homelessness as a top community priority.

Health Need	Justification
	- The county's median home rental cost at $2,374 is 41% higher than the median state home rental cost ($1,689) and the home ownership affordability index for the county (73.0) is substantially worse than for the state overall (88.1). - While homeowners statewide are spending approximately 31% of their income on their mortgage, at the county level homeowners are spending over 36%. - The housing affordability index for Santa Clara County (73.0) is lower (i.e., worse) than for California (88.1).[5] - Focus group participants mentioned out-migration from the county due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. - Some CHNA participants said high costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID. - Housing quality is also a concern; for example, children and young adults ages 6-20 countywide have worse blood lead levels (1.1%) than California children overall (0.5%). - It was noted by experts that during COVID, landlords may be evicting families with undocumented members because they expect that these families will not seek legal protections. - Geographic disparities and inequities: - East San José homeowners are spending over 40% of their income on their mortgages, and homeowners in the 94040 zip code of Mountain View are spending 50%. - Overall, the East San José area experiences higher levels of Neighborhood Deprivation (0.6) compared to the county overall (-0.8) and California as a whole (0.0). - The housing affordability index for East San José (60.5) and the 94040 zip code of Mountain View (51.0) is worse than for California (88.1).[6]

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[5] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median valued home." See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. *ESRI ArcGIS Blog*, December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

[6] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median valued home." See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. *ESRI ArcGIS Blog*, December 14, 2018. Retrieved from

Health Need	Justification
	○ The proportions of people who own their own homes in both the 94040 zip code of Mountain View (41%) and the 94085 zip code of Sunnyvale (38%) are substantially lower than the county as a whole (56%) or the state average (55%). ○ Particularly in East San José (20%) and the 94085 zip code of Sunnyvale (12%), the proportions of overcrowded housing units are much higher than in the state as a whole (8%). ○ The number of homeless individuals rose 31% between 2017 and 2019, primarily in San José and the northern parts of the county, including the 94040 zip code of Mountain View. ● Racial/ethnic disparities and inequities: ○ CHNA participants expressed the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing.
Health Care Access & Delivery	● Healthcare access and delivery, which affects various other community health needs, was identified as a top health need by more than half the CHNA's focus groups and nearly one-third of key informants. ● Experts and county residents felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. ● In Santa Clara County's schools, the ratio of students to each school nurse (2,992:1) exceeds the state ratio (2,410:1) by nearly 25%. ● The county's ratio of students to school speech, language, and hearing specialists (1,126:1) is larger than the state's (1,093:1). ● Many key informants and focus group participants mentioned that low-income residents may be required to prioritize rent and food over healthcare. ● Some CHNA participants noted that individuals who are not provided with sick time must choose to go unpaid in order to visit the doctor for themselves and/or family members, stating

https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

Health Need	Justification
	that expanded service hours on weekends and evenings are still needed.
	● It was stated that low-income and undocumented county residents especially have difficulty accessing insurance.
	● Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern.
	● CHNA participants identified the lack of information for patients about healthcare costs as a barrier to accessing care.
	● Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide as well as patients' lack of privacy. There was also concern expressed by providers about the lower reimbursement rate for telephone appointments (i.e., without video).
	● The need for healthcare workforce training in order to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Desired training topics were LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients who have mental health issues, are low-income, lack digital and/or English literacy, or are monolingual non-English speakers.
	● Other delivery issues included the need for healthcare worker education around public charge issues, and the need for greater language capacity.
	● More than one in ten (11%) Santa Clara County residents speak limited English, compared to less than 10% in California overall.
	● Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility in order to retain coverage were called out as specific concerns.
	● Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to healthcare among these groups.
	● Geographic disparities and inequities: ○ In East San José, one of the geographic areas where health disparities are concentrated, there is a higher

Health Need	Justification
	percentage of individuals enrolled in Medicaid or other public health insurance (42%) compared to the state average (38%). ○ In Sunnyvale (zip code 94085), another area of concentrated health disparities, a much lower proportion of individuals are enrolled in Medicaid/public health insurance (21%), but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%). ○ In Sunnyvale (zip code 94085) more than one in seven (14%), and in the East San José area more than two in ten (22%) residents speak limited English. ● Racial/ethnic disparities and inequities: ○ Preventable hospital stays (4,942 per 100,000 Black Medicare enrollees [adults aged 65 and over and persons with disabilities] and 3,969 per 100,000 Latinx Medicare enrollees in the county versus 3,358 per 100,000 Medicare enrollees statewide) may be a sign of inequitable access to high-quality care.
Diabetes & Obesity	● Approximately one-third of key informants and focus groups identified diabetes and obesity as a top health need. ● Two experts in Santa Clara County specifically called out diabetes as trending up in the community (from 6.8 per 100,000 in 2018 to 8.4 per 100,000 in 2019), while the trend for adult obesity remains flat. ● Key informants and focus group participants identified the need for nutrition education, particularly from a young age, and some key informants further noted the cost of healthy food as a barrier to good nutrition. ● The lack of physical activity was cited as a driver of obesity by multiple key informants, mostly in the context of the pandemic's interference with regular activities. ● The county's walkability index (9.9) is worse than the state's (11.2). ● Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. ● Among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in Santa Clara County (22.2 per 1,000 people) compared to the state rate (48.1 per 1,000).

Health Need	Justification
	- A smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (31%) compared to children statewide (35%). - Multiple residents made the connection between unhealthy eating and mental health—what's going on "in their head and their heart." - Geographic disparities and inequities: - SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%). - The walkability index for East San José (0.8) and the 94040 zip code of Mountain View (1.5), another area of concentrated health disparities, are substantially worse than the state's (11.2). - Racial/ethnic disparities and inequities: - The county's Pacific Islander and Latinx middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide; Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards.
Cancer	- Although cancer mortality rates are not as high in Santa Clara County as they are statewide, cancer is still one of the top three causes of death in the county. - The breast cancer incidence rate is slightly higher among Santa Clara County women (121.2 per 100,000) compared to California women overall (120.9 per 100,000). - The rate of cancer incidence among children ages 0-19 is slightly higher in the county (19.0 per 100,000) than the state (18.2 per 100,000). - Racial/ethnic disparities: - There are persistent disparities in cancer incidence rates and other cancer statistics. - Mammography screening levels, an early cancer detection measure, are lower for the county's Black women (33%), Latinas (29%), and Native American women (33%) than California women overall (36%). - The rate of cancer incidence among children ages 0-19 is highest among the county's white children (21.2) and Asian/Pacific Islander children (20.2); both rates are higher than the state (18.2).

Health Need	Justification
Maternal & Infant Health	- Maternal and infant health statistics (for all races/ethnicities together) in Santa Clara County are better than state benchmarks. However, the percentage of low birth-weight infants has been rising, which is a concerning trend. - Racial/ethnic disparities and inequities: - Teen births are significantly higher among the county's young Latinas (23.0 per 1,000 females age 15-19) than all females ages 15-19 statewide, (17.0 per 1,000), although the trend is improving. - A maternal and child health expert suggested that cultural norms and access issues may play into differences in teen birth statistics. - Low infant birth weight is a more frequent issue among Asian (8%) and Black (9%) babies born in the county compared to all babies statewide (7%). - Infant mortality is higher among Black babies. - A smaller proportion of Black (79%) and Latinx (78%) mothers in Santa Clara County receive early prenatal care than all Californian mothers (84%). - A maternal and child health expert indicated that inequities in maternal and infant health may also be traced back not only to healthcare access and delivery barriers, but to social determinants of health such as racism.
Oral/Dental Health	- Access issues related to oral health arose during the assessment. - Most oral health indicators in Santa Clara County are favorable compared to the state. However, the oral health expert described oral health needs as such: - Lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care. - Few pediatric dentists in the county, still fewer take Denti-Cal due to the low reimbursement rates, leading to a gap in services. - The special needs population as underserved by oral health specialists. - Low-income pregnant women often don't know that they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

Health Need	Justification
	● Racial/ethnic disparities and inequities: 　○ A substantially smaller proportion of Santa Clara County Asian/Pacific Islander children and youth who are involved in the child welfare system received a dental check-up (55%) than child welfare-involved children and youth statewide (62%).
Climate/Natural Environment	● Compared to the state as a whole, Santa Clara County is at significantly greater risk of heat waves (index of 10.6 versus 4.7 for California) and drought (index of 0.8 versus 0.7 for California) as well as coastal flooding (index of 2.6 versus 0.7 for California) and river flooding (index of 4.1 versus 2.1 for California). ● Public health experts cited lack of tree canopy cover in Santa Clara County, which is reflected in the statistical data (3.6%) as less than the state average (4.0%). ● Road network density (21.5 miles of road per square mile of land) and traffic volume (2,289 cars per day, per meter of roadway) were both significantly higher in Santa Clara County than state averages (18.0 and 1,991 respectively). ● Statistics suggest that asthma prevalence among people of all ages is higher in the county (9.5%) than the state (8.8%), and the county figure is trending higher. ● Geographic disparities and inequities: 　○ In East San José a smaller percentage of workers commute by transit, bicycle, or walking (5.8%) than in California overall (8.1%). 　○ An expert in Black health cautioned about high rates of asthma in areas with poor air quality. Such place-based inequities may be related to historical systemic housing discrimination (e.g., red-lining). ● Racial/ethnic disparities and inequities: 　○ Both focus group participants and key informants mentioned the adverse effects of environmental issues such as wildfires and related poor air, particularly on low-income and BIPOC individuals. 　○ One Santa Clara County key informant noted that asthma rates have been worsening, an issue that

Health Need	Justification
	○ disproportionately affects the BIPOC population not just in the county but across the nation.[7] ○ Overall, the annual number of unhealthy air days has been rising in Silicon Valley, which has been shown to disproportionately affect the residents of low-income neighborhoods.[8]
Unintended Injuries/Accidents	● The rate of emergency department visits for bicycle accidents among children ages 0-12 is higher in Santa Clara County (13.5 per 100,000) than the state rate (12.2 per 100,000). ● Two of the county's public health experts discussed high traffic volume and the need to prevent accidents and make roads safe for pedestrians and cyclists. ● Racial/ethnic disparities and inequities: 　○ Among children ages 0-12, ED visits for bicycle accidents are high among whites (27.6 per 100,000); for motor vehicle crashes, they are high among Blacks (387.5 per 100,000) and Latinxs (258.9 per 100,000); and for pedestrian accidents, they are high among Latinxs (19.3 per 100,000). 　○ Among older adults (ages 65+), falls deaths are highest among whites (68.1 per 100,000), Latinxs (51.7 per 100,000), and Asians (40.8 per 100,00-).
Community Safety (i.e., violence)	● While many community safety statistics are better in Santa Clara County compared to the state, the rate of rape per 100,000 people in Silicon Valley is high (40.0 versus 39.0 in California) and rising. ● Some experts expressed concern about COVID stress contributing to domestic violence; one mentioned that virtual visits make it harder for patients experiencing domestic violence to obtain both confidentiality and safety. ● Statistics show that juvenile felony arrests (age 10-17) are higher in the county (5.8 per 1,000) than the state (4.1 per 1,000). ● Racial/ethnic disparities and inequities: 　○ The homicide rate per 100,000 people is significantly higher among the Black population in the county (9.0) than the state rate (5.0).

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[7] Asthma and Allergy Foundation of American. (2020). Asthma Disparities in America. Retrieved from https://www.aafa.org/asthma-disparities-burden-on-minorities.aspx

[8] American Lung Association. (2020). *Disparities in the Impact of Air Pollution.* Retrieved from https://www.lung.org/clean-air/outdoors/who-is-at-risk/disparities

Health Need	Justification
	○ Black children age 0-17 are nearly twice as likely (13.9 per 1,000), and Latinx children somewhat more likely (8.3 per 1,000), to be the subject of a substantiated child abuse case than children statewide (7.5 per 1,000). ○ The county's Black children (ages 0-20) are also more likely to be in foster care (8.8 per 1,000) than are California children on average (5.3 per 1,000). ○ Juvenile felony arrests (age 10-17) are higher for the county's Black (23.0 per 1,000) and Latinx (9.3 per 1,000) youth than for California youth overall (4.1 per 1,000). ○ In Santa Clara County, Latinx youth are substantially overrepresented in the county's juvenile detention center population.
Sexually Transmitted Infections	● Most statistics on sexually transmitted infections are better for Santa Clara County than the state. ● HIV diagnoses among younger men (ages 13-24 and 25-44) are trending up in the county. ● Racial/ethnic disparities and inequities: ○ Black and Latinx men ages 13 and older in Santa Clara County are more than twice as likely to be diagnosed with HIV than California men overall.

The data also support continuing El Camino Health's work to address chronic conditions, in which it has specific expertise.

Health Need	Justification
Chronic Conditions (other than diabetes and obesity)	● Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: Mortality rates for heart disease, stroke, cancer, chronic liver disease/cirrhosis, and Alzheimer's disease and other dementias are all better than state benchmarks. ● Health conditions such as cardiovascular disease, cancer, and respiratory problems are among the top 10 causes of death in the county. ● The level of asthma prevalence for people of all ages is higher for Santa Clara County (10%) than the state (9%). ● One key informant noted that asthma rates have been worsening.

	- An expert in chronic disease mentioned a rise in dementia-related issues. - Two health experts mentioned the issue of hypertension, one in conjunction with poor mental health, and the other as a condition that is often unmanaged among unhoused patients. - Racial/ethnic disparities and inequities: - An expert in Black health cautioned about high rates of asthma in areas with poor air quality. - Heart disease and stroke were identified as two of the chronic conditions that are often seen in data on ethnic health disparities.

KEY TAKEAWAYS

The community health needs identified in Santa Clara County during the 2022 assessment were similar to those identified in 2019. However, the 2022 CHNA also revealed new concerns related to the effects of the COVID-19 pandemic, and increased concerns about housing insecurity, behavioral health, access to healthcare, and climate issues.

The hospitals conducted a robust assessment to meet state and federal requirements and to identify community health needs. The 2022 CHNA findings in this report reflect hundreds of statistical data points, interviews with local health experts, and conversations with community members and service providers representing some of Santa Clara County's most vulnerable populations. It provides a clear picture of how the community prioritizes its current health needs.

COVID-19 Pandemic: COVID-19 itself was not prioritized as a standalone health need but, understandably, was discussed in every case as a driver of other health needs such as economic insecurity and poor mental health. Most of the discussion about COVID itself centered on inequities among those who contracted COVID, and the related anxiety, depression, and grief that the community has experienced. COVID's negative impact on mental health was one of the strongest themes among key informants and focus group participants. Children and adolescents were of particular concern, as many had difficulty adapting to virtual learning, experienced significant isolation, and felt stress related to familial economic hardship. Experts noted an increase in youth suicide attempts about three months after the start of the pandemic. Another strong theme among key informants and focus group participants was the pandemic as a major driver of economic insecurity. Many residents experienced job loss or reduced hours for non-essential work starting in March 2020. Financial stability was challenging for low-income households; concerns about the ability to fulfill basic needs such as food and rent were significantly greater in this CHNA cycle. See further details on page 24.

Housing Insecurity: Most community feedback about this topic was related to the high cost of housing in Silicon Valley, which exacerbates economic insecurity and forces many people to choose between paying rent, buying food, and accessing healthcare. It was said there were very few rental-assistance resources that would prevent homelessness. Several CHNA participants noted that the lack of affordable housing leads to overcrowding, which is a driver of

many health issues, including the spread of infectious diseases like COVID. The lack of affordable housing also makes it difficult to house victims of domestic violence, individuals trying to get clean and sober, and people who are mentally unstable. It also limits the ability for people to run affordable board-and-care facilities for older adults and convalescents, and poses a barrier to healthcare and nonprofit employee recruitment. Finally, outmigration from Silicon Valley to exurban areas, or even other states, was mentioned more frequently than in 2019.

Behavioral Health: After economic security, behavioral health was the second-most pressing community priority in Santa Clara County. Since the pandemic began, demand for mental health services has substantially increased. Telehealth was seen as a positive trend in mental health. However, experts noted a recent increase in suicide deaths by overdose of prescription medicines. They also said they were seeing many more behavioral health patients in emergency departments, which was leading to much longer wait times to get mental health and addiction services. Marijuana use was identified as trending up, likely due to legalization for adults. Trauma was mentioned more often than in 2019.

Access to Healthcare: El Camino Health has focused on access to healthcare in every CHNA because access is crucial to improving the health of community members, in terms of both prevention and intervention. The Affordable Care Act and subsequent Medi-Cal expansion provided more opportunities for people to obtain health insurance. There was a greater focus in the current CHNA cycle on the difficulty of using health insurance due to a lack of health system literacy, the lack of extended hours, and large gaps in coverage for dental and other specialty care. Participants also frequently mentioned the lack of access to specialty care, specifically mental health and oral healthcare providers. Telehealth, which rose substantially due to the pandemic, was seen as a "mixed bag": some providers could obviate transportation barriers through telehealth, while others worried about the lack of privacy and the digital divide.[9] Also, it was noted that telephone appointments (without video) are not reimbursed at the same rate as video visits. Cultural sensitivity was mentioned as a concern for monolingual, LGBTQ+, Black, immigrant, and low-income people.

Climate Issues: Climate issues rose to the fore this cycle, including climbing temperatures, more extreme weather, flooding, and wildfires. Experts mentioned that BIPOC and low-income populations are more likely to live in areas affected by climate change (e.g., flooding). As wildfires have become larger and more common in the state, concerns about asthma in the local BIPOC community have also risen. A county public health expert noted a growing interest in their department in combating vulnerabilities to heat and fire. Several experts noted the need to improve community preparedness for climate crises.

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[9] Recent news reports state: "Roughly a quarter of Santa Clara County households don't have access to the internet. In San José, 36% of Latino families and 47% of African American families lacked broadband internet, according to a 2017 study. Approximately 70,000 county residents don't have access to the internet at modern speeds, and nearly 690,000 can only get access through a single provider." Source: Wolfe, E. (2022). Santa Clara County wants to close the digital divide. *San Jose Spotlight*. Retrieved from https://sanjosespotlight.com/santa-clara-county-wants-to-close-the-digital-divide-broadband-internet-access/

COVID-19

In late 2019, a new coronavirus (SARS-CoV-2) appeared. It causes a respiratory illness that is now called COVID-19.[10] The ensuing pandemic has been a health event of historic proportions.[11] By the end of March 2022, the COVID-19 pandemic killed close to one million Americans (nearly 0.3% of the U.S. population)[12], surpassing the 1918 influenza (H1N1) pandemic, which killed 550,000 Americans (0.5% of the U.S. population at that time).[13]

975,515 deaths

Santa Clara County Daily Averages[14]

189 cases
146 hospitalized
3 deaths
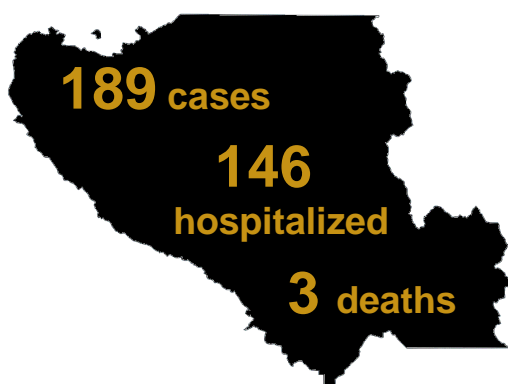
The COVID-19 pandemic shows signs of continuing for the foreseeable future. In Santa Clara County, the numbers of COVID-19 cases and deaths peaked several times in 2020, 2021, and 2022.[14] However, vaccinations—which began in early 2021—appear to be mitigating local hospitalizations and deaths.[14]

86% vaccinated

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[10] "COVID-19" stands for coronavirus disease 2019. Centers for Disease Control and Prevention. (2020). *COVID-19: Identifying the source of the outbreak.* Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/science/about-epidemiology/identifying-source-outbreak.html

[11] Hiscott, J., Alexandridi, M., Muscolini, M., Tassone, E., Palermo, E., Soultsioti, M., & Zevini, A. (2020). The global impact of the coronavirus pandemic. *Cytokine & Growth Factor Reviews*, 53, 1–9. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7254014/

[12] In the same time period, over 6.1 million people have been killed by the disease worldwide. Mortality data: The New York Times. (2022). The Coronavirus Pandemic. Retrieved from https://www.nytimes.com/news-event/coronavirus Population data: United States Census Bureau. (2022). United States. Retrieved from https://data.census.gov/cedsci/profile?q=United%20States&g=0100000US

[13] Noymer, A., & Garenne, M. (2000). The 1918 influenza epidemic's effects on sex differentials in mortality in the United States. *Population and Development Review*, *26*(3), 565–581. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740912/. And Centers for Disease Control and Prevention. (2019). 1918 Pandemic (H1N1 virus). Retrieved from https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

[14] Seven-day daily averages and vaccination rate as of late March 2022. The New York Times. (2022). California Coronavirus Cases. *The New York Times.* Retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html

Because COVID is a new virus, many health effects and healthcare needs are still emerging. This CHNA report summarizes what the participating hospitals know so far about the health condition and its social determinants. To capture the effects of COVID on the community, the hospitals collaborating on the 2022 community health needs assessment conducted various focus groups and interviews, including a focus group dedicated to health equity.[15] We also chose to add "documented ethnic and/or geographic disparities and inequities" to our criteria for identifying community health needs in 2022. The hospitals will continue to monitor and address health effects, trends, and healthcare needs of COVID-19 as they learn more about the disease, its progression, and its short- and long-term impacts.

The pandemic has exacerbated existing inequities in the health and welfare of vulnerable populations in the U.S., causing disproportionate illness and mortality for people in minority racial and ethnic groups (i.e., Black, Indigenous, and people of color: BIPOC),[16] people with certain pre-existing health conditions,[17] people living in crowded conditions,[18] and people who are classified as "essential workers" (at higher risk of workplace exposure).[19] Approximately one

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[15] CHNA participants, including those in the health equity focus group, are listed in Attachment 1.

[16] Marshall, W. F. (2020). *Coronavirus infection by race: What's behind the health disparities?* Mayo Clinic. Retrieved from https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802

[17] Arumugam, V. A., Thangavelu, S., Fathah, Z., Ravindran, P., Sanjeev, A. M. A., Babu, S., Meyyazhagan, A., Yatoo, M. I., Sharun, K., Tiwari, R. and Pandey, M. K. (2020). COVID-19 and the world with co-morbidities of heart disease, hypertension and diabetes. *Journal of Pure Applied Microbiology*, *14*(3):1623–1638. See also Lui, B., Samuels, J. D., & White, R. S. (2020). Potential pathophysiology of COVID-19 in patients with obesity. Comment on Br J Anaesth 2020; 125:e262–e263. *British Journal of Anaesthesia*, *125*(3), e283–e284. Retrieved from https://bjanaesthesia.org/article/S0007-0912(20)30439-6/pdf

[18] Arango, T. (2021). "We Are Forced to Live in These Conditions": In Los Angeles, Virus Ravages Overcrowded Homes. *The New York Times.* Retrieved from https://www.nytimes.com/2021/01/23/us/los-angeles-crowded-covid.html See also: California Institute for Rural Studies. (2018). *Farmworker Housing Study and Action Plan for Salinas Valley and Pajaro Valley.* Retrieved from https://www.co.monterey.ca.us/home/showdocument?id=63729 And Jiménez, M. C., Cowger, T. L., Simon, L. E., Behn. M., Cassarino, N., Bassett, M. T. (2020). Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Network Open.* *3*(8):e2018851. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769617 And Gebeloff, R., Ivory, D., Richtel, M., Smith, M., Yourish, K., Dance, S., Fortiér, J., Yu, E., & Parker, M. (2020). The Striking Racial Divide in How COVID-19 Has Hit Nursing Homes. *The New York Times.* Retrieved from https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html

[19] Campbell, J. (2020). "What Are Essential Services and Jobs During the Coronavirus Crisis?" *Huffington Post*. Retrieved from: https://www.huffpost.com/entry/what-are-essential-services-jobs_l_5e74eaacc5b6f5b7c543370c See also: Reitsma, M. B., Claypool, A. L., Vargo, J., Shete, P. B., McCorvie, R., Wheeler, W. H., Rocha, D. A., Myers, J. F., Murray, E. L., Bregman, B., Dominguez, D. M., Nguyen, A. D., Porse, C., Fritz, C. L., Jain, S., Watt, J. P., Salomon, J. A., & Goldhaber-Fiebert, J. D. (2021). Racial/Ethnic Disparities in COVID-19 Exposure Risk, Testing, and Cases at the Subcounty Level in California. *Health Affairs*, *40*(6). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00098

in 10 people who were infected experience "long COVID," a set of lingering symptoms including "fatigue, body aches, shortness of breath, difficulty concentrating" that lasts a year or more.[20]

Perhaps the most far-reaching impacts of COVID-19 are socioeconomic. The government mandates shutting down or limiting activities in major industries (tourism, hospitality, brick-and-mortar retail and services, etc.) exacerbated the inequities experienced by many of the vulnerable populations identified above. Women, BIPOC, young people (ages 16–24), and those with low income (usually defined as less than 80% of the area median income) or without college degrees have also been impacted by job loss, housing insecurity, food insecurity, and other difficulties, all of which are likely to persist.[21,22] Women in particular left the workforce in large numbers in 2020 and 2021, when school closures created a need for child care, a responsibility more commonly left to women.[23]

The inequitable health and economic outcomes can be attributed, in part, to structural and institutional racism.[24] BIPOC community members may cope with toxic stress due to their experiences of discrimination. The inflammation from toxic stress contributes to greater

[20] Komaroff, A. L. (2021). *The tragedy of long COVID.* Weblog, Harvard Health Publishing, Harvard Medical School. Retrieved from https://www.health.harvard.edu/blog/the-tragedy-of-the-post-covid-long-haulers-202010152479

[21] Udalova, V. (2021). *Initial Impact of COVID-19 on U.S. Economy More Widespread Than on Mortality. America Counts: Stories Behind the Numbers.* U.S. Census Bureau. Retrieved from https://www.census.gov/library/stories/2021/03/initial-impact-covid-19-on-united-states-economy-more-widespread-than-on-mortality.html See also: Gould, E. & Kassa, M. (2020). *Young workers hit hard by the COVID-19 economy.* Economic Policy Institute. Retrieved from https://www.epi.org/publication/young-workers-covid-recession/

[22] Ferreira, F. H. G. (2021). *Inequality in the Time of COVID-19.* International Monetary Fund. Retrieved from https://www.imf.org/external/pubs/ft/fandd/2021/06/inequality-and-covid-19-ferreira.htm See also: Perry, B. L., Aronson, B., & Pescosolido, B. A. (2021). *Pandemic precarity: COVID-19 is exposing and exacerbating inequalities in the American heartland.* Proceedings of the National Academy of Sciences, February 2021, *118*(8). Retrieved from https://www.pnas.org/content/118/8/e2020685118 Specific to California, see Bohn, S., Bonner, D., Lafortune, J., & Thorman, T. (2020). *Income Inequality and Economic Opportunity in California.* Public Policy Institute of California. Retrieved from https://www.ppic.org/wp-content/uploads/incoming-inequality-and-economic-opportunity-in-california-december-2020.pdf

[23] Bateman, N., & Ross, M. (2020). *Why has COVID-19 been especially harmful for working women?* Brookings Institute. Retrieved from https://www.brookings.edu/essay/why-has-covid-19-been-especially-harmful-for-working-women/

[24] Garcia, M. A., Homan, P. A., García, C., & Brown, T. H. (2020). The color of COVID-19: structural racism and the pandemic's disproportionate impact on older racial and ethnic minorities. *The Journals of Gerontology: Series B.* Retrieved from https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1735&context=sociologyfacpub See also: Pirtle, W. N. L. (2020). Racial capitalism: a fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Education & Behavior.* *47*(4):504–508. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7301291/

comorbidities among the BIPOC population in the U.S. compared to whites.[25] BIPOC individuals are also more likely to work higher-risk and/or low-wage jobs,[26] in part due to employment discrimination,[27] and to live in crowded or substandard conditions and impoverished neighborhoods, in part due to historical redlining policies and present-day housing discrimination.[28] All of these issues contribute to poorer health outcomes for BIPOC community members than white people for nearly all health conditions, including COVID-19 infection.

[25] Adler, N. E., & Rehkopf, D. H. (2008). U.S. Disparities in Health: Descriptions, Causes and Mechanisms. *Annual Review of Public Health*, 29:235–252. See also Logan, J. G., & Barksdale, D. J. (2008). Allostasis and allostatic load: expanding the discourse on stress and cardiovascular disease. *Journal of Clinical Nursing*, *17*(7b), 201–208. Retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2702.2008.02347.x And see Schulz, A. J., Mentz, G., Lachance, L., Johnson, J., Gaines, C., & Israel, B. A. (2012). Associations between socioeconomic status and allostatic load: effects of neighborhood poverty and tests of mediating pathways. *American Journal of Public Health*, *102*(9), 1706–1714. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3416053/

[26] See various articles related to essential workers and risk during the COVID-19 pandemic:
- Gould, E., & Shierholz, H. (2020). Not everybody can work from home: Black and Hispanic workers are much less likely to be able to telework. *Working Economics Blog* by the Economic Policy Institute. Retrieved from https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/
- Greenberg, J. (2020). Blacks, Hispanics less likely to have jobs where they can work from home. *PolitiFact* by The Poynter Institute. Retrieved from https://www.politifact.com/factchecks/2020/jun/16/desiree-rogers/blacks-hispanics-less-likely-have-jobs-where-they-/
- Krisberg, K. (2020). Essential workers facing higher risks during COVID-19 outbreak: Meat packers, retail workers sickened. *The Nation's Health* by the American Public Health Association. Retrieved from https://www.thenationshealth.org/content/50/6/1.1.
- Liu, J. (2020). Covid-19 patients twice as likely to be working from an office instead of home, CDC finds. *MakeIt* by CNBC. Retrieved from https://www.cnbc.com/2020/11/10/cdc-covid-19-patients-twice-as-likely-to-work-from-office-vs-home.html
- Dorman, P., & Mishel, L. (2020). *A majority of workers are fearful of coronavirus infections at work, especially Black, Hispanic, and low- and middle-income workers.* Economic Policy Institute. Retrieved from https://www.epi.org/publication/covid-risks-and-hazard-pay/
- Kinder, M. (2020). *Essential but Undervalued: Millions of health care workers aren't getting the pay or respect they deserve in the COVID-19 pandemic.* Brookings. Retrieved from https://www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/

[27] See meta-analysis: Neumark, D. (2018). Experimental research on labor market discrimination. *Journal of Economic Literature, 56*(3), 799-866. Retrieved from https://www.nber.org/system/files/working_papers/w22022/w22022.pdf

[28] Iton, A., & Ross, R. K. (2017). Understanding How Health Happens: Your Zip Code Is More Important Than Your Genetic Code. In *Public Health Leadership* (pp. 83–99). Routledge. Retrieved from https://zums.ac.ir//files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84 See also: Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA. Retrieved from

With regard to economic outcomes, people of color are more likely to have less formal schooling than whites, in part due to education discrimination[29] and in part because they are more likely to attend segregated, underperforming schools.[30] This, combined with possible employment discrimination, makes it more likely that they'll earn less, too.[31]

While the hospitals acknowledge the negative health effects of COVID-19 itself, this CHNA report focuses on identifying the broader health inequities and socioeconomic consequences of COVID-19 in Santa Clara County.

NEXT STEPS

After making this CHNA report publicly available by June 30, 2022, El Camino Health will solicit feedback and comments through its website's contact form. Community input will be collected until two subsequent CHNA reports have been posted to the Community Benefit page of its website.[32] El Camino Health will also develop a Plan and Implementation Strategy (based on the 2022 CHNA results).

https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf

[29] Adair, J. K. (2015). *The impact of discrimination on the early schooling experiences of children from immigrant families.* Washington, DC: Migration Policy Institute. Retrieved from https://www.migrationpolicy.org/research/impact-discrimination-early-schooling-experienceschildren-Immigrant-families See also Benner, A. D., & Graham, S. (2011). Latino Adolescents' Experiences of Discrimination Across the First 2 Years of High School: Correlates and Influences on Educational Outcomes. *Child Development*, 82(2), 508–519. https://doi.org/10.1111/j.1467-8624.2010.01524.x

[30] Reardon, S.F., Weathers, E.S., Fahle, E.M., Jang, H., & Kalogrides, D. (2019). *Is Separate Still Unequal? New Evidence on School Segregation and Racial Academic Achievement Gaps.* Retrieved from https://cepa.stanford.edu/content/separate-still-unequal-new-evidence-school-segregationand-Racial-academic-achievement-gaps

[31] Rodgers, W. M. (2019). Race in the labor market: The role of equal employment opportunity and other policies. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, 5(5), 198–-220. Retrieved from https://www.rsfjournal.org/content/rsfjss/5/5/198.full.pdf

[32] https://www.elcaminohealth.org/about-us/community-benefit

2. BACKGROUND

The Community Health Needs Assessment (CHNA) is designed as a tool for guiding policy, advocacy, and program-planning efforts. To identify and address the critical health needs of the community, the Santa Clara County Community Benefit Hospital Coalition (CBHC) formed in 1995. The CBHC brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, El Camino Health collaborated with the CBHC to conduct an extensive CHNA.

In 2019, two hospital members of the CBHC were sold to Santa Clara County.[33]Therefore, beginning in 2021, four of the remaining nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[34] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA builds upon the earlier assessments conducted by these entities, distills new qualitative and quantitative research, prioritizes local health needs, and identifies areas for improvement. As with prior CHNAs, this assessment also lists Santa Clara County's assets and resources related to identified health needs. Using all of this information, the members of this informal collaborative will develop strategies to address critical health needs and to improve the health and well-being of community members.

For the purposes of this assessment, the definition of "community health" is not limited to traditional health measures. In addition to the physical health of community members, it includes indicators related to the quality of life (for example, access to healthcare, affordable housing, food security, education, and employment) and the physical, environmental, and social factors that influence the health of the county's residents. This broad definition reflects our hospitals' philosophy that many factors affect community health, and that community health cannot be adequately understood or addressed without consideration of trends outside the realm of healthcare.

CHNA PURPOSE AND ACA REQUIREMENTS

In 2021–2022, El Camino Health conducted an extensive community health needs assessment (CHNA) for the purpose of identifying critical health needs of the community. The 2022 CHNA will also serve to assist El Camino Health in meeting IRS CHNA requirements pursuant to the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA, which was enacted on March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provided guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate all nonprofit hospitals

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[33] County of Santa Clara, Office of Communications and Public Affairs. (2019). *Acquisition Information.* Retrieved from https://news.sccgov.org/office-public-affairs/hospital-acquisition-update/acquisition-information

[34] The four entities are El Camino Health, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

to conduct a CHNA and develop and adopt an implementation strategy every three years.[35] The CHNA must be conducted by the last day of a hospital's taxable year.

The CHNA process, completed in 2022 and described in this report, was conducted in compliance with current federal requirements. This CHNA report documents how the assessment was conducted, including the community served, who was involved in the assessment, the process and methods used, and the community's significant health needs that were identified and prioritized as a result of the assessment. The 2022 assessment includes input from local residents and experts in public health, clinical care and others.
Available to the public for review and comment, the 2022 CHNA serves as a tool for guiding policy and program planning efforts. It also serves to assist in developing Community Benefit Plans pursuant to California State Senate Bill (SB) 697.

SB 697, enacted in 1994, requires private nonprofit hospitals to conduct a community needs assessment and to consult with the community on a plan to address their identified needs. The community needs assessment must be conducted every three years. Hospitals are also required to submit an annual report to the California Office of Statewide Health Planning and Development, which must include descriptions of strategies that hospitals have engaged to address the identified community needs.

The 2022 CHNA meets both State of California (SB 697) and federal (IRS) requirements mandated by the ACA.

BRIEF SUMMARY OF 2019 CHNA

In 2019, El Camino Health participated in a collaborative process to identify significant community health needs and meet state and federal requirements. The 2019 CHNA is posted on El Camino Health's public website.[36]

The health needs that were identified and prioritized through the 2019 CHNA process are listed below in order of priority:

1. Housing and Homelessness
2. Access and Delivery
3. Behavioral Health
4. Economic Security (including Food Security)
5. Diabetes/Obesity
6. Cognitive Decline
7. Oral/Dental Health

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[35] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf
[36] https://www.elcaminohealth.org/sites/default/files/2019-06/2019-community-health-needs-assessment-20190615.pdf

For the 2022 CHNA, the informal collaborative built upon existing work by starting with a list of previously identified health needs. Updated secondary data were collected for these health needs, and community input was used to add health needs to the list and to delve deeper into questions about inequities and other barriers to health, the effects of the COVID-19 pandemic on community needs, and solutions to the needs.

WRITTEN PUBLIC COMMENTS ON 2019 CHNA

To offer the public a means to provide written input on the 2019 CHNA, El Camino Health maintains a Community Benefit page on its website,[37] where it posts reports and provides an online contact form. This venue will allow for continued public comments on the 2022 CHNA report.

At the time this CHNA report was completed, El Camino Health had not received written comments about the 2019 CHNA report. El Camino Health will continue to track any submissions made and will ensure that all relevant comments are reviewed and addressed by appropriate staff.

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[37] https://www.elcaminohealth.org/about-us/community-benefit

3. ABOUT EL CAMINO HEALTH

El Camino Health includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care and primary care locations across Santa Clara County. Hospital key medical specialties include cancer, heart and vascular, lifestyle medicine, men's health, mental health and addictions, lung, mother-baby, orthopedic and spine, stroke and urology. Affiliated partners include El Camino Health Medical Network, El Camino Health Foundation and Concern.

MISSION

It is the mission of El Camino Health to heal, relieve suffering and advance wellness as the community's publicly accountable health partner.

HISTORY IN BRIEF

Local voters approved the formation of a healthcare district in 1956 by a 12-to-1 margin. The Santa Clara County Board of Supervisors appointed a five-member board for the district. The district board's first decision was the selection of a 20-acre orchard on Grant Road in Mountain View as the site for the new hospital, and it chose the name El Camino Hospital. In 1957, voters approved a $7.3 million bond issue, again by a large margin, to finance the building and operation of the hospital. Construction of the four-story hospital began in 1958. By 1961, all necessary preparations had been made, and the hospital admitted its first patients on September 1.

Continuing a steady pace of growth over the next several decades, the hospital added an array of community need-based services, including an outpatient surgery center, family birthing center, emergency, radiology and intensive care facilities, a psychiatric unit and a senior resource center. During the hospital's third decade in the community, the Board established the El Camino Hospital Foundation, now known as El Camino Health Foundation, to raise charitable contributions in support of the hospital.

In 2006, after the second groundbreaking event in El Camino Hospital's history, construction began on the new seismically compliant main hospital building at the Mountain View campus. Three years later, the state-of-the-art hospital in Mountain View opened on November 15, 2009. In 2008, the hospital acquired the assets of the former Community Hospital of Los Gatos. The former owners closed the hospital in April 2009, but a fully renovated and staffed Los Gatos Hospital reopened that July. The 143-bed hospital continues to offer full-service, acute care to residents of Los Gatos and surrounding communities, just as it had been doing since it opened in 1962.

El Camino Health Medical Network, an affiliate of El Camino Health, aspires to elevate the healthcare experience – beyond healing – for the communities it serves. Through physician partnerships, it provides patients with healthcare options that fit their lifestyle. Urgent care,

primary care and specialty care services are provided at 13 locations across Santa Clara County.

In addition to delivering healthcare services across Santa Clara County, El Camino Health's employee assistance and mental health program, Concern, offers employers across the country an optimized blend of human connection, compassion, and technology to help employees build resilience and achieve emotional well-being. Services include resources for employees and their families to stay calm and effective even when dealing with setbacks, change and/or pressure. Concern has been affiliated with the hospital corporation since 1981.

SPECIALTY CARE AND INNOVATIONS

El Camino Health provides specialty programs and clinical areas of distinction that are highly regarded throughout the Bay Area.

Some programs and accomplishments unique to El Camino Health are:

- Distinguished hospitals. Our fully accredited hospitals, Los Gatos and Mountain View, have received numerous awards and honors for high-quality healthcare.
- Exceptional talent. Our reputation attracts high-caliber doctors who are approachable and friendly, a nursing culture exceptional for its highly personalized patient and family care, and leadership with a deeply personal commitment.
- Innovative approaches to care. We seek new treatments and techniques, and contribute to the medical community through clinical trials.
- A focus on health. Our regional Men's Health Program offers a team approach to care and has a variety of specialists who are focused on men's health issues, including heart and vascular, urology, sleep disorders, sexual dysfunction and healthy weight. We created the South Asian Heart Center and the Chinese Health Initiative to address unique health disparities in our patient population.
- A healing environment. Our spaces were specially designed for tranquility and comfort, such as our labyrinth walk.

El Camino Health earned five stars from the Centers for Medicare and Medicaid Services, an 'A' grade from the Leapfrog Group, the Healthgrades Outstanding Patient Experience Award, and spots on the Newsweek Best Maternity Care Hospitals and IBM-Watson Health Top 100 Hospitals lists in 2021 alone. El Camino Health is also recognized as a national leader in the use of health information technology and wireless communications. El Camino Health has been awarded the Gold Seal of Approval from The Joint Commission for its Stroke Program as well as four consecutive American Nurses Credentialing Center (ANCC) Magnet Recognitions for Nursing Care.

COMMUNITY BENEFIT PROGRAM

For more than 55 years, El Camino Health has provided healthcare services beyond its walls — crossing barriers of age, education and income level — to serve the people of its region, because a healthier community benefits everyone.

Building a healthier community requires a combined effort. It has been the privilege of El Camino Health to collaborate with community members who have expertise in understanding health disparities in local cities, as well as organizations with similar missions. Working together has vastly multiplied El Camino Health's ability to make a difference.

El Camino Health, in partnership with El Camino Healthcare District, provides funding through the Community Benefit Program in the form of grants and sponsorships to organizations that demonstrate an ability to impact the health needs of vulnerable, underserved and at-risk community members.

Every year, El Camino Health publishes the Community Benefit Annual Report to inform the community about Community Benefit Program financials, the grant programs and how these funded services improve the health of vulnerable populations both through direct services and prevention initiatives.[38]

DEMOGRAPHIC PROFILE OF COMMUNITY SERVED

The IRS defines the "community served" by a hospital as those individuals living within its hospital service area, including low-income or underserved populations. El Camino Health is located in Santa Clara County, and its community encompasses most of the cities in that county. The cities served by the hospital are:

North County	West County	Mid-County
Los Altos	Cupertino	Alviso
Los Altos Hills	Los Gatos	Campbell
Loyola	Monte Sereno	San José
Mountain View	Saratoga	Santa Clara
Sunnyvale		

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[38] https://www.elcaminohealth.org/about-us/community-benefit

Map of Service Area

Orange stars represent El Camino Hospital campuses.

Santa Clara County

Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2020, approximately 1.93 million people lived here, making it the sixth largest county in California by population. San José is its largest city, with over 1.01 million people (52% of the total). The population of the county is substantially more dense than the state, with 9,115 people per square mile compared to 8,486 per square mile in California.

The median age in Santa Clara County is 38.1 years old. More than 22% of the county's residents are under the age of 18, and over 13% are 65 years or older. Among the population

aged 75 and older, nearly half (48%) are living with a disability.[39] Santa Clara County is also very diverse, with sizable proportions of Asian, Latinx, and white populations.
Race/Ethnicity in Santa Clara County

Race/Ethnicity	Santa Clara County Total Percent of County (Alone or in Combination with Other Races)*
African/African Ancestry	2.3%
American Indian/Alaskan Native	0.2%
Asian	38.5%
Hispanic/Latinx	25.1%
Pacific Islander/Native Hawaiian	0.3%
White	29.9%
Multiracial	3.4%
Some Other Race	0.2%

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
*Percentages do not add to 100% because they overlap.

Nearly four in ten (39%) people in Santa Clara County were born outside the United States. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[40] Our communities earn some of the highest annual median incomes in the U.S., but they also bear some of the highest costs of living. The median household income in Santa Clara County is $124,055, far higher than California's median of $75,325.[40]

Yet the California Self-Sufficiency Standard,[41] set by the Insight Center for Community Economic Development, suggests that many households in Santa Clara County are unable to

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[39] Census data in prior paragraphs from https://www.census.gov/quickfacts
[40] Data from https://www.census.gov/quickfacts
[41] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

meet their basic needs.[42] (The Standard in 2021 for a family with two children was $144,135.) Housing costs are high: In 2021, the median home price was $1.4 million[43] the median rent was $2,374.[44] A total of 26% of children are eligible for free or reduced-price lunch and close to one quarter (23%) of children live in single-parent households. About 4% of people in our community are uninsured.

Area Household Income Ranges
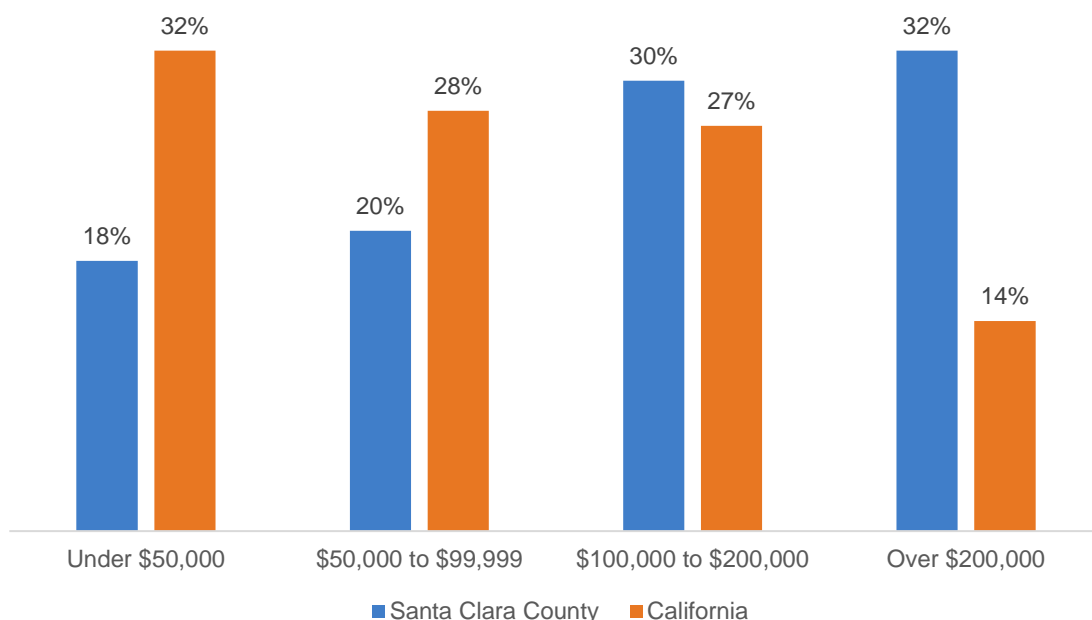
Source: Census Reporter, https://censusreporter.org/profiles (American Community Survey, 2019).

The minimum wage in Santa Clara County[45] was $15.45–$16.30 per hour in 2021, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 27% increase in the cost of living in Santa Clara County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 5.4% per year average increase in wages in the San Jose-Sunnyvale-Santa Clara metropolitan area between 2018 and 2020.

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[42] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org

[43] Redfin. (2021.) *Santa Clara County Housing Market.* Retrieved from https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market

[44] U.S. Census American Community Survey, 2015-2019.

[45] Alaban, L. (2021). Minimum wage goes up in South Bay -- with mixed reaction. *San Jose Spotlight.* Retrieved from https://sanjosespotlight.com/minimum-wage-in-san-jose-goes-up-splitting-business-and-economic-leaders/

Correlation Between Income Inequality & Non-White Population, By Zip Code
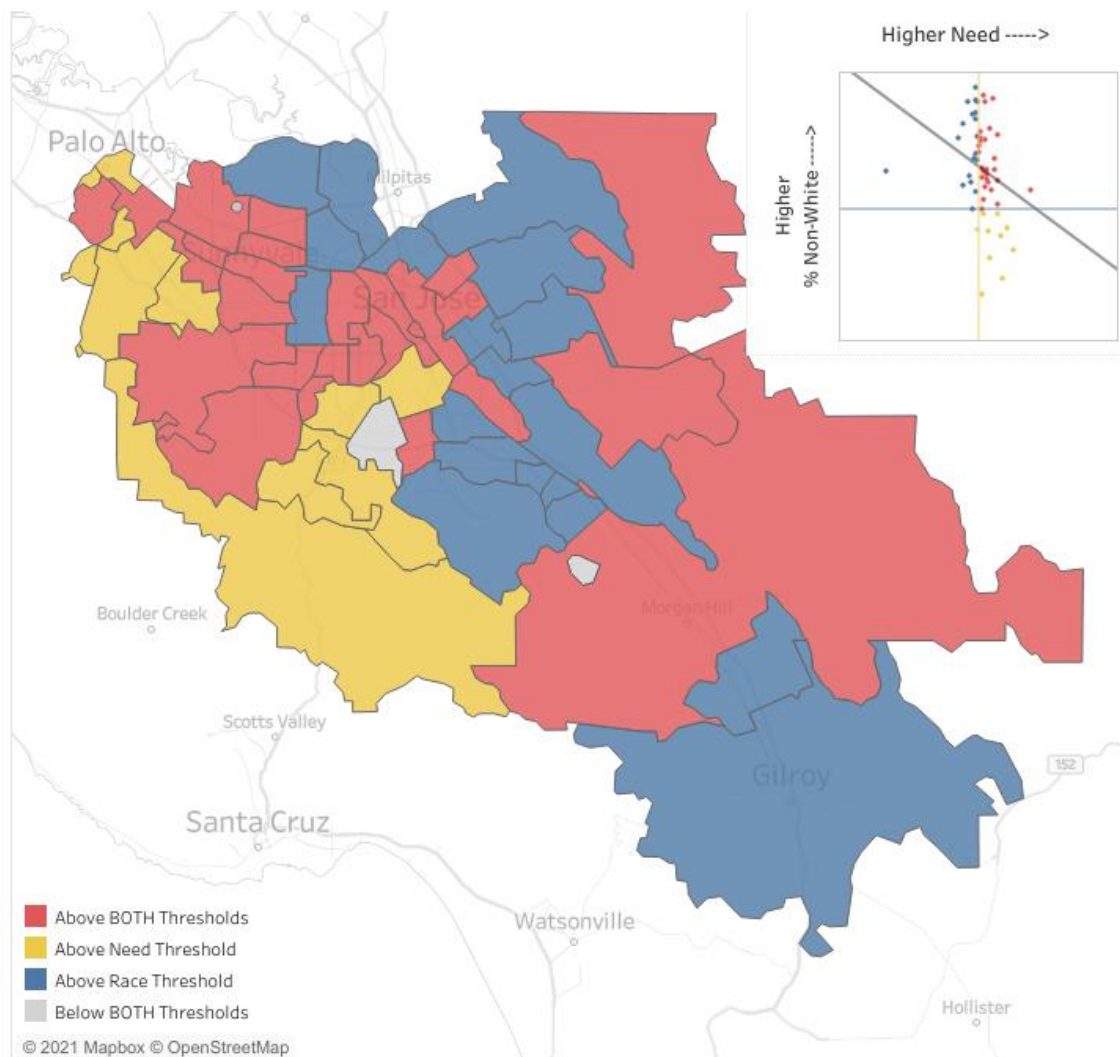
Map: Parts of the county exhibit income inequality (red and yellow areas). In many places where income inequality is high, non-white community members are also in the majority (red areas). "Need Threshold" is the U.S. Gini Index, 0.4. "Race Threshold" is 50% non-white.

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the county's population overall is healthier than the national average.[46] Although the county is quite diverse and has substantial resources (see *Attachment 3: Assets and Resources*), there is significant inequality in the population's social determinants of health and health outcomes. For

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[46] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while Santa Clara County is scored at -0.8. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

example, the Gini Index, a measure of income inequality,[47] is higher in certain Zip Codes compared to others (see map above).

Certain areas also have poorer access to high speed internet (e.g., Zip Codes 95013, 95140), or to walkable neighborhoods (e.g., Zip Codes 95002, 95141), or jobs (e.g., Zip Codes 95020, 95130). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

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[47] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms.* Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

4. ASSESSMENT TEAM

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

The following organizations collaborated with El Camino Health to prepare the 2022 Community Health Needs Assessment (CHNA):

- Lucile Packard Children's Hospital-Stanford
- Stanford Health Care
- Sutter Health (including Mills-Peninsula Medical Center, Menlo Park Surgical Hospital, and Palo Alto Medical Foundation)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights, LLC, an independent local research firm, completed the CHNA.
For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

The project managers for this assessment were Melanie Espino and Jennifer van Stelle, PhD, the co-founders and principals of Actionable Insights. Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, housing, STEM (science, technology, engineering, and math) education, youth development and community collaboration. AI conducted community health needs assessments for seven hospitals during the 2021–2022 CHNA cycle.

In addition, El Camino Health has partnered with Actionable Insights to provide strategic planning support to ensure that its community benefit investments are addressing identified community health needs. This has become especially important in the most recent CHNA cycles, as the community focuses more on healthcare access and social determinants of health.

More information about Actionable Insights is available on the company's website.[48]

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[48] https://actionablellc.com/

5. PROCESS AND METHODS

The hospitals and health systems listed in Section 4 formed a collaborative to work on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over ten months in 2021 and culminated in this report, which was written for El Camino Health in late 2021 and early 2022. The phases of the CHNA process are depicted below and described in this section.

Secondary Data Collection → Primary Data Collection → Data Synthesis → Health Needs List → Prioritization → Report Writing

The members of this collaborative contracted Actionable Insights (AI) to collect primary qualitative data — through key informant interviews and focus groups — and secondary qualitative and statistical data from the public Community Health Data Platform sponsored by Kaiser Permanente as well as other online sources and the county's Public Health Department.

SECONDARY DATA COLLECTION

More than 250 quantitative health indicators were analyzed to assist the collaborative with understanding the health needs in Santa Clara County and assessing the priority of those needs in the community. Data were collected from existing sources using the public Community Health Data Platform sponsored by Kaiser Permanente[49] and other online sources, such as KidsData.com, the California Department of Public Health and the U.S. Census Bureau, as well as the two county public health departments. Findings from the previous community health needs assessment (2019), reports from Joint Venture Silicon Valley, and available sub-county data (cities and neighborhoods) were also used.

As a further framework for the assessment, the collaborative requested that the data analysis address the following questions:
- How do these indicators perform against accepted benchmarks (statewide rates and averages)?
- What are the inequitable outcomes and conditions for people in the community?

Data sources were selected to understand general county-level health, specific underserved and/or underrepresented populations, and to fill previously identified information gaps. Also, data on potential health disparities by geographic area and ethnicity were analyzed. These data were used to inform our health needs list.

PRIMARY DATA COLLECTION (COMMUNITY INPUT)

Primary research was conducted for this assessment. Two strategies were used for collecting community input: first, key informant interviews with local experts; second, focus groups with

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[49] https://public.tableau.com/app/profile/kp.chna.data.platform/viz/CommunityHealthNeedsDashboard-AllCountiesinKPStates/Starthere

professionals who represent and/or serve the community or community members (residents) themselves.

The assessment included input from key informants and focus group participants representing these populations:[50]
- Low-income
- Minority
- Medically underserved
- Homeless
- Older adults
- Youth

The collaborative sought to build upon prior CHNAs by focusing the primary research on topics and subpopulations that are less well understood via the statistical data. For example, the experiences of the Black population in Santa Clara County are often obscured by statistics that represent an entire county's population rather than the Black population as a particular sub-group. The 2022 team specifically convened a focus group of Black professionals to better understand through this primary qualitative research.

Each interview and focus group was recorded as a standalone piece of data. Recordings were transcribed, and then the research team used qualitative research software tools to analyze the transcripts for common themes. The team also tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. The collaborative used this tabulation to help assess community health priorities. In all, the collaborative solicited input from nearly 90 community leaders and representatives of various organizations and sectors. These representatives either work in the health field or improve health conditions by serving those from high-need populations. *See Attachment 1: Community Leaders, Representatives and Members Consulted for the list of organizations that participated in the CHNA, along with their expertise and mode of consultation (focus group or key informant interview).*

Key Informant Interviews

Primary research was conducted In March and April 2021 via key informant interviews with seven Santa Clara County or dual-county (Santa Clara and San Mateo counties) experts from various organizations in the health and human services sectors. Interviews were conducted virtually via Zoom for approximately one hour. Prior to each interview, participants were asked to complete a short online survey, in which they were asked to identify the health needs they felt were the most pressing among the people they serve. Interviewees could choose up to three needs from the list of needs presented to them, which had been identified in one or both counties in 2019, or could write in needs that were not on the combined 2019 list. Also in the survey, participants were advised of how their interview data would be used and were asked to

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[50] The IRS requires that community input include the low-income, minority, and medically underserved populations.

consent to be recorded.[51] Finally, participants were offered the option of being listed in the report and were asked to provide some basic demographic information (also optional).

The discussions centered around four questions for each health need that was prioritized by interviewees:
- How do you see this need playing out in the community?
- Which populations are experiencing inequities with respect to this need?
- How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?
- What is needed (including models/best practices) to better address this need?

Details of Key Informant Interviews

Name	Agency	Expertise	Date
Kristina Lugo	Avenidas	Senior health needs	3/9/2021
Bonnie Broderick	County of Santa Clara, Department of Public Health	Chronic diseases	3/22/2021
Rhonda McClinton-Brown	Healthy Communities, County of Santa Clara Public Health Department	Public health	4/5/2021
Dana Bunnett	Kids in Common	Child & youth wellness	4/5/2021
Charisse Feldman	County of Santa Clara Public Health Department	Maternal/teen health	4/14/2021
Maribel Martinez	County of Santa Clara, Office of LGBTQ Affairs	LGBTQ+ health needs	4/15/2021
Shakalpi Pendurkar DDS, MPH	formerly of Gardner Family Health Network	Oral health	4/29/2021

Focus Groups

Focus groups with community leaders and residents were convened between April and June 2021. A total of 66 professionals and four safety net clinic patients participated in various focus groups. Collaborative members and/or nonprofit hosts recruited participants for the groups.

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[51] Only individuals who consented to be recorded were interviewed.

These participants represented low-income, minority and/or medically underserved populations in the community. AI sent a similar survey to focus group participants as was sent to key informants, and asked focus groups the same questions during discussion as were asked of key informants; facilitators modified the questions appropriately for each audience.[52] Focus group discussions centered on the needs that had received the most votes from prospective participants in the online pre-survey.

Details of Focus Groups

Topic	Focus Group Host/Partner	Date	Number of Participants
Adult mental/behavioral health	El Camino Health & Sutter Health	4/12/2021	13
Health equity	Stanford Health Care	4/14/2021	10
Santa Clara County social services	El Camino Health	4/19/2021	12
Safety net clinics and their patients	Stanford Health Care & Sutter Health	4/26/2021	12
Youth mental health	Lucile S. Packard Children's Hospital-Stanford	4/29/2021	12
Health of safety net clinic patients*	Gardner Health Services	6/7/2021	4
Black health	Bay Area Community Health Advisory Council (BACHAC)	6/14/2021	7

* Indicates resident/community member group.

See *Attachment 4: Qualitative Research Protocols* for complete protocols and questions, including pre-surveys. See *Attachment 1: Community Leaders, Representatives, and Members Consulted* for a list of key informants and focus group or interview details.

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[52] Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

CHNA Participant Demographics

A total of 77 people participated in focus groups or interviews for the CHNA. More than three out of every four (77%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder represented Santa Clara County only (23%).

The charts below show the age ranges of participants, as well as their race; note that individuals could choose more than one race (N=74). One in five (20%) of participants were of Hispanic/Latinx ethnicity (N=76). Nearly two-thirds of participants (64%) identified as female, with almost all of the rest identifying as male (N=76). On average, participants were aged 49 (N=74).

Participant Age Groups
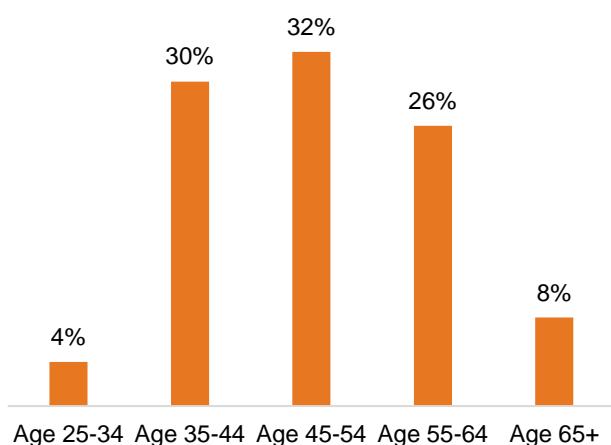
Participant Racial/Ethnic Groups
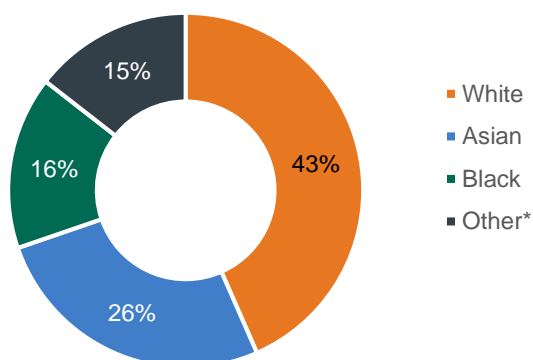
* "Other" includes American Indian/AK Native & Native HI/Pacific Islander.

INFORMATION GAPS AND LIMITATIONS

A lack of data limited our ability to fully assess some health issues that were identified as community needs during the 2022 CHNA process. Conducting the 2022 CHNA presented unique challenges for data collection:

1. As was the case across the nation due to the COVID-19 pandemic, public health departments' epidemiologists lacked sufficient resources to conduct data analyses in the same way they had in years past. This affected our ability to assess data on infectious diseases, cancer, etc.
2. Our CHNA, as it has since 2012, employed data from the publicly available Kaiser Permanente Community Health Needs Dashboard. As of 2021, the platform no longer provides data breakdowns by race/ethnicity and instead simply offers correlations between race and poor health outcomes (which are presented in this report).

In both cases, when current data were lacking, Actionable Insights relied on data from our previous CHNA.

3. In years past, our CHNAs relied on the California Healthy Kids Survey (CHKS) for data about child and adolescent mental health and emotional wellbeing. However, Santa Clara County has not opted in to conduct the CHKS in recent years. Therefore, these data are lacking for the county.

4. Because of the pandemic, it was not safe to bring community members together in person. Moreover, while it was possible to conduct focus groups and interviews virtually (i.e., via Zoom), the most vulnerable community members often did not have access to the technology needed for a virtual meeting. Also, nonprofit partners advised that the community was severely stressed (financially and emotionally) by the pandemic and felt it was inappropriate to burden them with CHNA data collection requests. Although Actionable Insights was able to conduct one focus group with safety net clinic patients, in order to best represent the perspectives and experiences of low-income, minority, and underserved community members during the pandemic, they spoke with a wide array of nonprofit staff who work with vulnerable populations. We acknowledge this as a limitation in our 2022 CHNA data.

Lastly, some indicators are difficult to measure or are just emerging. Statistical information related to these topics was scarce:

- Youth cigarette and e-cigarette use
- Recent marijuana use and related behavioral health data
- Domestic violence and related community safety data
- Impact of social media on adolescent mental health
- Cognitive decline data, including Alzheimer's Disease prevalence rate and hospice admissions for dementia
- Caregiver impact data (unpaid care, health effects)
- Oral health data
- Data on experiences of discrimination
- Data breakdowns by income/socioeconomic status
- Data on economic inequities within key zip codes

PROCESS OF IDENTIFYING COMMUNITY HEALTH NEEDS

The collaborative began the 2022 CHNA planning process in January of 2021. The collective goal for the assessment was to gather community feedback and existing data about local health needs to inform how each member hospital would select specific issues to address with Community Benefit in its service area. The collaborative's members each engaged Actionable Insights, a local consulting firm with expertise in community health needs assessments.

Community feedback was gathered between March and June 2021 via individual interviews with seven local experts and convening eight focus groups. The experts were asked to: discuss the top needs of their constituencies, including barriers to health; identify populations experiencing inequities with respect to the needs; give their perceptions of how things have changed over the

past three years, including how the pandemic affected the needs; and share which solutions may improve health (such as services and policies).

The focus group discussions centered on four questions (see page 43), which were modified appropriately for each audience. The focus groups comprised local residents and people who serve them. Participants included professionals in the fields representing low-income, minority, and/or medically underserved populations in the community.

Secondary data were obtained from a variety of sources, including the public Community Health Data Platform and the Santa Clara County Public Health Department.

Health needs described in this report are either a poor health outcome and its health driver(s), or a health driver associated with a poor health outcome. El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which were filtered using the following criteria (see chart on next page):

1. Must fit the definition of a "health need." *(See Definitions box, opposite.)*

   and

2. Is suggested or confirmed by at least two sources (i.e. more than one source of secondary and/or primary data).

   and

3. Must be prioritized by at least one-third of focus groups or key informants,

   or

4. Two or more direct indicators must fail the benchmark by 5 percent or more,

   or

5. Two or more direct indicators must exhibit documented inequities by race.

DEFINITIONS

Health condition: A disease, impairment, or other state of physical or mental health that contributes to a poor health outcome.

Health driver: A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes. May be a social determinant of health.

Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

Health need: A poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need.

Health outcome: The measurable impact — morbidity (quality of life) and mortality (death) — of a disease within a community.

Health Needs Identification Criteria
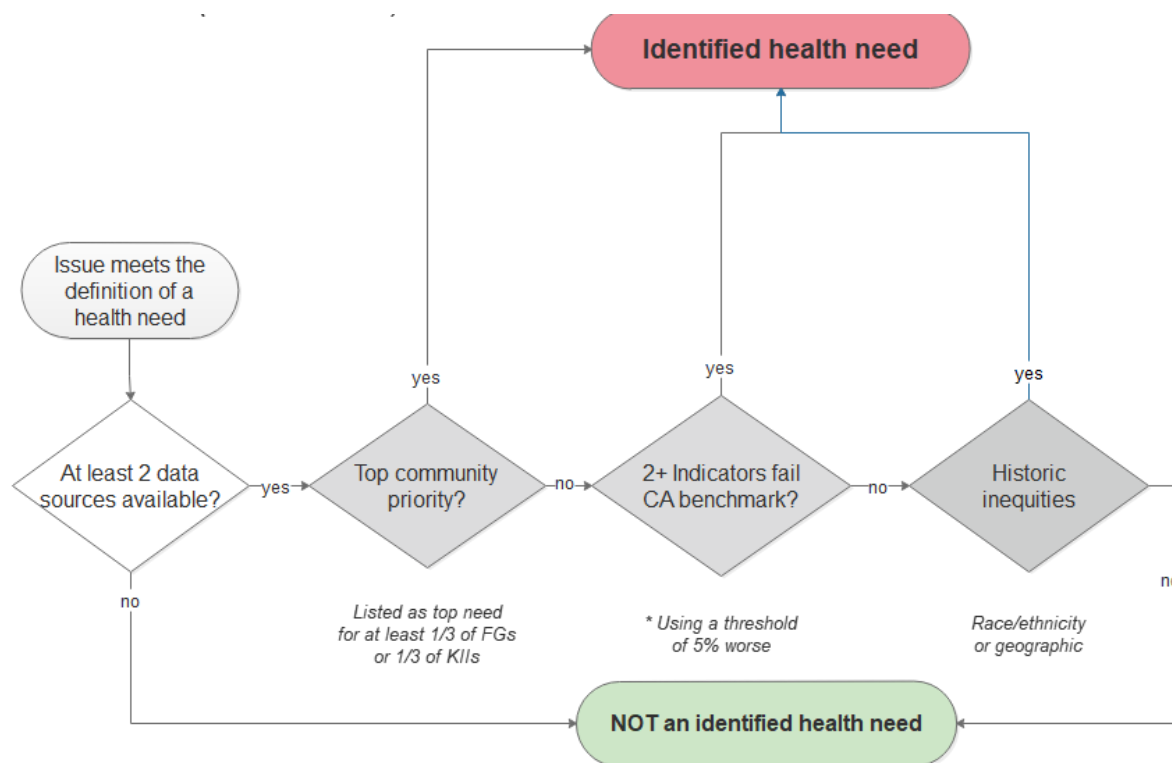
These data are described in the summary descriptions of each health need, which appear on the following pages.

PROCESS OF PRIORITIZING THE HEALTH NEEDS

The IRS CHNA requirements state that hospital facilities must identify and prioritize significant health needs of the community.

As described in the Process and Methods section, qualitative input was solicited from focus group and interview participants about which needs they thought were the highest priority (most pressing).

El Camino Health used this input to identify the significant health needs; therefore, the 2022 health needs listed in this report reflect the health priorities of the community, as follows:

1. Economic Stability
2. Behavioral Health
3. Housing & Homelessness
4. Health Care Access & Delivery
5. Diabetes & Obesity
6. Cancer
7. Maternal & Infant Health
8. Oral/Dental Health

9. Climate/Natural Environment
10. Unintended Injuries/Accidents
11. Community Safety
12. Sexually Transmitted Infections

Summarized descriptions of each health need appear in Section 6: Prioritized Community Health Needs.

6. PRIORITIZED COMMUNITY HEALTH NEEDS

The processes and methods described in Section 5: Process and Methods resulted in the prioritization of 12 health needs (see list on previous page). Each description summarizes the statistical data and community input collected during the community health needs assessment.

ECONOMIC STABILITY

Nearly all focus groups and almost three-quarters of key informants identified economic stability as a top community priority. According to the U.S. Office of Disease Prevention and Health Promotion, "many people can't afford things like healthy foods, health care, and housing. …People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or [chronic] conditions… may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy."[53]

The cost of living in Santa Clara County is extremely high, and income inequality in Silicon Valley is 1.5 times higher than at the state level. More specifically, the 94040 and 94043 zip code areas of Mountain View have a higher level of income inequality (both 0.5 on the Gini index) than either the county or the state overall (both 0.4 on the Gini index). In addition, the East San José area experiences higher levels of Neighborhood Deprivation[54] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0). Further, while the index that maps geographic access to job opportunities for the county (50, on a scale of 0 to 100) is similar to California overall (48), jobs proximity index metrics for East San Jose (2) and the 94040 zip code in Mountain View (10) are much worse. The median household income in East San José ($79,602) is also lower than even the state median ($82,053), let alone the county median household income ($129,210).

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of Santa Clara County Black (45%), Pacific Islander (38%), and Latinx (46%) 11th-graders met or exceeded grade-level English-language arts standards compared to California 11th-graders overall (57%). Also, a smaller percentage of local Latinx 11th graders met or exceeded math standards (28%) versus California's 11th-graders (32%). Related to these statistics, much smaller proportions of the county's Black (32%), Pacific Islander (34%), and Latinx (38%) high school graduates completed college-preparatory courses compared to high school graduates statewide (47%). In our 2019 CHNA report, we described similar inequities in educational attainment. In some county sub-geographies in particular, the proportion of adults who do not have at least a high

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[53] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030. (Undated). *Economic Stability.* Retrieved from
https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

[54] The Neighborhood Deprivation Need Rating is comprised of 13 key measures across the dimensions of wealth and income, education, occupation, and housing conditions. All four East San José zip codes have the worst scores in the county. Rating scale ranges from -3.5 (best) to 3.5 (worst).

school diploma is much higher (East San José, 31%; 94040 in Mountain View, approximately 28%) than the state average (18%). Educational inequities, often related to neighborhood segregation[55], lead to educational disparities that begin at an early age: the elementary school proficiency index, which measures the academic performance of 4th-graders, is significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4).

While 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion rises to 58% among Santa Clara County households. Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards. Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty). In our 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic instability can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

> *"Extremely low-income households, primarily from communities of color, were hit the hardest [by COVID-19]. The groups that we served saw their incomes drop by two-thirds from the start of the pandemic until now [one year later]... outside of just paying the rent, healthcare, food, and transportation were all the top things that they needed money for, to help with. And before this pandemic started, all these extremely low-income households were most likely severely rent-burdened, paying more than 50 percent of their income towards rent, but they were one crisis away, and now we've got a thousand crises."*
>
> *— Social Services Agency Focus Group Participant*

Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also "overrepresented in both frontline and hardest-hit sectors" of the economy.[56] Prior to the pandemic, the cost of childcare may also have been a limiting factor; infant child care (age 0-2) cost $20,746 per year in Santa Clara County, compared to $17,384 on average statewide.

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[55] Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA. Retrieved from https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf

[56] Bohn, S., Cuellar Mejia, M., & Lafortune, J. (2021). *Multiple Challenges for Women in the COVID-19 Economy*. Public Policy Institute of California. Retrieved from https://www.ppic.org/blog/multiple-challenges-for-women-in-the-covid-19-economy/

Similarly, pre-K child care (age 3-5) cost $15,315 in Santa Clara County versus $12,168 on average in California overall. Economic insecurity affects single-parent households more than dual-parent households[57]; in East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).

BEHAVIORAL HEALTH

Behavioral health, which includes mental health and trauma as well as consequences such as substance use, ranked high as a health need, being prioritized by all focus groups and more than half of key informants.

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported an increased demand for services; however, children and adolescents were of particular concern. Statistics from prior to the pandemic's advent suggest that youth mental health is an issue: Students in Santa Clara County have lower access to psychologists at school (1,199:1) compared to students statewide (1,041:1, a 15% difference). Perhaps in part due to these access issues, the county's youth self-harm injury hospitalization rate (32.7 per 100,000 age 0-17) is significantly higher than the state's rate (22.4 per 100,000). Experts noted the lack of mental health providers (348.0 per 100,000 people in the county vs. 352.3 per 100,000 at the state level) and addiction services overall, especially in non-English languages.

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data prior to the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among Santa Clara County's Black population occur at nearly twice the rate (25.0 per 100,000 people) as for all Californians (14.0 per 100,000). Self-harm injury hospitalizations are much higher for the county's white youth (66.3 per 100,000 age 0-17) and Latinx youth (31.9 per 100,000) than for all California youth (22.4 per 100,000). The county's white suicide rate for all ages (13 per 100,000 people) remains persistently higher than the state rate (11 per 100,000 people). Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are

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[57] Western, B., Bloome, D., Sosnaud, B., & Tach, L. (2012). Economic insecurity and social stratification. *Annual Review of Sociology,* 38, 341-359. Retrieved from https://scholar.harvard.edu/files/brucewestern/files/western_et_al12.pdf

more likely to receive poor quality care when treated."[58] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment" pose barriers to community members who are Black, Indigenous, or other people of color (BIPOC) seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[59] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) were substantially higher for Black (23.0 per 1,000) and Latinx (9.3) Santa Clara County youth than for California youth overall (4.1 per 1,000).

> *"I think one of the questions is how do we, as hospital systems, commit to parity, to equity in terms of access to mental health support, knowing it really is the primary health need of our families right now across the country and within San Mateo and Santa Clara counties."*
>
> *— Health Equity Focus Group Participant*

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services and there are very few inpatient psychiatric beds for acute/high needs.[60] It was stated that services for people without health insurance can be expensive and difficult to access.

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[58] McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope),* 27(2), 393–403. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

[59] Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today,* American Counseling Association. Retrieved from https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

[60] Valley Medical Center's Barbara Arons Pavilion provides 60 acute inpatient psychiatric beds; however, its facility is "in poor condition [with]…serious design flaws." Santa Clara County is currently building a new facility to replace the Pavilion, slated to be completed in late 2023, with 42 beds for adults and 31 beds for children and teens. Forestieri, K. (2021). Santa Clara County unveils plans for a $233M psychiatric hospital serving kids and adults. *Palo Alto Online.* Retrieved from https://paloaltoonline.com/news/2021/02/27/santa-clara-county-unveils-plans-for-a-233m-psychiatric-hospital-serving-kids-and-adults

HOUSING & HOMELESSNESS

More than half of focus groups and one key informant identified housing and homelessness as a top community priority. Housing costs and other costs of living in Santa Clara County are extremely high; the county's median home rental cost at $2,374 is 41% higher than the median state home rental cost ($1,689) and the home ownership affordability index for the county (73.0) is substantially worse than for the state overall (88.1). Moreover, while homeowners statewide are spending approximately 31% of their income on their mortgage, at the county level homeowners are spending over 36%, East San José homeowners are spending over 40%, and homeowners in the 94040 zip code of Mountain View are spending 50% of their income on their mortgages. Overall, the East San José area experiences higher levels of Neighborhood Deprivation[61] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0).

Most feedback about housing from key informants and focus group participants concerned housing affordability. The housing affordability index for Santa Clara County[62] (73.0) is lower (i.e., worse) than for California (88.1), but higher (i.e., better) than areas such as East San José (60.5) or the 94040 zip code of Mountain View (51.0). The proportions of people who own their own homes in both the 94040 zip code of Mountain View (41%) and the 94085 zip code of Sunnyvale (38%) are substantially lower than the county as a whole (56%) or the state average (55%). CHNA participants expressed the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Focus group participants mentioned out-migration from the county due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason.

Other CHNA participants said high costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID. Particularly in East San José (20%) and the 94085 zip code of Sunnyvale (12%), the proportions of overcrowded housing units are much higher than in the state as a whole (8%). However, housing quality is also a concern; for example, children and young adults ages 6-20 countywide have worse blood lead levels (1.1%) than California children overall (0.5%).

Economic instability (see Economic Stability description) can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face. Homelessness rose in 2019 (the most recent county homeless count) primarily in San José and the northern parts of the county, including the 94040

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[61] The Neighborhood Deprivation Need Rating is comprised of 13 key measures across the dimensions of wealth and income, education, occupation, and housing conditions. All four East San José zip codes have the worst scores in the county. Rating scale ranges from -3.5 (best) to 3.5 (worst).

[62] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median valued home." See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. *ESRI ArcGIS Blog*, December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

zip code of Mountain View. It was noted by experts that during COVID, landlords may be evicting families with undocumented members because they expect that these families will not seek legal protections.

> *"Earlier last year, I was working in the COVID hotels and I was having people come in who... said that COVID was a godsend because it's the first time in 20 years that they had ever been able to have a roof over their head and have… three square [meal]s a day."*
>
> *— Health Equity Focus Group Participant*

HEALTH CARE ACCESS & DELIVERY

Health care access and delivery, which affects various other community health needs, was identified as a top health need by more than half the CHNA's focus groups and nearly one-third of key informants. Experts and county residents felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Healthcare access may be especially problematic for youth in the community: In Santa Clara County's schools, the ratio of students to each school nurse (2,992:1) exceeds the state ratio (2,410:1) by nearly 25%. Further, the county's ratio of students to school speech, language, and hearing specialists (1,126:1) is larger than the state's (1,093:1). In addition, Black and Latinx Santa Clara County residents experience significantly worse health compared to county residents of other races; for example, preventable hospital stays (4,942 per 100,000 Black Medicare enrollees [adults aged 65 and over and persons with disabilities] and 3,969 per 100,000 Latinx Medicare enrollees in the county versus 3,358 per 100,000 Medicare enrollees statewide) may be a sign of inequitable access to high-quality care. Certainly in East San José, one of the geographic areas where health disparities are concentrated, there is a higher percentage of individuals enrolled in Medicaid or other public health insurance (42%) compared to the state average (38%). Conversely, in Sunnyvale (zip code 94085), another area of concentrated health disparities, a much lower proportion of individuals are enrolled in Medicaid/public health insurance (21%), but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).

Many key informants and focus group participants connected healthcare access with economic instability, such as having to choose whether to pay for housing or for healthcare. Others noted that individuals who are not provided with sick time must choose to go unpaid in order to visit the doctor for themselves and/or family members, stating that expanded service hours on weekends and evenings are still needed. It was stated that low-income and undocumented county residents especially have difficulty accessing insurance. Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern; in our 2019 CHNA report, Latinx county residents were significantly less likely to have health insurance than others. Additionally, CHNA participants identified the lack of information for patients about healthcare costs as a barrier to accessing care.

"I personally have a problem accessing healthcare because I'm a single parent, I don't earn [only] the minimum wage. And for that reason, I don't qualify by their standards, because according to them, I'm making so much money that I don't qualify. And it's not worth it for me to pay $500 for health insurance or dental insurance where the individual plan - it has a lot of exclusions."

— Clinic Patient Focus Group Participant

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide as well as patients' lack of privacy. There was also concern expressed by providers about the lower reimbursement rate for telephone appointments (i.e., without video).

The need for healthcare workforce training in order to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas that were identified included LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients who have mental health issues, are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included education of healthcare workers around public charge issues, and the need for greater language capacity. More than one in ten (11%) Santa Clara County residents speak limited English, compared to less than 10% in California overall. However, there are even more-glaring geographic disparities: in Sunnyvale (zip code 94085) more than one in seven (14%), and in the East San José area more than two in ten (22%) residents speak limited English. Limited English proficiency can restrict healthcare access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility in order to retain coverage were called out as specific concerns. Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to healthcare among these groups.

DIABETES & OBESITY

Approximately one-third of key informants and focus groups identified diabetes and obesity as a top health need. Two experts in Santa Clara County specifically called out diabetes as a rising problem in the community, while the trend for adult obesity remains flat. Currently, 8.4% of Santa Clara County community members have diabetes, compared to 9.9% of all Californians. Key informants and focus group participants identified the need for nutrition education, particularly from a young age, and some key informants further noted the cost of healthy food as a barrier to good nutrition. SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%).

The lack of physical activity was cited as a driver of obesity by multiple key informants, mostly in the context of the pandemic's interference with regular activities. Associated with this concern, the county's walkability index (9.9) is worse than the state's (11.2), while the walkability index for East San José (0.8) and the 94040 zip code of Mountain View (1.5), another area of concentrated health disparities, are substantially worse than either. The county's Pacific Islander and Latinx middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide; Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards. Orange cells in the tables denote statistics that are five percent or more worse than the benchmark.

Students Meeting Healthy Body Composition Standards[63]

	California	Santa Clara County (SCC)	SCC Black	SCC Latinx	SCC Pacific Islander
5th Graders	78%	83%	81%	71%	75%
7th Graders	79%	85%	80%	74%	68%
9th Graders	81%	87%	82%	77%	72%

Students Meeting All Fitness Standards

	California	Santa Clara County (SCC)	SCC Black	SCC Latinx	SCC Pacific Islander
5th Graders	24%	27%	23%	16%	21%
7th Graders	30%	32%	26%	22%	27%
9th Graders	34%	39%	35%	27%	23%

Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. Data show that, among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in Santa Clara County (22.2 per 1,000 people) compared to the state rate (48.1 per 1,000). Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (31%) compared to children statewide (35%). Multiple residents

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[63] Statistics provided in the table are the inverse of "Students' Body Composition Needs Improvement – Health Risk."

made the connection between unhealthy eating and mental health—what's going on "in their head and their heart."

Our 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates compared to the state, and the county's Black population also experiencing higher rates of diabetes. Although key informants and focus group participants did not connect diabetes and obesity with health disparities or inequities, experts writing on behalf of the American Diabetes Association describe placing "socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations."[64]

CANCER

Although cancer mortality rates are not as high in Santa Clara County as they are statewide, cancer is still one of the top three causes of death in the county. Additionally, there are persistent disparities in cancer incidence rates and other cancer statistics. Both of these facts make cancer an issue of concern in the county.

The breast cancer incidence rate is slightly higher among Santa Clara County women (121.2 per 100,000) compared to California women overall (120.9 per 100,000). East San José and the 94040 zip code of Mountain View have the same breast cancer incidence rates as the county overall. Mammography screening levels, an early cancer detection measure, are lower for the county's Black women (33%), Latinas (29%), and Native American women (33%) than California women overall (36%). Our 2019 CHNA report indicated that Black county residents have a higher incidence of breast cancer, lung cancer, prostate cancer, and a higher prevalence of cancer of all sites combined, while Latina residents have a substantially higher incidence of cervical cancer.

> *"When you look at race, ethnicity, and disparities, the African-American, the Latinx community are going to be the more impacted negatively. And then Asians… [for example,] Tongans are very different than the Chinese. And so, again, how do you see different rates of heart disease and **cancers** in some of the subgroups? So that's one slice, is race, [at which] to look carefully and see the disparities."*
>
> *— Public Health Expert*

In addition, the rate of cancer incidence among children ages 0-19 is slightly higher in the county (19.0 per 100,000) than the state (18.2 per 100,000) and highest among the county's white children (21.2 per 100,000) and Asian/Pacific Islander children (20.2 per 100,000).

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[64] Ogunwole, S. M. & Golden, S. H. (2021). Social Determinants of Health and Structural Inequities—Root Causes of Diabetes Disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from https://care.diabetesjournals.org/content/44/1/11

The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, residents are more likely to be obese, which is a cancer risk factor). The Institute states, "Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and/or institutional inequalities."[65]

MATERNAL & INFANT HEALTH

Nearly all maternal and infant health statistics in Santa Clara County are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among the county's young Latinas (23.0 per 1,000 females age 15-19) than all females ages 15-19 statewide, (17.0 per 1,000), although the trend is improving. A maternal and child health expert suggested that cultural norms and access issues may play into these differences.

As another example, low infant birth weight is a more frequent issue among Asian (8%) and Black (9%) babies born in the county compared to all babies statewide (7%), and the overall trend is worsening. Infant mortality is also higher among Black babies.

> *"The Black and Pacific Islander populations have continued to shoulder a lot of layers of disparity and inequity,... which we already saw in our maternal, child, and adolescent health indicators, whether it was low birth weight or exclusive breastfeeding."*
>
> *— Public Health Expert*

Additionally, a smaller proportion of Black (79%) and Latinx (78%) mothers receive early prenatal care than all Californian mothers (84%). A maternal and child health expert indicated that these inequities may also be traced back not only to healthcare access and delivery barriers, but to social determinants of health such as racism.

ORAL/DENTAL HEALTH

Access issues related to oral health arose during the assessment. An oral health expert described the lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care.

Most specifically, the oral health expert called out the fact that of the few pediatric dentists in the county, still fewer take Denti-Cal due to the low reimbursement rates, leading to a gap in

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[65] National Cancer Institute. (2020). *Cancer Disparities.* Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

services. For example, a substantially smaller proportion of Santa Clara County Asian/Pacific Islander children and youth who are involved in the child welfare system received a dental check-up (55%) than child welfare-involved children and youth statewide (62%). In our 2019 CHNA report, a smaller proportion of children countywide had a recent dental exam compared to children across the state.

Other data from our 2019 CHNA suggest that the county's adults were more likely to experience dental decay than Californians overall. Santa Clara County adults also had a higher rate of emergency department visits for non-traumatic dental conditions than the state rate.

The oral health expert also identified the special needs population as underserved by oral health specialists. Finally, the expert noted that low-income pregnant women often don't know that they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

CLIMATE/NATURAL ENVIRONMENT

Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. Compared to the state as a whole, Santa Clara County is at significantly greater risk of heat waves (index of 10.6 versus 4.7 for California) and drought (index of 0.8 versus 0.7 for California) as well as coastal flooding (index of 2.6 versus 0.7 for California) and river flooding (index of 4.1 versus 2.1 for California). Public health experts cited lack of tree canopy cover in Santa Clara County, which is reflected in the statistical data (3.6%) as less than the state average (4.0%). Tree canopy cover in East San José (3.9%) is also less than the state. Both focus group participants and key informants mentioned the adverse effects of environmental issues such as wildfires and related poor air, particularly on low-income and BIPOC individuals.

> *"I don't think asthma was mentioned, but I mean, that's just one outgrowth of poor air quality in some of our communities. ...So, air quality, water. Wildfires, you know, people of color are usually the most impacted by that as well."*
>
> *— Black Health Focus Group Participant*

Road network density (21.5 miles of road per square mile of land) and traffic volume (2,289 cars per day, per meter of roadway) were both significantly higher in Santa Clara County than state averages (18.0 and 1,991 respectively). In particular, in East San José a smaller percentage of workers commute by transit, bicycle, or walking (5.8%) than in California overall (8.1%). The environmental cost of high traffic volume includes air pollution, which can aggravate asthma. One Santa Clara County key informant noted that asthma rates have been worsening, and an expert in Black health cautioned about high rates of asthma in areas with poor air quality. Such place-based inequities may be related to historical systemic housing discrimination (e.g., red-

lining).[66] Statistics suggest that asthma prevalence among people of all ages is higher in the county (9.5%) than the state (8.8%), and the county figure is trending higher. Overall, the annual number of unhealthy air days has been rising in Silicon Valley.

UNINTENDED INJURIES/ACCIDENTS

Road network density (21.5 miles of road per square mile of land) and traffic volume (2,289 cars per day, per meter of roadway) were both significantly higher in Santa Clara County than state averages (18.0 and 1,991 respectively). One consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents. In particular, the rate of emergency department visits for bicycle accidents among children ages 0-12 is higher in Santa Clara County (13.5) than the state rate (12.2). Two of the county's public health experts discussed high traffic volume and the need to prevent accidents and make roads safe for pedestrians and cyclists.

By race, among children ages 0-12 in Santa Clara County, ED visits for bicycle accidents are highest among whites (27.6); for motor vehicle crashes, they are high among Blacks (387.5) and Latinxs (258.9); and for pedestrian accidents, they are high among Latinxs (19.3). Racial inequities in accident rates have been found nationwide, and are attributed in part to unequal access to safe transportation.[67] The absence of sidewalks in low-income neighborhoods is another factor related to inequities in pedestrian accident rates nationally.[68]

Other unintended injuries include falls. Among older adults (ages 65+) in Santa Clara County, falls deaths are highest among whites (68.1), Latinxs (51.7), and Asians(40.8).

COMMUNITY SAFETY

While many community safety statistics are better in Santa Clara County compared to the state, the rate of rape in Silicon Valley is high (40.0 versus 39.0 in California) and rising. In addition, the homicide rate is significantly higher among the Black population in Santa Clara County (9.0) than the state rate (5.0). This latter difference may, in part, be attributed to residential

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[66] Iton, A., & Ross, R. K. (2017). Understanding How Health Happens: Your Zip Code is More Important Than Your Genetic Code. In *Public Health Leadership*, Callahan, R.F. & Bhattacharya, D., eds. (pp. 83-99). New York, NY: Routledge. Retrieved from https://zums.ac.ir//files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84. See also: Duncan, D. T., & Kawachi, I. (Eds.). (2018). *Neighborhoods and Health.* Oxford, UK: Oxford University Press.

[67] Hamann, C., Peek-Asa, C., & Butcher, B. (2020). Racial disparities in pedestrian-related injury hospitalizations in the United States. *BMC Public Health*, 20(1), 1-7. Retrieved from https://link.springer.com/article/10.1186/s12889-020-09513-8 and

[68] Lu, W., McKyer, E.L.J., Lee, C., Ory, M.G., Goodson, P., & Wang, S. (2015). Children's active commuting to school: an interplay of self-efficacy, social economic disadvantage, and environmental characteristics. *International Journal of Behavioral Nutrition and Physical Activity.* 12(1):29. Retrieved from https://ijbnpa.biomedcentral.com/articles/10.1186/s12966-015-0190-8

segregation, which has been shown to be related to structural discrimination[69] (see *Housing and Homelessness* description).

Some experts expressed concern about COVID stress contributing to domestic violence; one mentioned that virtual visits make it harder for patients experiencing domestic violence to obtain both confidentiality and safety. There are disparities in domestic violence: Black children age 0-17 are nearly twice as likely (13.9 per 1,000), and Latinx children somewhat more likely (8.3 per 1,000), to be the subject of a substantiated child abuse case than children statewide (7.5 per 1,000). Researchers attribute these disparities to differences in family circumstances that put children at greater risk of abuse (e.g., being young and/or single parents, experiencing poverty).[70]

> *"... especially for our patients who are in situations with violent partners it was great to have the in-person encounter as a sort of legitimate reason for that patient to get away from the partner, to be able to speak with a provider confidentially. And now with virtual visits, it's really hard to be able to discreetly ensure that confidentiality; that person has to do that visit from a home or someplace where it's a little harder for you to directly ask if it's a safe place to talk, and also for them to really be as inclined to set up visits for check-ins for safety."*
>
> *— Health Equity Focus Group Participant*

Building on the differences in child abuse statistics, the county's Black children (ages 0-20) are also more likely to be in foster care (8.8 per 1,000) than are California children on average (5.3 per 1,000). Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.[71] Statistics show that juvenile felony arrests (age 10-17) are higher in Santa Clara County (5.8 per 1,000) than the state (4.1 per 1,000) and,

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[69] Knopov, A., Rothman, E.F., Cronin, S.W., Franklin, L., Cansever, A., Potter, F., Mesic, A., Sharma, A., Xuan, Z., Siegel, M. and Hemenway, D. (2019). The role of racial residential segregation in black-white disparities in firearm homicide at the state level in the United States, 1991-2015. *Journal of the National Medical Association*, 111(1), pp.62-75. Retrieved from https://www.researchgate.net/profile/Anita-Knopov/publication/326323244_The_Role_of_Racial_Residential_Segregation_in_Black-White_Disparities_in_Firearm_Homicide_at_the_State_Level_in_the_United_States_1991-2015/links/5bee3267299bf1124fd5e3f3/The-Role-of-Racial-Residential-Segregation-in-Black-White-Disparities-in-Firearm-Homicide-at-the-State-Level-in-the-United-States-1991-2015.pdf

[70] Font, S. A., Berger, L. M., & Slack, K. S. (2012). Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review,* 34(11), 2188-2200. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3439815/. See also: Black Child Legacy Campaign. (2021). *Child Abuse and Neglect.* Retrieved from https://blackchildlegacy.org/resources/child-abuse-and-neglect/

[71] See, for example, Cutuli, J.J., Goerge, R.M., Coulton, C., Schretzman, M., Crampton, D., Charvat, B.J., Lalich, N., Raithel, J., Gacitua, C. and Lee, E.L., 2016. From foster care to juvenile justice: Exploring characteristics of youth in three cities. *Children and Youth Services Review*, 67, pp.84-94. Retrieved from https://www.aisp.upenn.edu/wp-content/uploads/2020/11/From-Foster-Care-to-Juvenile-Justice.pdf . And see Yi, Y., & Wildeman, C. (2018). Can foster care interventions diminish justice system inequality?. *The Future of Children*, 28(1), 37-58. Retrieved from https://files.eric.ed.gov/fulltext/EJ1179175.pdf

specifically, higher for the county's Black (23.0) and Latinx (9.3) youth. In Santa Clara County, Latinx youth are substantially overrepresented in the county's juvenile detention center population.[72] These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.[73]

SEXUALLY TRANSMITTED INFECTIONS

Although statistics on sexually transmitted infections are better for Santa Clara County than the state, there are concerning trends. For example, HIV diagnoses among younger men (ages 13-24 and 25-44) are on the rise. In our 2019 CHNA report, we found that the proportion of people who were not screened for HIV was higher in Santa Clara County than statewide.

Additionally, there are disparities; for example, Black and Latinx men ages 13 and older in Santa Clara County are more than twice as likely to be diagnosed with HIV than California men overall. In our 2019 CHNA report, statistics showed that the Black population in Santa Clara County was also more likely to be diagnosed with early syphilis than all Californians. The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the healthcare system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to "stay sexually healthy."[74]

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[72] County of Santa Clara. (2020). *Santa Clara County Juvenile Justice Annual Report.* Retrieved from https://probation.sccgov.org/sites/g/files/exjcpb721/files/documents/2021_09_17_Juvenile%20Justice%20Annual%20Report_2020_Final.pdf

[73] Gallegos, A. H., & White, C. R. (2013). Preventing the School-Justice Connection for Youth in Foster Care. *Family Court Review*, 51(3), 460-468. And see: Foster, M. & Gifford, E. (2004). "The Transition to Adulthood for Youth Leaving Public Systems: Challenges to Policies and Research," in *On the Frontier of Adulthood: Theory, Research, and Public Policy*, eds. Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., & Rubén G. Rumbaut. Chicago: University of Chicago Press.

[74] Centers for Disease Control and Prevention. (2020). *STD Health Equity.* Retrieved from https://www.cdc.gov/std/health-disparities/default.htm

7. EVALUATION OF 2020–2022 IMPLEMENTED STRATEGIES

In 2018–2019, El Camino Health participated in a Community Health Needs Assessment similar to the collaborative 2022 effort.

The 2019 CHNA report is posted on the Community Benefit page of the El Camino Health website.[75] IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years.[76]

After reviewing the findings of the 2019 CHNA, El Camino Health's Community Benefit Advisory Council (CBAC) identified nine health needs to address in FY20 and the subsequent two fiscal years with community benefit grant funding.

The health needs fall under three health priority areas:

HEALTHY BODY	HEALTHY MIND	HEALTHY COMMUNITY
● Diabetes & Obesity ● Chronic Conditions (other than Diabetes & Obesity) ● Healthcare Access & Delivery ● Oral Health	● Behavioral Health ● Cognitive Decline	● Violence & Injury Prevention ● Economic Stability ● Housing & Homelessness

Due to the timing of the CHNA publication and the submission of year-end data from grants, annual data for FY22 (July 1, 2021–June 30, 2022) is unavailable for inclusion. Each year, the Community Benefit Program publishes an Annual Report to the Community available on the Community Benefit page of the website.[77]

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[75] https://www.elcaminohealth.org/about-us/community-benefit

[76] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf

[77] https://www.elcaminohealth.org/about-us/community-benefit

For additional details on El Camino Health's Community Benefit Program results in fiscal years 2020 and 2021 and the first six months of fiscal year 2022, see *Attachment 6: FY20 – FY22 Year-over-Year Dashboard.*

8. CONCLUSION

El Camino Health worked with its collaborative partners, pooling expertise and resources, to conduct the 2022 Community Health Needs Assessment in Santa Clara County.

By gathering secondary data and conducting new primary research as a team, the partners were able to understand the community's perception of health needs as well as prioritize health needs with an understanding of how each compares against benchmarks.

The 2022 CHNA, which builds upon prior assessments, meets federal (IRS) and California state requirements.

Next steps for El Camino Health:

- After the CHNA is adopted by the hospital's board, make the CHNA report publicly available on the website (by June 30, 2022).
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address.
- Develop strategies to address priority health needs (independently or with collaborative partner hospitals).
- Ensure Community Benefit Plan and Implementation Strategy is approved by the hospital board (by June 2022).

9. LIST OF ATTACHMENTS

1. Community Leaders, Representatives and Members Consulted
2. Secondary Data Indicators List
3. Community Assets and Resources
4. Qualitative Research Protocols
5. IRS Checklist
6. FY20 – FY22 Year-over-Year Dashboard

ATTACHMENT 1. COMMUNITY LEADERS, REPRESENTATIVES AND MEMBERS CONSULTED

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities, and the medically underserved. Interviewees and focus group participants discussed health needs in both San Mateo and Santa Clara counties unless otherwise noted (i.e., designated "SCC").

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Organizations							
1	Interview	Kristina Lugo, Vice President, Individual and Family Services, Avenidas	Senior health needs	1	Low-income, medically underserved	Leader	3/9/2021
2	Interview	Bonnie Broderick, Program Manager, County of Santa Clara, Department of Public Health	SCC: Chronic diseases	1	Low-income, medically underserved	Leader	3/22/2021
3	Interview	Rhonda McClinton-Brown, Branch Director, Healthy Communities, County of Santa Clara Public Health Department	SCC: Public health	1	Low-income, medically underserved	Leader	4/5/2021
4	Interview	Dana Bunnett, Executive Director, Kids in Common	SCC: Child & youth wellness	1	Low-income	Leader	4/5/2021

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
5	Interview	Charisse Feldman, Public Health Nurse Manager II/MCAH Director, Santa Clara County Public Health Department	SCC: Maternal/ teen health	1	Low-income, medically underserved	Leader	4/14/2021
6	Interview	Maribel Martinez, Director, County of Santa Clara, Office of LGBTQ Affairs	SCC: LGBTQ+ health needs	1	Medically underserved, minority	Leader, representative	4/15/2021
7	Interview	Shakalpi Pendurkar DDS, MPH, Director, San Mateo County Oral Public Health Program (formerly Supervising Dentist of Gardner Family Health Network, Santa Clara County)	SCC: Oral health	1	Low-income, medically underserved	Leader	4/29/2021
8	Focus Group	Hosts: El Camino Health & Sutter Health	Adult mental/ behavioral health	13	Medically underserved	(see below)	4/12/2021
		Attendees:					
		Zena Andreani, Program Manager-Crisis Intervention and Suicide Prevention Center, StarVista				Leader	
		Mark Cloutier, CEO, Caminar				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Scott Gilman, Director of Behavioral Health and Recovery Services, San Mateo County Health				Leader	
		Ashley Hartoch, Complex Care Manager, Stanford Health Care				Leader	
		Tiffany Ho, MD DFAPA, Behavioral Health Medical Director, County of Santa Clara Health System				Leader	
		Susan Houston, Vice President of Older Adult Services, Peninsula Family Service				Leader	
		Lauren Johnson, Manager, Community Engagement, Scrivner Center For Mental Health & Addiction Services, El Camino Health				Leader	
		Teresa Johnson, Teresa Johnson, Director Food & Nutrition Services, The Health Trust				Leader	
		Mego Lien, Prevention Services Division Manager, County of Santa				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Clara Behavioral Health Services Department					
		Lan Nguyen, Program Manager, Santa Clara County Behavioral Health Services Department - Suicide and Crisis Services				Leader	
		Dr. Munisha Vohra, MA, LCSW, Director of Clinical Services, Community Overcoming Relationship Abuse				Leader	
		Program Manager , LMFT, Momentum for Health				Leader	
		Next Door Solutions to Domestic Violence				Leader	
9	Focus Group	Host: Stanford Health Care	Health equity	10	Medically underserved, minority	(see below)	4/14/2021
		Attendees:					
		Steven Adelsheim, Director, Stanford Psychiatry Center for Youth Mental				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Health and Wellbeing, Stanford Department of Psychiatry and Behavioral Sciences					
		David Chang, Clinical Assistant Professor, Department of Medicine, Division of Primary Care and Population Health; also Assistant Health Officer, San Mateo County Health, Division of Public Health, Policy, & Planning				Leader	
		Sang-ick Chang, M.D., MPH, Associate Dean and Division Chief, Primary Care & Population Health, Stanford Medical School				Leader	
		Meenadchi Chelvakumar, Clinical Assistant Professor, Primary Care Provider, Stanford/Ravenswood Family Health Network				Leader	
		Ryan Padrez, Assistant Clinical Professor of Pediatrics; Medical Director, Stanford University School of Medicine; The Primary School				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Loto Reed, Program Specialist, Wellness and Community Engagement, Stanford University				Leader	
		Stephen Richmond, Clinical Assistant Professor, Stanford University				Leader, representative	
		Baldeep Singh, Clinical Chief, Stanford Internal Medicine, Co-Director, Pacific Free Clinic				Leader	
		Clinical Associate Professor, Stanford Healthcare				Leader	
		Stanford University Division of Primary Care and Population Health				Leader	
10	Focus Group	Host: El Camino Health	SCC: Social services	12	Low-income	(see below)	4/19/2021
		Attendees:					
		Ray Bramson, Chief Operating Officer, Destination: Home				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Kelly Chau, Ph.D., Senior Vice President of Programs, The Health Trust				Leader	
		Nicole Fargo, Associate Director, Community Services Agency				Leader	
		Mike Gonzalez, Manager, Community Resource Center, Santa Clara Family Health Plan				Leader	
		Brian Greenberg, VP/Programs and Services, LifeMoves				Leader	
		Nereyda Hurtado, Associate Director, Grail Family Services				Leader	
		Josh Selo, Executive Director, West Valley Community Services				Leader	
		Director of Programs and Services, Sunnyvale Community Services				Leader	
		Executive Director, Midtown Family Services				Leader	
		African American Community Service Agency				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		El Camino Health				Leader	
		Peninsula Healthcare Connection				Leader	
11	Focus Group	Host: Stanford Health Care & Sutter Health	Safety Net Clinics	12	Low-income, medically underserved	(see below)	4/26/2021
		Attendees:					
		Anupama Balakrishnan, Chief Medical Officer, Indian Health Center of Santa Clara Valley				Leader	
		Alma Burrell, Associate Director, Roots Community Health Center				Leader	
		Will Cerrato, Clinics Manager, San Mateo Medical Center / RotaCare Free Clinics				Leader	
		Parneet Dhindsa, MPH, Planned Parenthood Mar Monte				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Poorva Kamath, Medical Director, AACI				Leader	
		Stephanie Kleinheinz, CEO, School Health Clinics of Santa Clara County				Leader	
		Haleh Sheikholeslami, Medical Director/MD, Peninsula Healthcare Connection				Leader	
		Chief Executive Officer, Ravenswood Family Health Network				Leader	
		Medical Director of Healthcare Services, Samaritan House				Leader	
		Gardner Health Services				Leader	
		North East Medical Services				Leader	
		San Mateo Medical Center				Leader	
12	Focus Group	Host: Lucile S. Packard Children's Hospital-Stanford	Youth Mental Health	12	Medically underserved	(see below)	4/29/2021

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Attendees:					
		Arash Anoshiravani, Medical Director, Teen Van, Stanford School of Medicine				Leader	
		Vinney Arora, Executive Director, My Digital TAT2				Leader	
		William Blair, MVLA Wellness Coordinator, MVLA School District				Leader	
		Judith Gable, LCSW, Director of Collaborative Counseling Program, Acknowledge Alliance				Leader	
		Melissa Guariglia, PsyD, School-Based & Clinical Services Department Director, StarVista				Leader	
		Vicki Harrison, MSW, Program Director, Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine				Leader	

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Jamila McCallum, Regional Director, Edgewood San Mateo, Edgewood Center for Children and Families				Leader	
		Ron Pilato, Chief Psychologist and Training Director, Community Health Awareness Council (CHAC)				Leader	
		Nkia Richardson, Executive Director, CASA of San Mateo County				Leader	
		Marico Sayoc, Executive Director, Counseling and Support Services for Youth				Leader	
		Executive Director, Adolescent Counseling Services				Leader	
		Uplift Family Services				Leader	
13	Focus Group	Host: Bay Area Community Health Advisory Council (BACHAC)	Black Health	7[78]	Minority, medically underserved	(see below)	6/14/2021

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[78] One attendee did not give permission to be listed in this appendix.

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
		Attendees:					
		Dieter Bruno, Chief Medical Officer, Dignity Health-Sequoia Hospital				Leader, representative	
		Davina Hurt, Councilwoman & Boardmember of CARB/BAAQMD, City Of Belmont and California Air Resources Board/Bay Area Air Quality Management District				Leader, representative	
		Lisa Tealer, Executive Director, Bay Area Community Health Advisory Council (BACHAC)				Leader, representative	
		Bay Area Community Health Advisory Council				Leader, representative	
		Bay Area Community Health Advisory Council				Leader, representative	
		Unity Care Group				Leader, representative	
Community Residents							

ID #	Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
14	Focus Group	Host: Gardner Health Services	Health clinic patients	4	Low-income, medically underserved	Members	6/7/21

ATTACHMENT 2. SECONDARY DATA INDICATORS LIST

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Adults with 1-3 Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to one to three adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.
Behavioral Health	Adults with 4 or More Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to four or more adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.
Behavioral Health	Children with 2 or More Adverse Experiences (ages 0-17, parent reported)	Estimated percentage of children ages 0-17 who have experienced two or more adverse experiences	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the US Census Bureau, American Community Survey. 2012-16. (Jan. 2021).
Behavioral Health	Current Smokers	Percentage of adults who are current smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
Behavioral Health	Deaths Due to Chronic Liver Disease and Cirrhosis	Percentage of deaths that occurred due to liver disease and Cirrhosis	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Deaths of Despair	Rate of deaths of despair	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral Health	Drug Induced Deaths	Percentage of deaths that occurred due to drugs	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Behavioral Health	Drug Overdose Deaths	Percentage of deaths that occurred due to drug overdoses	National Center for Education Statistics-Mortality Files NCES. 2015-16.
Behavioral Health	Excessive Drinking	Percentage of Adults Drinking Excessively	Centers for Disease Control and Prevention, Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Behavioral Health	Frequent Mental Distress, Adults (14+ days per month)	Percentage of adults who report frequent mental distress (14 or more mentally unhealthy days) in the past 30 days	Santa Clara County Public Health Department-Behavioral Risk Factor Survey. 2013-14.
Behavioral Health	Impaired Driving Deaths	Estimated deaths that occurred due to impaired driving	National Highway Traffic Safety Administration Fatality Analysis Reporting System. 2014-18.
Behavioral Health	Insufficient Sleep	Percentage of population with insufficient sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
Behavioral Health	Mental Health Hospitalizations among	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5-14	California Office of Statewide Health Planning and Development special tabulation; California Dept.

Category	Indicator	Indicator Description	Data Source
	Children (ages 5-14) (per 1,000)		of Finance, Population Estimates and Projections. 2020.
Behavioral Health	Mental Health Hospitalizations among Youth (ages 15-19) (per 1,000)	Number of hospital discharges for mental health issues per 1,000 children and youth ages 15-19	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Behavioral Health	Mental Health Providers	Number of mental health providers per populations of 100,000	Chronic Conditions prevalence State/County Level: All Beneficiaries by Age, 2007-2018
Behavioral Health	Opioid Overdose Deaths	Estimated deaths that occurred due to opioid overdose deaths	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral Health	Poor Mental Health (days per month)	Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
Behavioral Health	Population 65 & Older Living Alone	Estimated number of the population who is 65 and older that are living alone	US Census Bureau, US Census Bureau, American Community Survey. 2012-16. 2012-16.
Behavioral Health	Ratio of Students to School Psychologists	Ratio of the number of students compared to the number of number of school psychologists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Behavioral Health	Social Associations (per 10,000)	Estimated number of social Associations per 10,000 people	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	Suicide Deaths	Rate of Deaths due to Suicide	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral Health	Youth Self-Harm Injury ED Visits (age 0-17)	Percent of youth self-harm reported in children ages 0-17	California Department of Public Health, California EpiCenter. 2013-14.
Behavioral Health	Youth Self-Harm Injury Hospitalization	Percent of hospitalizations reported from youth self-harm	California Department of Public Health, California EpiCenter. 2013-14.
Cancer	Breast Cancer Incidence	Estimate number of Breast Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Breast Cancer Screening (Mammogram)	Estimated number of breast cancer screenings (mammograms) performed	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Cancer	Cancer Incidence among Children (ages 0-19)	The amount of cancer incidents that occurred among children ages 0-19	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).
Cancer	Colorectal Cancer Incidence	Estimate number of Colorectal Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.

Category	Indicator	Indicator Description	Data Source
Cancer	Deaths Due to All Cancers	Estimated number of deaths reported that were caused by all cancers	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Colorectal Cancer[3]	Estimated number of deaths that occurred due to colorectal cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Female Breast Cancer	Estimated number of deaths that occurred due to female breast cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Lung Cancer	Estimated number of deaths that occurred due to lung cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Prostate Cancer	Estimated number of deaths that occurred due to prostate cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Lung Cancer Incidence	Estimated number of incidents reported that occurred due to lung cancer	National Cancer Institute State Cancer Profiles. 2013-17.

Category	Indicator	Indicator Description	Data Source
Cancer	Prostate Cancer Incidence	Estimated number of incidents reported that occurred due to prostate cancer	National Cancer Institute State Cancer Profiles. 2013-17.
Climate/ Natural Environment	% Change in Mean Travel Time to Work (minutes) - Silicon Valley	The change in mean travel time to work in the silicon valley by percent	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Air Pollution: PM2.5 Concentration (parts per million)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Harvard University Project (UCDA). 2018
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 0-4) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (0-4)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 5-17) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (5-17)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Prevalence, Adults	Percent Adults with Asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Asthma Prevalence, All Ages	Percent of population with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Asthma Prevalence, Seniors Aged 65+	Percent of population 65 and older with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Children Ever Diagnosed with Asthma (ages 1-17)	Percentage of children ages 1-17 whose parents report that their child has ever been diagnosed with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Coastal Flooding Risk	Coastal Flooding Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Deaths Due to Chronic Lower Respiratory Disease	Rate of deaths due to Chronic Lower Respiratory Disease	UCLA Center for Health Policy Research, California Health Interview Survey. 2020.
Climate/ Natural Environment	Drought Risk	Drought Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Heat Wave Risk	Heat Wave Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Respiratory Hazard Index	Respiratory Hazard Index	EPA National Air Toxics Assessment. 2014.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	River Flooding Risk	River Flooding Risk Index	FEMA Hazards Index. 2020
Climate/ Natural Environment	Road Network Density (miles of road per square mile of land)	Total road network density in terms of road miles per square mile	Environmental Protection Agency, EPA Smart Location Database. 2011.
Climate/ Natural Environment	Traffic Volume (per meter of roadway	Average traffic Volume per meter of roadway	EJSCREEN: Environmental Justice Screening and Mapping Tool
Climate/ Natural Environment	Travel Time to Work (minutes) - Silicon Valley	How much time is taken in minutes traveling to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Tree Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011.
Climate/ Natural Environment	Workers Commuting by Transit, Biking or Walking	Percentage of commuters commuting by transit, biking or walking	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Workers Driving Alone to Work	Percentage of worker who drive alone to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Workers Driving Alone with Long Commutes	Percentage of workers with long commute who drive alone to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Community Safety	Children in Foster Care (ages 0-20) (per 1,000)	Number of children and youth under age 21 in foster care per 1,000	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Children with Substantiated Cases of Abuse or Neglect (ages 0-17) (per 1,000)	Number of substantiated cases of abuse and neglect per 1,000 children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. 2019.
Community Safety	Deaths Due to Homicide	Percentage of Deaths due to homicide	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Community Safety	Domestic Violence-Related Calls for Assistance among Adults (ages 18-69) (per 1,000)	Number of domestic violence calls for assistance per 1,000 population	California Dept. of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (Jul. 2019); California Dept. of Finance, Population Estimates and Projections. 2019.
Community Safety	Felony Arrests among Juveniles (ages 10-17) (per 1,000)	Number of juvenile felony arrests per 1,000 youth ages 10-17	California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. 2019.
Community Safety	Firearm Related Deaths Rate	Number of firearm related deaths (per 100,000 pop.)	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	Median Length of Stay (months) in Foster Care among Children Entering Foster Care (ages 0-17)	Median length of stay in foster care, in months, for children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Rapes Rate - Silicon Valley	Rate of rapes in the Silicon Valley (per 100,000 pop.)	California Department of Justice; California Department of Finance. 2018.
Community Safety	Violent Crimes Rate	Violent crime rate (per 100,000 pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
COVID-19	Cumulative total deaths	Cumulative count of total number of deaths from COVID-19	The New York Times. (2022). California Coronavirus Tracker. *The New York Times.* Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 27, 2022.
COVID-19	Fully vaccinated (all ages)	Cumulative percentage of population (of county or state) who have received one (J&J) or two (mRNA) vaccinations and a booster shot (if last vaccination was at least six months prior)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 27, 2022.
COVID-19	Seven-day average number of daily cases	Number of new daily cases, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 27, 2022.

Category	Indicator	Indicator Description	Data Source
COVID-19	Seven-day average number of daily deaths	Number of deaths daily, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 27, 2022.
COVID-19	Seven-day average number of people hospitalized daily	Number of people hospitalized daily, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 27, 2022.
Diabetes and Obesity	5th Graders Body Composition at Health Risk (worst rating)	Percent of 5th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes and Obesity	5th Graders Meeting All Fitness Standards	Percentage of public school students in grade 5 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	7th Graders Body Composition at Health Risk (worst rating)	Percent of 7th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes and Obesity	7th Graders Meeting All Fitness Standards	Percentage of public school students in grade 7 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	9th Graders Body Composition at Health Risk (worst rating)	Percent of 9th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	9th Graders Meeting All Fitness Standards	Percentage of public school students in grade 9 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	Convenience Stores (per 1,000 population)	Rate of Convenience Stores per populations of 1,000	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015
Diabetes and Obesity	Deaths Due to Diabetes	Percent of deaths due to diabetes	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2014-16. 2019.
Diabetes and Obesity	Diabetes Prevalence	Percentage Adults with Diagnosed Diabetes (Age-Adjusted)	University of California Center for Health Policy Research, California Health Interview Survey. 2017.
Diabetes and Obesity	Diabetes, Share of Hospitalizations among Children (ages 0-17)	Percentage of hospital discharges among children ages 0-17 for diabetes	California Office of Statewide Health Planning and Development custom tabulation. 2019.
Diabetes and Obesity	Exercise Opportunities	Percent of the population that live in close proximity to a park or recreational facility	Esri Business Analyst. 2020.
Diabetes and Obesity	Food Environment Index	Food Environment Index	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	Fruit/Vegetable Consumption among Children (age 2-11), 5 or More Servings in Previous Day	Estimated percentage of children ages 2-11 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily	UCLA Center for Health Policy Research, California Health Interview Survey. 2018.
Diabetes and Obesity	Grocery Stores (per 1,000 population)	Grocery Stores rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Low Access to Grocery Store (percent population)	Percentage of population with low access to a grocery store	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Obesity (Adult)	Percentage of adults who were ever diagnosed with diabetes	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Supercenters & Club Stores (per 1,000 population)	Supercenters & Club Stores rate (per 1,000 population	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Walkability Index	Walkability Index	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	Percentage of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	California Dept. of Education, Test Results for California's Assessments. 2020.

Category	Indicator	Indicator Description	Data Source
Economic Stability	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	Percent of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	California Dept. of Education, Test Results for California's Assessments. 2020.
Economic Stability	Adults Without a College Degree	Percent of adults who did not receive a college degree	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Adults Without a High School Diploma	Percent of adults who did not receive a high school diploma	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	Estimated annual cost of full-time licensed child care for infant children ages 0-2	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Stability	Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center	Estimated annual cost of full-time licensed child care for preschool children ages 3-5	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Stability	Children Eligible for Free and Reduced-Price Lunch	Percentage of children who are eligible for free and reduced-price lunch	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Economic Stability	Children in Single-Parent Households	Percentage of Children who reside in Single-Parent households	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Children in Working Families for Whom	Percentage of children ages 0-12 in working families whom are able to access licensed childcare	California Child Care Resource and Referral Network, California Child Care Portfolio (Apr.

Category	Indicator	Indicator Description	Data Source
	Licensed Childcare is Available (ages 0-12)		2020); U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. public use Microdata. 2020.
Economic Stability	Children Living in Food Insecure Households (ages 0-17)	Percentage of children living in food insecure household under the age of 18	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.
Economic Stability	Children Living in Poverty	Percent Population Under Age 18 in Poverty	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Children Without Secure Parental Employment (ages 0-17)	Estimated percentage of children under age 18 living in families where no resident parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey	Population Reference Bureau, analysis of data from US Census Bureau, American Community Survey. 2012-16. microdata files. 2019.
Economic Stability	Economically Precarious Households by Education Level, High School Diploma or GED	Percent of Economically Precarious Households with Education Levels of High School Diploma or GED	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Education Level, Less Than High School	Percent of Economically Precarious Households with education levels Less Than High School	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by	Percent of economically precarious households with	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.

Category	Indicator	Indicator Description	Data Source
	Education Level, Some College or Associate's	education levels of some college or associate's	
Economic Stability	Economically Precarious Households by Employment Status, Full Time Full Year, 2 Adults	Percent of economically precarious households with employment status of full time, full year and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Employment Status, Not in Workforce, 2 Adults	Percent of economically precarious households with employment status of not being in the workforce with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Employment Status, Part Time Part Year, 2 Adults	Percent of economically precarious households with employment status of part time, part year, and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Gender (men)	Percent of economically precarious households with men	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Gender (women)	Percent of economically precarious households with women	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Elementary School Proficiency Index	Elementary School Proficiency index	HUD Policy Development and Research. 2016.
Economic Stability	Food Insecure	Percentage of Total Population with Food Insecurity	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.

Category	Indicator	Indicator Description	Data Source
Economic Stability	Free and Reduced-Price Lunch Enrollment	Percentage of Total Population with Reduced- Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Economic Stability	High School Graduates Completing College Preparatory Courses	Percentage of public school 12th grade graduates completing courses required for UC and/or CSU entrance, with a grade of C or better	California Dept. of Education, Graduates by Race and Gender (May 2018).
Economic Stability	Income Inequality	Number of the total population with income inequality	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Income Inequality - Gini Index	Gini Index Value	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Job Proximity Index (neighborhood)	Job proximity index	US Department of Housing and Urban Development Job Proximity Index. 2014.
Economic Stability	Math Scores (3rd graders)	Average 3rd grade math scores	Stanford Education Data Archive. 2018.
Economic Stability	Median Household Income	Median household income	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	On-Time High School Graduation	Percent of High Schoolers who graduated on time	Dept of Education ED Facts & state data sources. 2015-16.
Economic Stability	Poverty Rate	Rate of the population in poverty	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Economic Stability	Preschool Enrollment	Percentage of Population age 3-4 Enrolled in preschool	US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Ratio of Students to Academic Counselors (N students per counselor)	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (Academic Counselor)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest. 2019.
Economic Stability	Reading Below Proficiency (4th grade)	Percent of 4th graders reading below proficiency	California Department of Education. 2015-16.
Economic Stability	Reading Scores (3rd graders)	Percent of 3rd graders reading below proficiency	Stanford Education Data Archive. 2018.
Economic Stability	SNAP Enrollment	Percent Population Receiving SNAP Benefits	US Census Bureau, US Census Bureau, American Community Survey. 2012-16. 2012-16.
Economic Stability	Students Not Completing High School	Percentage of public high school students who do not complete high school, based on the four-year adjusted cohort dropout rate	California Dept. of Education, Cohort Outcome Data (Jun. 2017) & Adjusted Cohort Graduation Rate and Outcome Data. 2019.
Economic Stability	Students Truant from School (per 100 enrolled)	Number of K-12 public school students reported as being truant at least once during the school year per 100 students	California Dept. of Education, Truancy Data. 2017.
Economic Stability	Unemployment Rate	Rate of population who are unemployed	US Department of Labor, Bureau of Labor Statistics. 2018.

Category	Indicator	Indicator Description	Data Source
Economic Stability	Young People Not in School and Not Working	Percentage of young people ages 18-24 who are not in school and not working	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Children Living in Limited English-Speaking Households (ages 0-17)	Estimated percentage of children ages 0-17 living in households in which (i) no person age 14 or older speaks English only, and (ii) no person age 14 or older who speaks a language other than English speaks English very well	Population Reference Bureau, analysis of U.S. Census Bureau US Census Bureau, American Community Survey. 2012-16. public use microdata. 2019.
Health Care Access and Delivery	Children with Health Insurance Coverage (ages 0-18)	Estimated percentage of children ages 0-18 with and without health insurance coverage at the time of survey, by type of insurance and age group	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. Summary Files and Public Use Microdata. 2018.
Health Care Access and Delivery	Deaths Due to Cerebrovascular Disease (Stroke)	Rate of deaths due to Cerebrovascular Disease (Stroke)	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Health Care Access and Delivery	Deaths Due to Coronary Heart Disease	Rate of deaths due to Coronary Heart Disease	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Flu vaccinations (Medicare enrollees)	Percent of Medicare enrollees who received the flu shot	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Health Care Access and Delivery	Heart Disease Deaths	Rate of deaths due to Heart Disease	CDC, Interactive Atlas of Heart Disease and Stroke. 2016-18.
Health Care Access and Delivery	High Speed Internet	Percent of population with high speed internet	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Kindergarteners with All Required Immunizations	Percent of Kindergarteners with All Required Immunizations	California Dept. of Public Health, Immunization Branch, Kindergarten Data and Reports. 2019.
Health Care Access and Delivery	Limited English Proficiency	Percent of population with limited English Proficiency	US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Medicaid/Public Insurance Enrollment	Percent of population enrolled in Medicaid/ Public insurance	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Other Primary Care Providers (not PCPs) (N people per provider)	Ratio of people per provider for other primary care providers (not PCPs)	Chronic Conditions prevalence State/County Level: All Beneficiaries by Age, 2007-2018
Health Care Access and Delivery	Percent Uninsured	Percent Uninsured Population	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Population Over Age 75 with a Disability	Percent population over the age of 75 with a disability	US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Population with Any Disability	Percent population with any disability	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Premature Death (years of potential life lost before age 75)	Years of Potential Life Lost, Rate per 100,000 Population	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Health Care Access and Delivery	Premature Mortality Rate (under age 75, age-adjusted)	Mortality Rate for population under 75 years old	National Center for Education Statistics, NCES - Mortality Files. 2015-16.
Health Care Access and Delivery	Preventable Hospital Stays (Medicare enrollees)	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Health Care Access and Delivery	Primary Care Physicians Rate	Rate of Primary Care Physicians per 100,000 population	Health Resources and Service Administration Area Resource File. 2016-18.
Health Care Access and Delivery	Ratio of Students to School Nurses	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (School Nurse)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Ratio of Students to School Speech/Language/ Hearing Specialists	Ratio of Students to School Speech/Language/Hearing Specialists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Health Care Access and Delivery	Uninsured Children		US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Children Living in Crowded Households (ages 0-17)	Estimated percentage of children under age 18 living in households with more than one person per room of the house	Population Reference Bureau, analysis of U.S. Census Bureau US Census Bureau, American Community Survey. 2012-16. public use Microdata. 2019.
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 0-5)	Percentage of children/youth ages 0-5 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5	Percentage of children/youth ages 0-5 with blood lead levels of	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood

Category	Indicator	Indicator Description	Data Source
	mcg/dL, among Those Tested (ages 0-5)	at least 9.5 micrograms per deciliter, among those screened	Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels of at least 9.5 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.
Housing and Homelessness	Homeownership Rate	Percent of population that are homeowners	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Housing Affordability Index	Housing Affordability Index	Esri Business Analyst. 2020.
Housing and Homelessness	Median Rental Cost	Median rental cost in dollars per month	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Moderate Housing Cost Burden	Percent of moderate housing cost burden	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Neighborhood Deprivation Index	Neighborhood Deprivation Index	UCDA calculation with U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. data
Housing and Homelessness	Overcrowded Housing	Percent of population living in houses with more than one person per room of the house	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Percent of Income for Mortgage	Percent of income spent on home mortgage	Esri Business Analyst. 2020.
Housing and Homelessness	Population Density (people per square mile)	Population Density measured in people per square mile	US Department of Labor, Bureau of Labor Statistics. 2018.
Housing and Homelessness	Residential Segregation - Black/White	Residential Segregation Index amongst Black and White population	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Residential Segregation - Non-White/White	Residential Segregation Index amongst Non-White and White population	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Severe Housing Cost Burden	Percent of population with a severe housing cost burden	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Severe Housing Problems (one or more of: overcrowding, high costs, lack of kitchen, lack of plumbing)	Percent of population with one or more of the following severe housing problems; overcrowding, high costs, lack of kitchen or lack of plumbing	Comprehensive Housing Affordability Strategy (CHAS) data. 2013-17. .
Housing and Homelessness	Students Recorded as Homeless at Some Point during the School Year	Percentage of public school students recorded as being homeless at any point during a school year	California Dept. of Education, Coordinated School Health and Safety Office custom tabulation & California Basic Educational Data System. 2019.
Maternal and Infant Health	Babies Born at a Very Low Birthweight	Percentage of infants born at very low birthweight (less than 1,500 grams or about 3 lbs., 5 oz)	California Dept. of Public Health, Birth Statistical Master Files; CDC WONDER, Natality Public-Use Data. 2019.

Category	Indicator	Indicator Description	Data Source
Maternal and Infant Health	Babies Born to Mothers Who Received Prenatal Care in the First Trimester	Percent of Babies Born to Mothers Who Received Prenatal Care in the First Trimester	California Dept. of Public Health, Birth Statistical Master Files. 2020.
Maternal and Infant Health	Babies Breastfed Exclusively in Hospital	Percent of babies breastfed exclusively in the hospital	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.
Maternal and Infant Health	Babies Breastfed in Hospital (at Any Time)	Percent of babies breastfed in the hospital at any time	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.
Maternal and Infant Health	Infant Deaths (per 1,000 live births)	Rate of infant deaths per 1,000 live births	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Maternal and Infant Health	Population Under Age 18	Percent of the population is younger than 18 years old	US Census Bureau, American Community Survey. 2012-16.
Maternal and Infant Health	Preterm Births	Percent of births taken place before mother was at full term	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Maternal and Infant Health	Teen Births (per 1,000 females ages 15-19)	Number of births per 1,000 young women ages 15-19	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data. 2019.

Category	Indicator	Indicator Description	Data Source
Oral/Dental Health	Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.	Percent of Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.	University of California, Berkeley, Center for Social Sciences Research California Child Welfare Indicators Project, 2018
Oral/Dental Health	Dentists Rate	Dentists per population of 100,000	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Oral/Dental Health	ED Visits for Non-Traumatic Dental Conditions	Rate of ED Visits for Non-Traumatic Dental Conditions	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Oral/Dental Health	Never Had Dental Exam (ages 2-11)	Percent of Children Ages 2-11 who had never received a dental exam	University of California Center for Health Policy Research, California Health Interview Survey. 2016.
Sexually Transmitted Infections	Chlamydia Incidence	Chlamydia rates per 100,000 people, 2007-2016, Santa Clara County	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	Chlamydia Incidence among Youth (ages 10-19)	Number of chlamydia infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics:

Category	Indicator	Indicator Description	Data Source
			2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018)
Sexually Transmitted Infections	Early Syphilis	Early syphilis rates (per 100,000 people	CalREDIE & CDPH-STD
Sexually Transmitted Infections	Gonorrhea Incidence among Youth (ages 10-19)	Number of gonorrhea infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018).
Sexually Transmitted Infections	HIV Prevalence (not including AIDS), Age 13 and Over	Rate of HIV infections (not including AIDS) per 100,000 people age 13 and over	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	HIV/AIDS Deaths	Rate of deaths caused by HIV/AIDS	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Sexually Transmitted Infections	HIV/AIDS Prevalence	HIV/AIDS rates (Per 100,000 Pop.)	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.

Category	Indicator	Indicator Description	Data Source
Unintended Injuries/ Accidents	Bicycle Accident ED Visits (ages 0-12)[3]	Bicycle accident ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Falls Deaths (ages 65+)	Falls death rate amongst elderly ages 65 and older (per 100,000)	California Department of Public Health, California EpiCenter. 2013-14.
Unintended Injuries/ Accidents	Falls ED Visits (ages 0-12)	Falls ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Falls ED Visits (ages 65+)	Falls ED visit rate amongst adults 65 and older (per 100,000)	California Department of Public Health, California EpiCenter. 2013-14.
Unintended Injuries/ Accidents	Falls Hospitalizations (ages 0-12)	Falls hospitalization rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Falls Hospitalizations (ages 65+)	Falls hospitalization rate amongst children ages 0-12 (per 100,000)	California Department of Public Health, California EpiCenter. 2013-14.
Unintended Injuries/ Accidents	Injury Deaths (Intentional and Unintentional)	Age-Adjusted Rate of unintentional injury deaths (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.

Category	Indicator	Indicator Description	Data Source
Unintended Injuries/ Accidents	Motor vehicle crash deaths	Age-adjusted number of deaths due to motor vehicle crashes per 100,000 population	NCHS National Vital Statistics System. 2015-2019.
Unintended Injuries/ Accidents	Motor vehicle crash ED visits age 0-12	Motor vehicle crash ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Pedestrian accident deaths	Age-adjusted number of deaths due to pedestrian accidents per 100,000 population	NCHS National Vital Statistics System. 2015-2019.
Unintended Injuries/ Accidents	Pedestrian accident ED visits age 0-12	Pedestrian accident ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Poisoning – share of hospitalizations among children ages 0-17	Percentage of hospital discharges among children ages 0-17 for poisoning	California Office of Statewide Health Planning and Development custom tabulation (Sept. 2019).
Unintended Injuries/ Accidents	Poisoning accidents age 0-12 hospitalizations	Poisoning accidents hospitalization rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Unintended Injuries/ Accidents	Poisoning accidents ED visits age 0-12	Poisoning accident ED visit rate amongst children ages 0-12 (per 100,000)	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.

Category	Indicator	Indicator Description	Data Source
Unintended Injuries/ Accidents	Traumatic injuries – share of hospitalizations among children ages 0-17	Percentage of hospital discharges among children ages 0-17 for traumatic injuries	California Office of Statewide Health Planning and Development custom tabulation (Sept. 2019).

ATTACHMENT 3. COMMUNITY ASSETS AND RESOURCES

Programs and resources available to meet identified community health needs are listed on the following pages, organized in two categories:

- Assets. Includes alliances, initiatives, campaigns, and general resources
- Resources. Includes public/government services, school-based services, community-based organization services, and clinical hospitals and clinic services

GENERAL RESOURCES

- 211 (United Way). A free, confidential referral and information service that helps people find local health and human services by web, phone, and text.
- Aunt Bertha aka FindHelp.org
- Community Health Partnership
- Ethiopian Community Services
- FIRST 5 Santa Clara County (children 0-5)
- The Health Trust
- Listing of Santa Clara County programs and services
- Santa Clara County Public Health Department
- Vietnamese-American Service Center

COMMUNITY HEALTH NEEDS

BEHAVIORAL/MENTAL HEALTH

Assets

- ASPIRE youth mental health program
- CareSolace
- Corporation/El Centro de Bienestar
- Depression and Bipolar Support Alliance (DBSA)
- Gardner Family Care
- Gilroy Behavioral Health
- HEARD (Health Care Alliance for Response to Adolescent Depression)
- Hope Counseling Center Services
- NAMI
- Project Safety Net (Palo Alto) youth suicide prevention coalition
- South Bay Project Resource
- Tobacco Free Coalition Santa Clara

- UJIMA Adult & Family Services
- Young Adult Transition Team same as La Plumas Mental Health

Resources

- Adolescent Counseling Services
- allcove
- Alum Rock Counseling Center
- Asian Americans for Community Involvement (AACI) support services for survivors of domestic violence
- Bay Area Children's Association (BACA)
- Bill Wilson Center
- Billy DeFrank LGBT Community Center
- CA Dept of Rehabilitation, San Jose District
- Caminar
- Casa de Clara
- Catholic Charities
- Chamberlain's Mental Health (Gilroy)
- Child Advocates of Silicon Valley
- Community Health Awareness Council (CHAC)
- Community Solutions
- Counseling and Support Services for Youth (CASSY)
- Crestwood Behavioral Health
- County of Santa Clara Behavioral Health Services, including Mental Health Crisis Services and The Q Corner (LGBTQ+ support)
- Discovery Counseling Center (Morgan Hill)
- Eastern European Services Agency
- Eating Disorder Resource Center of Silicon Valley
- Ethnic Cultural Community Advisory Committees (ECCAC)
- Grace Community Center
- In-Home Supportive Services (IHSS)
- Jewish Family Services of Silicon Valley
- Josefa Chaboya de Narvaez Mental Health
- Law Foundation of Silicon Valley Mental Health Advocacy Project
- LGBT Youth Space Drop-In Center
- LifeMoves counseling
- Maitri support services for survivors of domestic violence
- MayView Community Health Centers, members of Ravenswood Family Health Network (Mountain View, Palo Alto, Sunnyvale)
- Mekong Community Center
- Mental Health Urgent Care
- Momentum for Mental Health

- Momentum-Alliance for Community Care
- NAMI (National Alliance on Mental Illness)
- Next Door Solutions support services for survivors of domestic violence and gender-based violence, therapy, counseling, support groups
- Parents Helping Parents
- Ravenswood Family Health Center
- Rebekah's Children's Services (Gilroy)
- Recovery Café
- San José Behavioral Health Hospital
- San José Vet Center
- Santa Clara Valley Medical Center Sunnyvale Behavioral Health Center
- Services for Brain Injury
- Silicon Valley Independent Living Center (SVILC)
- Sourcewise
- Supporting Mamas
- Uplift Family Services
- YMCA Silicon Valley Project Cornerstone and support services for survivors of domestic violence

CANCER

Assets

- American Cancer Society
- Bonnie J. Addario Lung Cancer Foundation
- Cancer Support Community
- Leukemia & Lymphoma Society
- Vietnamese Reach for Health Initiative

Resources

- Asian American Cancer Support Network
- Bay Area Cancer Connections
- Cancer CAREpoint
- Latinas Contra Cancer
- Real Options - mammograms

CLIMATE/NATURAL ENVIRONMENT

Assets

- Acterra
- Audubon Society of Santa Clara County
- California League of Conservation Voters

- Canopy
- Committee for Green Foothills
- Midpeninsula Regional Open Space District
- Peninsula Open Space Trust
- San Francisquito Watershed Council
- Santa Clara County Parks
- The Santa Clara Valley Open Space Authority
- Sierra Club – Loma Prieta Chapter

COMMUNITY SAFETY

Assets

- County of Santa Clara East San José Prevention Efforts Advance Community Equity Partnership - PEACE Partnership
- Promoting Healthy Relationships Campaign in South San José/South County
- SafeCare Home Visiting Services
- Safe Kids Santa Clara/San Mateo coalition
- Santa Clara County Child Abuse Prevention Council
- Santa Clara County Human Relations Commission
- Santa Clara County Office of Gender-Based Violence Prevention
- Santa Clara County Office of Women's Policy: Santa Clara County Domestic Violence Council
- Santa Clara County Public Health Department, including "We All Play a Role" in Violence Free Communities Campaign, Safe and Healthy Communities Division (violence and injury prevention) including anti-bullying resources for parents
- South County United for Health collaborative
- South County Youth Task Force

Resources

- Alum Rock Counseling Center
- Asian Americans for Community Involvement – Asian Women's Home, Center for Survivors of Torture
- Bill Wilson Center: Safe Place
- CHAC (Community Health Awareness Counseling)
- Community Solutions
- Family & Children Services of Silicon Valley: Domestic Violence Survivor Support Services
- GoNoodle online lessons on bullying awareness
- ICAN (Vietnamese parenting classes)
- Maitri: Anjali Transitional Housing Program

- Next Door Solutions to Domestic Violence: The Shelter Next Door
- Peace Builders Program (elementary schools)
- PlayWorks
- Rebekah Children's Services
- San José Mayor's Gang Prevention Task Force
- San José Police Department Family Violence Center
- Santa Clara County Juvenile Probation Department programs
- StrongHearts Native Helpline: domestic and sexual violence helpline
- Sunday Friends violence prevention classes
- Uplift Family Services counseling for all high schools in the Campbell Union High School District; Crisis Intervention Programs
- YMCA Silicon Valley / Project Cornerstone, Support Services, Emergency Shelter

DIABETES & OBESITY

See Economic Stability for free food resources.

Assets

- Bay Area Nutrition and Physical Activity Collaborative (BANPAC)
- California WALKS Program
- Community Alliance with Family Farmers (CAFF) Foundation:
- Green Belt Alliance
- Pacific Institute
- Santa Clara County Diabetes Prevention Initiative
- Santa Clara County Office of Education's Coordinated School Health Advisory Council
- Sunnyvale Collaborative
- YMCA National Diabetes Prevention Program

Resources

- African American Community Services Agency
- Asian Americans for Community Involvement Clinic
- Boys and Girls Clubs of Silicon Valley
- Breathe CA
- Challenge Diabetes Program
- Children's Discovery Museum
- Choices for Children: 5 Keys for Child Care
- Community Service Agency Mountain View
- County of Santa Clara Parks and Recreation Department (incl. community centers)
- Eritrean Community Center

- Ethiopian Community Center
- FIRST 5 Family Resource Centers
- Fit Kids Foundation
- Gardner Clinic
- Healthier Kids Foundation
- Kaiser Permanente Farmer's Markets (open to the community)
- Lucile Packard Children's Hospital Pediatric Weight Control Program
- Playworks
- Project Access
- San Francisco Planning & Urban Research (SPUR) Double Up Food Bucks
- Santa Clara County Public Health Department Breastfeeding Program
- Silicon Valley HealthCorps
- Second Harvest Food Bank
- Somos Mayfair
- Sunnyvale Community Services
- THINK Together
- Veggielution: Healthy Food Access and Engagement for Low-Income Families
- West Valley Community Services

ECONOMIC STABILITY

Education, employment, and poverty. See also Housing and Homelessness.

Assets

- California Budget & Policy Center
- Silicon Valley Leadership Group

Resources

- African American Community Services Agency
- allcove
- Bay Area Legal Aid
- CalFresh
- CalWorks
- Catholic Charities
- Center for Employment Training (CET)
- City of San José employment resource center
- Community Service Agencies (Mountain View/Los Altos, Sunnyvale, West Valley)
- Connect Center CA (Pro-match and Nova job centers)

- Day Worker Center (Mountain View)
- Emergency Assistance Network of Santa Clara County
- Employment Development Department
- Eritrean Community Center
- Occupational Training Institute
- Social Services Agency of Santa Clara County
- SparkPoint
- United Way Bay Area
- Veterans Administration employment center
- Women, Infants, and Children (WIC) Nutrition Services
- Work 2 Future

Food Resources

- The Food Connection
- Fresh Approach –mobile food pantry
- Hope's Corner
- Loaves and Fishes
- Meals on Wheels (The Health Trust and Sourcewise)
- Santa Maria Urban Ministries
- St. Joseph's Cathedral
- St. Joseph's Family Center—food bank and hot meals (Gilroy)
- St. Vincent De Paul
- Salvation Army
- Second Harvest Food Bank
- Valley Verde
- Vietnamese-American Service Center

HEALTH CARE ACCESS AND DELIVERY

Health Care Facilities and Systems

- El Camino Hospital – Los Gatos
- El Camino Hospital – Mountain View
- Good Samaritan Hospital
- Kaiser Foundation Hospital – San Jose
- Kaiser Foundation Hospital – Santa Clara
- Lucile Packard Children's Hospital Stanford
- O'Connor Hospital
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara Valley Health & Hospital System
- Stanford Health Care

- VA Hospital Menlo Park (U.S. Department of Veterans Affairs)
- VA Palo Alto Health (U.S. Department of Veterans Affairs)

Community Clinics

- Asian Americans for Community Involvement
- allcove (physical health consultation for youth 12-25)
- Bay Area Community Health (formerly Foothill Community Health Center; multiple clinics)
- Cardinal Free Clinics (incl. Pacific Free Clinic)
- Gardner Health Services
- Indian Health Center
- Mar Monte Community Clinic
- MayView Community Health Centers, members of Ravenswood Family Health Network (Mountain View, Palo Alto, Sunnyvale)
- Medical Respite Program
- Planned Parenthood Mar Monte
- Peninsula Healthcare Connection
- Ravenswood Family Health Center
- Roots Community Health Center
- RotaCare Bay Area
- School Health Clinics of Santa Clara County

Mobile Health Services

- County of Santa Clara Public Health Department Needle Exchange Program sites
- Gardner Mobile Health Center
- Health Mobile (Dental)
- Lucile Packard Children's Hospital Teen Van
- Santa Clara Valley Homeless Health Care Program Van

Other Access-Related Assets

- Caltrain
- Santa Clara Valley Bicycle Coalition
- Santa Clara Valley Transit Authority (VTA)
- Silicon Valley Leadership Group – Advocacy
- Silicon Valley Bicycle Coalition – Advocacy
- SPUR – Advocacy

Other Access-Related Resources

- Avenidas
- City Team Ministries

- College health centers (public and private universities [4], community colleges [7])
- Community Services Agency
- El Camino Health Roadrunners
- Heart of the Valley Escorted Transportation (nonprofit)
- Love Inc.
- Mountain View Community Shuttle
- Outreach & Escort, Inc.
- Peninsula Family Services – Ways to Work
- School health clinics (San José High, Overfelt, Washington, Franklin-McKinley Neighborhoods)

HOUSING & HOMELESSNESS

Assets

- Abode Services—supportive housing- county paying for success initiative for chronic homelessness
- "All the Way Home" Campaign to End Veteran Homelessness – City of San José, Santa Clara County and the Housing Authority have set a goal of housing all of the estimated 700 homeless veterans by 2017 (new)
- Catholic Charities
- Community plan to end homelessness in Santa Clara County
- Destination Home
- MyHousing.org
- Palo Alto Housing Corporation
- Santa Clara County Housing Task Force
- Santa Clara County Housing Authority
- Santa Clara County Office of Supportive Housing
- VA Housing Initiative

Resources

- Asian Americans for Community Involvement (AACI) domestic violence shelter
- American Vets Career Center
- Bill Wilson Center emergency shelter for youth
- Casa de Clara (Catholic volunteer group—services to women and children in downtown San José including shelter, food, clothing, emotional support, and referrals for housing, employment, and counseling)
- Catholic Charities Housing—affordable housing units
- Chinese Community Center of the Peninsula

- CityTeam
- Community Services Agency emergency shelter
- Community Service Agency Homeless Prevention Services
- Community Solutions domestic violence shelter
- Destination Home
- Downtown Streets Team
- Dress for Success—interview suits and job development
- EHC Life Builders Emergency Housing Consortium
- Foster youth group home providers
- Gilroy Compassion Center
- Goodwill Silicon Valley
- The Health Trust Housing for Health
- HomeFirst
- Hope Services—employment for adults with developmental disabilities
- Housing Opportunities for Persons with AIDS
- InnVision the Way Home
- Life Moves (Homeless Housing)
- Love Inc.
- Maitri transitional housing for domestic violence survivors
- New Directions
- New Hope House
- Next Door Solutions domestic violence shelter
- NOVA Workforce development
- Rebuilding Together (repairs to keep people in homes)
- Sacred Heart Community Services
- Sacred Heart Community Services emergency assistance
- St. Joseph emergency assistance
- Salvation Army
- Senior Housing Solutions
- Sunnyvale Community Services—housing and emergency assistance
- Unity Care—Foster youth housing
- Unity Care—foster youth employment assistance Community-Based Organizations - Employment
- West Valley Community Services emergency assistance
- YWCA Silicon Valley domestic violence shelter

MATERNAL/INFANT HEALTH

Assets

- Healthier Kids Foundation
- March of Dimes

Resources

- Birthright of San José
- Casa Natal Birth and Wellness Center
- Continuation schools (parenting classes)
- First 5 Santa Clara County New Parent Kits
- Grail Family Services
- Informed Choices (Gilroy)
- La Leche League (Campbell, San Jose, Santa Clara)
- Nursing Mothers Counsel
- Real Options — prenatal care
- San Juan Diego Women's Center / Birth and Beyond
- Santa Clara County Department of Public Health: Black Infant Health (BIH) Program, Breastfeeding Support Program, Nurse-Family Partnership Program home visitation model, WIC
- Supporting Mamas

ORAL/DENTAL HEALTH

Assets

- County of Santa Clara Public Health Department Oral Health Program
- First 5 – oral health education and referral services
- Santa Clara County Dental Society
- Women, Infants, and Children (WIC)

Resources

- Children's Dental Center
- Foothill Community Health Center
- Head Start
- Health Mobile
- Healthier Kids Foundation
- Onsite Dental Care Foundation
- Santa Clara Valley Medical Center Dental Clinics

SEXUALLY TRANSMITTED INFECTIONS

Assets

- Santa Clara County HIV Commission

Resources

- Asian Americans for Community Involvement: HOPE Program

- Asian American Recovery Services
- Billy DeFrank LGBT Community Center
- Community Health Partnership—Every Woman Counts, Transgender Health
- The Health Trust AIDS Services
- The LGBTQ Youth Space
- Real Options
- Santa Clara County Needle Exchange Program
- Teen Success

UNINTENDED INJURIES/ACCIDENTS

Assets

- The Health Trust Healthy Aging Partnership, Agents for Change promoting older adult pedestrian safety
- SafeKids Santa Clara County coalition
- Safe Routes to School
- Santa Clara County Public Health Department Falls Prevention Task Force

Resources

- Catholic Charities Senior Wellness Centers fall prevention classes
- City departments of transportation
- Korean American Community Services: Matter of Balance program
- Santa Clara County Poison Control
- Santa Clara County Public Health Department Center for Chronic Disease and Injury Prevention
- Matter of Balance fall prevention program for older adults
- Stepping On fall prevention program for older adults
- Strong for Life free group exercise program for seniors promoting strength, mobility,
- YMCA (free camps and scholarships for swim lessons)

ATTACHMENT 4. QUALITATIVE RESEARCH PROTOCOLS

CHNA KII Protocol - Professionals (60 min.)

PREP

- Schedule call, send survey and main questions [*minimum: 1 week ahead of time*].
- 48 hours before:
    - Review the individual's background on LinkedIn and/or their organization's website; review their survey response (health needs they identified).
    - Send reminder email; remind them of their survey response (most pressing needs among those they serve) and the main questions.
        - If they didn't respond to the survey, include the link and ask them to respond ASAP before the interview.

INTRODUCTION (5 MIN.)

[Start recording from the beginning of the session.]

- Welcome and thanks
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA).
    - A CHNA is required of all non-profit hospitals in the U.S. every three years. The report based on this assessment will be a snapshot in time; this report will be published next year (in 2022) and consulted through 2025.
    - Will inform investments that hospitals make to address community needs.
- Our interview is scheduled for sixty minutes -- does that still work for you?
- Today's questions:
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs
    - How things may have changed in the past few years (trends)
    - Any models or best practices you know of for addressing the needs
    - Areas of concern
    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
    - Will record so that we can get the most accurate record possible
    - Will not share the audio itself; transcript will go to hospitals
    - Hospitals will make decisions about which needs they can best address

○ We can keep anything confidential, even the whole interview. Let me know any time.
○ *[First half depends on their survey response:]* Plan to name *you/your organization* in the report where we list all the experts we consulted, but will not attach your name to any quotes we might use.
● Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email.]

**KICK ON
ZOOM
RECORDING!**

HEALTH NEEDS DISCUSSION (35 MIN.)

You identified [*read list*] as the most pressing needs for the people you serve. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. Please describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. *Probe:* Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location (DUAL COUNTY -- between counties?), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
[*Prompts for populations if they are having trouble thinking of any*: DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lag what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you've heard about, or practices you've read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 MIN.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 MIN.)

I know you didn't identify the coronavirus as a specific need; would you mind...
● Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
● What inequities are you seeing?
● How have things changed since COVID began?

ADDITIONAL COMMENTS (TIME PERMITTING)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 MIN.)

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this interview, please feel free to send me an email.

Thank you so much for contributing your expertise and experience to the CHNA.

CHNA FG Protocol - Professionals (90 min.)

PREP

- Schedule group of 8-10 participants. If needed, create recruitment email/flyer for hospital rep. Ahead of time, send participants:
    - Pre-focus group survey and main questions [*minimum: 1 week ahead of time*].
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- 48 hours before, prepare:
    - Review the individuals' backgrounds on LinkedIn and/or their organizations' websites; review their survey responses (health needs they identified).
    - Send reminder email; if any didn't respond to the survey, include the link and ask them to respond ASAP before the focus group.
    - Ensure you have PDF of agenda/questions ready.

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is _____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA)
    - The report based on this assessment will be a snapshot in time, required of all non-profit hospitals in the U.S. every three years; this report will be published next year (in 2022) and consulted through 2025
    - Will inform investments that hospitals make to address community needs
- Today's questions: *show slide*
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs
    - How things may have changed recently (trends)
    - Any models or best practices you know of for addressing the needs
    - Areas of concern
    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:

- ○ We are recording this group so that we can make sure to get your words right.
  - ○ Will not share the video itself; transcript or notes will go to hospital
  - ○ When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
  - ○ If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- ● Guidelines:
  - ○ We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
  - ○ We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
  - ○ It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- ● Any questions before I begin? [If we don't have the answer, commit to finding it and sending later via email.]

HEALTH NEEDS DISCUSSION (45 MIN.)

As a group, you identified [*read list*] as the most pressing needs for the people you serve -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."
   Probe: Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location (DUAL COUNTY -- between counties), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
   [*Prompts for populations if they are having trouble thinking of any:* DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration

status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lags what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you have heard about, or practices you have read about in literature.]

OK, let's get started. For [name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]

Only if their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 MIN.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 MIN.)

I know you didn't identify the coronavirus as a specific need; would you mind...
● Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
● What inequities are you seeing?
● How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (TIME PERMITTING)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this

spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 MIN.)

Thank you for contributing your expertise and experience to the CHNA.

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this discussion, please feel free to send me an email.

CHNA Zoom[79] FG Protocol – Community Members (90 min.)

PREP

- Work with host to schedule group of 8-10 participants. If needed, create recruitment email/flyer for host. Ahead of time, have host send participants:
    - Pre-focus group health needs survey [depending on group]
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- Prepare:
    - PDF of agenda/questions
    - Review pre-survey responses
    - PDF of health needs list (including definition of health care access) [if no pre-survey]
    - Zoom poll of health needs [if no pre-survey]

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is _____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- Purpose:
    - You are here today to let nonprofit hospitals know what the biggest health needs are in our county.
    - This is called the Community Health Needs Assessment (CHNA), which is required every three years by the IRS, so it is an official, public report.
    - Hospitals will use this to plan how they will use their resources to improve health and wellness in our county.
- Today's questions: *show slide*
    - What are the needs?
        - Which groups of people are doing better or worse when it comes to the needs?
        - What can hospitals/health systems do to improve health in the community?
    - We will also talk about your pandemic experience and what you think the long-term effects will be (not just on health, but overall).

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[79] If planning to do a What'sApp FG, can revise this protocol.

- ○ Lastly, we will get your perspective about equity and cultural competence when it comes to health care.
- ● Confidentiality:
  - ○ We are recording this group so that we can make sure to get your words right.
  - ○ We will only use first names here -- you will be anonymous. (If you want to use a fake name that's OK, too!)
  - ○ Will not share the video itself; transcript will go to hospital.
  - ○ When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
  - ○ If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!
- ● Guidelines:
  - ○ We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
  - ○ We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
  - ○ If no pre-survey: You have a choice of a $25 credit to Amazon or Target. Please chat your email address to my colleague [*name*] now, along with your choice. If you don't tell her which one you prefer, we'll send you an Amazon credit.
  - ○ It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- ● Any questions before we begin? *[If we don't have the answer, commit to finding it and sending later via email.]*

HEALTH NEEDS DISCUSSION (45 MIN.)

If no pre-survey: We are going to show you a list of health needs in our county from 2019. [*show slide*] You'll see that there are regular physical health conditions, like cancer (we added COVID), and other kinds of needs, like food insecurity and housing. We're going to read the needs, then put up a poll for you to choose the three you think are the most urgent and important in your community.

[Read off needs, then launch zoom poll. Give people 2 minutes to complete.]

If collected by pre-survey, start here: As a group, you identified [*read list*] as the most important needs in your community -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **what the need looks like in your community**, including what barriers might exist to people having better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."
    [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **what groups of people are better or worse off than others** for that need and explain how or why.
    [*Prompts for populations if they are having trouble thinking of any*: income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Finally, I'll ask you to describe, for that need, **what you think the people in charge should do to support, enhance, facilitate, or fund** to help communities become healthier / improve everyone's lives.

OK, let's get started. For [name first need], [start at Q1; address all three questions, then go back to Q1-3 with second need, then again with third, then go on to the questions below.]

YOUR PANDEMIC EXPERIENCE (15 MIN.)

We all know that the coronavirus has been really disruptive to our normal lives since March of 2020. Specifically, we want to hear about your experience with getting health care since then. First, we'll review the answers to the poll questions, then we'll talk more.

- Poll question results:
    a. What is your health insurance status? *[Describe results].*
    b. Do you have a doctor you see regularly? *[Describe results].*
    c. Has the pandemic made it more or less difficult to access the health care you need? *[Describe results].*

Tell us more about how the pandemic affected your ability to access health care.
[Potential probes] Tell us more about your reasons for putting off a regular appointment or not seeing a provider for something that went wrong. Tell us your opinion of virtual appointments. How did you like them? What was good about them (maybe even better than an in-person appointment)? What about them could be improved?

- **Not only thinking about healthcare, but more generally:** What do you think the long-term impact of the pandemic will be on you, your family, and your friends and neighbors?

YOUR PERCEPTION OF EQUITY ISSUES (20 MIN.)

As you probably know, people have been talking about issues of <u>equity</u> much more than ever before. "Equity" means fairness and unbiased treatment. When it comes to health care, what's your perspective about equity and cultural competence? For example:
- What do you think are the barriers to everyone having the same access to health care?
- What do you think are the barriers to everyone getting the same quality of health care?
- We've heard that not all providers know how to care for people in a respectful and culturally competent way. What do you think those providers are missing? What do you think they need to learn?
- What can hospitals and health systems do to best address equity for you and the people in your community?

CLOSING (1 MIN.)

Thank you for contributing your opinions and experience to the CHNA.

You can contact us if you want any more information about the assessment. If anything occurs to you later that you would like to add, please feel free to send me an email.

ATTACHMENT 5. IRS CHECKLIST

Section §1.501(r)(3) of the Internal Revenue Service code describes the requirements of the CHNA.

Federal Requirements Checklist		Regulation Section Number	Report Reference
A. Activities Since Previous CHNA(s)			
Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.		(b)(5)(C)	Section #2
Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).		(b)(6)(F)	Section #7 & Attachment 6
B. Process & Methods			
Background Information			
Identifies any parties with whom the facility collaborated in preparing the CHNA(s).		(b)(6)(F)(ii)	Section #4
Identifies any third parties contracted to assist in conducting a CHNA.		(b)(6)(F)(ii)	Section #4
Defines the community it serves, which: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.		(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.		(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.			Section #3
Health Needs Data Collection			
Describes data and other information used in the assessment:		(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).		(b)(6)(F)(ii)	Attachments 1 & 2
b. Describes methods of collecting and analyzing the data and information.		(b)(6)(ii)	Section #5

Federal Requirements Checklist		Regulation Section Number	Report Reference
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.		(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.		(b)(6)(F)(iii)	Section #5
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.		(b)(5)(i)(A)	Section #5 & Attachment 1
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)		(b)(5)(i)(B)	Section #5 & Attachment 1
I. Medically underserved populations		(b)(5)(i)(B)	Section #5 & Attachment 1
II. Low-income populations		(b)(5)(i)(B)	Section #5 & Attachment 1
III. Minority populations		(b)(5)(i)(B)	Section #5 & Attachment 1
c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).		(b)(5)(ii)	Section #5 & Attachment 1
Describes how such input was provided (e.g., through focus groups, interviews or surveys).		(b)(6)(F)(iii)	Section #5 & Attachment 1
Describes over what time period such input was provided and between what approximate dates.		(b)(6)(F)(iii)	Section #5 & Attachment 1
Summarizes the nature and extent of the organizations' input.		(b)(6)(F)(iii)	Section #5 & Attachment 1
C. CHNA Needs Description & Prioritization			
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).		(b)(4)	Section #6
Prioritized description of significant health needs identified.		(b)(6)(i)(D)	Section #6

Federal Requirements Checklist			Regulation Section Number	Report Reference
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.			(b)(6)(i)(D)	Section #5
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.			(b)(4) (b)(6)(E)	Attachment 3
D. Finalizing the CHNA				
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.			(a)1	Section #2
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).			(b)(iv)	Section #8
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).			(b)(7)(i)(A)	By 6/30/2022
	a.	May not be a copy marked "Draft".	(b)(7)(ii)	By 6/30/2022
	b.	Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	By 6/30/2022
	c.	Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	By 6/30/2022
	d.	Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	By 6/30/2022
	e.	Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	By 6/30/2022
	f.	Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	By 6/30/2022

Further IRS requirements available:

- §1.501(r)-3(b)(iv) and (v): separate and joint CHNA reports
- §1.501(r)-3(d): requirements that apply to new hospital facilities, transferred or terminated hospital facilities, and newly acquired hospital facilities
- §1.501(r)-3(a)(2) and (c): implementation strategy requirements

ATTACHMENT 6. FY20 – FY22 YEAR-OVER-YEAR DASHBOARD

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY	Primary Care/Safety Net Clinic	Individuals served	-	-	700	895	210	185
		Medical appointments	-	-	1000	1,885	800	592
		Patients screened for depression with a positive result who are offered integrated behavioral health services	-	-	80%	74%	80%	92%
		Patients who rate their MA or PN as excellent or good and will recommend AACI to their family and friends	-	-	-	-	90%	96%
		Female patients receiving a cervical cancer screening	-	-	68%	47%	90%	64%
	Free Medication for Uninsured and Underserved	Patients served (full program)	2,800	3,520	3,000	2,906	2,100	1,813
		Prescriptions filled (full program)	22,000	32,767	28,000	34,601	16,000	16,895
		Patients who report that they are very satisfied with the quality of service	97%	97%	97%	100%	97%	92%
		Patients who reported that they are very satisfied with the time waited for services	97%	91%	97%	87%	97%	92%
		Patients who reported that they are very satisfied with the time waited for medication information	97%	88%	97%	93%	97%	92%
	Children's Asthma Program	Individuals served (children, parents, teachers and care providers) through air quality assessment and asthma management training	800	630	350	622	100	890
		Children with asthma receiving multi-session asthma education who show an increase in knowledge/skills	70%	65%	50%	72%	50%	83%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY		Home, school, and childcare centers served that reduce environmental hazards/triggers for asthma, as measured by assessments of respiratory hazards using the EPA's best-practice environmental checklist	60%	100%	50%	0%	50%	100%
	School Nurse Program #1	Students served	3,350	2,885	2,700	2,668	1,200	1,000
		Hearing screenings- all TK, K, grade 2,5 & 8th graders	-	-	-	-	1,000	466
		Vision Screenings- all TK, K, grades 2,5, & 8th graders	-	-	-	-	1,000	466
		Staff trained in Epi-Pen	-	-	-	-	40%	30%
		Students with failed vision screening who see a provider and receive glasses or other needed services	-	-	-	-	10%	0%
		Students in Transitional Kindergarten, Kindergarten & 7th grade out of compliance with required immunizations who become compliant	-	-	30%	134%	50%	0%
	School Nurse Program #2	Students served	3,950	2,815	3,850	3,863	2,000	2,248
		Kindergarten students enrolled in Rosemary and Lynhaven schools who are noncompliant with immunizations receive their required vaccinations by California School Immunization Law	-	-	18%	91%	68%	100%
		School staff (including teachers, psychologists, speech language pathologists and other staff members) who receive Epi-Pen Trainings	-	-	65%	69%	45%	82%
		Classrooms participating in handwashing videos and teeth brushing	-	-	45%	42%	32%	44%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY		videos among two Title 1 elementary schools						
		Special education students who receive flu vaccinations (due to being a vulnerable population)	-	-	18%	19%	13%	36%
	Patient Engagement Learning Collaborative of Safety-net Clinics	Clinic staff who attend Learning Collaborative training sessions on patient attribution and patient engagement	60	60	60	59	32	65
		Patients who complete the program who rate at least a 2 point increase in their confidence in connecting with their primary care provider using technology as assessed by pre/post survey	-	-	-	-	N/A	N/A
		Telehealth visits as a proportion of all patient visits from baseline of 13%	-	-	-	-	N/A	N/A
		Staff who rate their confidence level regarding Ask-Tell-Ask at 4 or above as assessed by post training evaluation	-	-	-	-	N/A	N/A
		Staff who feel more prepared to support their health center's telehealth activities for seniors with chronic conditions at 5 or above as assessed by pre/post evaluations	-	-	-	-	N/A	N/A
	School Nurse Program #3	Students served	1,103	964	1,300	1,295	2,025	1,879
		Students who failed a vision or hearing screening who saw a healthcare provider	-	-	-	-	25%	30%
		Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	-	-	-	-	15%	28%

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Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY		Students in TK, Kindergarten & 7th grade non-compliant with required vaccines who become compliant	-	-	50%	65%	35%	70%
		Students who are out of compliance with TB testing who become compliant	-	-	-	-	20%	64%
		First grade students out of compliance with required physical who become compliant	-	-.	15%	58%	N/A	N/A
	COVID Community Testing & Vaccine Program	Individuals served	-	-	400	1,221	N/A	N/A
		COVID-19 vaccinations (including booster vaccines)	-	-	-	-	N/A	N/A
	Prediabetes and Diabetes Clinical Intervention Program	Patients served	1,500	1,706	1,370	1,105	700	1,052
		Services provided, including patient visits with a Registered Dietitian and/or Wellness Coordinator	2,910	3,563	2,650	3,429	1,690	2,486
		Patients demonstrating a reduction in body weight	49%	42%	40%	47%	40%	51%
		Patients demonstrating a reduction in HbA1c levels	44%	41%	40%	51%	40%	40%
	Youth Movement & Mindfulness	Students served	38,250	39,308	38,250	91,181	72,820	135,175
		Schools served	184	197	184	184	204	333
		GoNoodle physical activity breaks played	238,000	218,924	238,000	287,964	7,057,218	8,631,891
		Teachers who believe GoNoodle benefits their students' focus and attention in the classroom	92%	N/A	93%	0%	75%	75%
		Teachers who report GoNoodle has had a positive impact on their students' emotional health	-	-	-	-	75%	75%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY	**Mobile Dental Services**	Low-income and homeless individuals served	-	-	200	193	50	52
		Dental procedures provided	-	-	1,200	1,205	150	158
		Patients who report increased knowledge about their oral health	-	-	90%	89%	85%	85%
		Patients who report no pain after their first visit	-	-	90%	90%	90%	90%
	Youth Diabetes & Obesity Clinical Prevention Program	Youth patients served	200	216	230	208	150	126
		Services provided	500	733	800	834	500	295
		Patients who decrease their BMI percentile	30%	44%	30%	39%	25%	38%
		Patients who demonstrate retention of key health material through assessments	-	-	65%	90%	65%	100%
		Patients who demonstrate increased knowledge about topics related to diabetes and obesity	40%	87%	75%	94%	N/A	N/A
	Bilingual Cancer Education, Screening, and Patient Navigation Program	Individuals served	-	-	214	224	120	123
		Services provided	-	-	458	464	332	303
		Clients who agree or strongly agree that they better understand key cancer prevention and health messages	-	-	70%	90%	70%	95%
		Navigation clients who demonstrate a better understanding of their health options by their ability to list two or more options to address their health concerns	-	-	90%	97%	90%	98%
		Health navigation participants who agree or strongly agree that they were overall satisfied with services received	-	-	85%	97%	85%	100%
		Students served	2,200	2,133	1,900	1,992	600	1,677

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY BODY	School Nurse Program #4	Staff completing health related trainings	-	-	75%	78%	60%	92%
		Decrease in students chronically absent from school (includes Distance Learning/10% or more absenteeism)	-	-	3%	3%	2%	1%
		Students with a failed Kindergarten oral health screening who see a dentist	-	-	-	-	20%	17%
		Students who failed a health screening seeing a medical provider	-	-	-	-	30%	28%
	Physical Activity & Anti-bullying Program	Students served	2,332	1,953	1,950	404	1,500	445
		Teachers/administrators reporting that Playworks positively impacts school climate	95%	100%	95%	0%	N/A	N/A
		Teachers reporting that overall student engagement increased use of positive language, attentiveness and participation in class	90%	100%	90%	0%	N/A	N/A
		Teachers/administrators surveyed who agree or strongly agree that Playworks helps increase physical activity	95%	100%	91%	0%	N/A	N/A
		Teacher/administrators who agree or strongly agree that Playworks helps increase social awareness and self-regulation	-	-	90%	0%	N/A	N/A
	Assistance and Navigation Program for the Blind and Visually Impaired	Individuals served	65	65	62	65	32	35
		Services provided (information & referral, intake, counseling, support group, adapted daily living skills, orientation & mobility, assistive technology, low vision evaluation)	475	521	475	491	255	268
		Clients who rate at least a 4 on a scale of 1 (unsatisfactory) to 5 (satisfactory) that they were informed about	90%	100%	90%	100%	90%	100%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
		resources, community agencies and programs that are available to help live with vision loss						
		Clients who report being somewhat confident to confident in their ability to safely move within their residence	85%	92%	85%	100%	85%	100%
		Clients who indicate that they are able to read printed material after program participation	70%	82%	70%	75%	70%	100%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND	**Bilingual Mental Health Counseling Services**	Individuals served (unduplicated)	-	-	-	-	15	21
		Services Provided	-	-	-	-	230	146
		Statistically Significant Improvement from pre- to-post test on Perceived Stress Scale (PSS)	-	-	-	-	N/A	N/A
		Statistically Significant Improvement from pre- to-post test on Hispanic Stress Inventory: all 5 Scales	-	-	-	-	N/A	N/A
	School-based Mental Health Counseling Program #1	Students served	280	222	240	429	131	115
		Counseling sessions provided	1,755	1,501	1,000	1,622	700	560
		Students who improved by at least 3 points from pre-test to post-test on the 40-point Strengths and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11-17)	50%	N/A	50%	33%	N/A	N/A
		Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher or therapist report (for students age 10 and under)	50%	N/A	50%	48%	N/A	N/A
	Alzheimer's Disease and Related Disorders Assistance Program	Individuals served	530	305	300	186	125	161
		Services provided	625	705	650	1,086	319	239
		Information and Referral Services clients who agree or strongly agree they are able to find resources to utilize	95%	93%	95%	93%	N/A	N/A
		Educational Sessions or Caregiver Training recipients who agree or strongly agree they were satisfied with the services received	95%	96%	95%	93%	N/A	N/A

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND		Care consultation participants who agree or strongly agree they are better informed of necessary steps to address identified needs	90%	92%	90%	86%	N/A	N/A
	Foster Teen Program	Foster teens served	80	129	80	78	50	53
		New volunteer Court Appointed Special Advocates (CASAs)	80	103	80	78	50	53
		CASA high school seniors who earn their diploma or equivalent	80%	98%	80%	87%	N/A	N/A
		CASAs who will report that their assigned foster youth has a greater sense of well-being	-	-	90%	90%	N/A	N/A
	School Mental Health Counseling Program #2	Students served	395	230	157	181	68	75
		Service hours provided	4,251	5,284	1,750	2,046	705	801
		Students who improve on treatment plan goals by 20% in 6 months and 50% by the end of the school year as measured by counselor report	80%	70%	80%	86%	60%	64%
		Students who improved by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 10 and under)	50%	50%	50%	61%	N/A	N/A
		Students who improved by at least 3 points from pre-test (at the beginning of counseling services) to post-test (prior to termination of services) on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11-17)	50%	42%	50%	50%	N/A	N/A
		Older adults served	95	145	120	159	90	91

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND	Older Adult Case Management Program	Encounters	500	2,513	850	951	800	824
		Clients who experience reduced isolation as measured by an improved score on the UCLA Loneliness Scale	-	-	-	-	20%	13%
		Clients who report utilization of at least two behavioral health services	95%	94%	75%	72%	50%	39%
	Mental Health Counseling at Homeless Shelters	Individuals served	150	187	160	171	75	78
		Services provided (Individual, group and milieu therapy)	375	390	375	361	100	105
		Clients who attend at least three individual therapy sessions who report improved functioning and well-being	85%	93%	85%	81%	N/A	N/A
		Clients who learned how trauma affects themselves and their family	-	-	75%	75%	N/A	N/A
		Practicum students who report that their experience will be useful in their future ability to serve the greater community	-	-	85%	90%	N/A	N/A
	School Mental Health Counseling Program #3	Individuals served	-	-	775	1,065	380	462
		Services provided (in hours)	-	-	850	1,025	425	530
		Teachers who participate in model push-in lessons related to inclusivity and diversity who identify positive student engagement in the lesson of at least 70% or higher. FY22	-	-	-	-	60%	60%
		Parents who participate in Parent Education Seminar will increase their self-reported readiness to support their student's mental health needs.	-	-	80%	102%	80%	75%
		Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment	-	-	50%	10%	N/A	N/A

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND		based on self-report (middle school for students age 11-17).						
		Third through fifth-grade students (aged 8-12) who increased from baseline survey (scale of 1-2) to end of year wellness and school connectedness survey. (Based on the Panorama Wellness Survey).	-	-	50%	65%	N/A	N/A
	Mental Health Community Clinic	Patients served	25	24	25	28	17	25
		Services provided	330	438	350	532	220	209
		Patients who avoid psychiatric hospitalization for 12 months after admission after beginning services with Momentum	97%	95%	97%	89%	97%	100%
	Clinical Mental Health Services	Patients served	200	257	260	383	100	372
		Services provided (psychiatry, therapy, and case management)	645	397	600	628	380	290
		Depression screenings provided	-	-	200	300	80	262
		Psychiatric patients not hospitalized in a 12-month period	90%	85%	90%	93%	85%	95%
		Psychiatry patients that attend scheduled follow up appointments	70%	60%	75%	90%	60%	95%
		Patients for depression that attend scheduled follow up appointments with Psychiatrist	-	-	55%	55%	45%	95%
	School-based Mental Health Counseling #4	Students served in Campbell Union High School District with individual and/or group counseling and classroom presentations	2,900	1,496	1,650	1,289	500	818
		Service hours provided	2,070	1,946	1,345	1,284	570	605
		Students who increase their school attendance for pre to post rating	30%	20%	20%	20%	N/A	N/A

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND		(defined as at least one point change on the CANS 50 assessment), among the students served who have school attendance issues						
		Students who decrease high risk behaviors from pre to post rating (defined as at least alone point change on the CANS 50 assessment), among students served who have high risk behaviors	60%	65%	60%	56%	N/A	N/A
		Students who decrease their thoughts and feelings of suicide from pre to post rating (defined as at least a one point change on the CANS 50 assessment), among students served with suicidal thoughts and feelings	80%	80%	80%	80%	N/A	N/A
		Students who increase coping skills from pre to post rating (defined as at least a one point change on the CANS 50 assessment), among students served with trauma, depression, anxiety, and/or anger	80%	80%	80%	80%	N/A	N/A
HEALTHY COMMUNITY	Hypertension Management Program	Individuals served	-	-	80	96	60	74
		Hypertension class participants will improve blood pressure by 7mmHg	-	-	30%	56%	35%	32%
		Hypertension class participants will measure 8 BP readings within 4 months	-	-	50%	100%	55%	50%
		Hypertension class participants adopt health behaviors to improve BP by self-reporting increased fruit and vegetable consumption	-	-	30%	59%	35%	32%
		Individuals served (unduplicated)	-	-	-	-	98	142

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY COMMUNITY	Culturally-focused Health Education, Screenings and Lifestyle Programs	Services provided, including dietitian consultations and chronic disease health education workshops	-	-	-	-	225	343
		Healthy Habits, Healthy Lifestyle participants who are very motivated or motivated to make lifestyle change on exercise, diet, sleep or stress-reduction.	-	-	-	-	80%	95%
		Participants who strongly agree or agree that dietitian consultations help them improve their eating habits	-	-	-	-	95%	96%
		Participants who strongly agree or agree that the services received (such as health education and screening) helped them better manage their health	-	-	-	-	94%	94%
	Domestic Violence Services	Adults served through the Comprehensive Services For Victims of Domestic Violence Program	132	123	146	141	69	91
		Services provided	560	567	521	726	267	323
		Surveyed participants who report that they have gained at least one strategy to increase their safety or their children's safety	80%	93%	80%	92%	90%	96%
		Clients engaged in Self-Sufficiency Case Management during the grant period will maintain the level of self-sufficiency	55%	49%	55%	46%	75%	75%
	Culturally-focused Chronic Conditions Management Programs	Individuals served	121	151	100	115	70	81
		Services provided	659	827	518	585	330	362
		Improvement in average level of weekly physical activity from baseline	21%	21%	21%	20%	21%	20%
		Improvement in average levels of daily servings of vegetables from baseline	20%	19%	20%	20%	20%	18%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY COMMUNITY		Improvement in levels of HDL-C as measured by follow-up lab test	5%	5%	6%	5%	5%	5%
		Improvement in cholesterol ratio as measured by follow-up lab test	6%	6%	7%	6%	6%	6%
	Nutrition Access/ Education for Low-income Households	Individuals/households served	300	280	280	312	136	113
		Services provided	491	403	500	1,182	198	644
		Participants report increased food security for themselves and their families by at least one unit of measurement, as measured by pre- and post-program surveys.	-	-	-	-	80%	69%
		Participants reporting an increase in their knowledge of nutrition and healthy cooking, as measured by pre- and post-participation surveys and final focus group	80%	91%	80%	95%	80%	56%
	Social Work Case Management at Community Services Agency	Households served	125	157	150	163	163	184
		Households that receive intensive Case Management services	20	50	20	32	25	25
		Case managed clients who increased in 3 of the 18 domains measured by Self Sufficiency Index	80%	91%	90%	91%	N/A	N/A
		Food pantry clients overcoming food insecurity as indicated on client survey	-	-	-	-	N/A	N/A
		Clients will remain stably housed after 3 months of receiving emergency financial assistance	-	-	90%	92%	N/A	N/A
	Social Work Case Management for Older Adults at Community Services Agency	Older adults served	45	45	45	83	30	32
		Encounters provided	260	320	300	449	160	199
		Case managed clients who increased in 3 of the 18 domains measured by Self Sufficiency Index	90%	94%	91%	96%	N/A	N/A

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
Support Grants (≤ $30K)								
HEALTHY BODY	**School-based Healthy Behavior Education for Youth**	Students served	5,600	5,471	5,250	173	1,200	15
		Students who report being active one or more hours per day after program engagement	56%	60%	58%	0%	N/A	N/A
		Students who report the knowledge to limit sweetened beverages to 0 per day after program engagement	75%	58%	75%	42%	N/A	N/A
	Screening/ Referrals and Nutrition Education for Families at Community Service Agency	Individuals served	560	401	396	468	300	434
		Encounters (screenings, workshops and class sessions)	560	468	515	544	400	550
		Parents will report that they have gained a better understanding of how to support their child's healthy development	65%	75%	65%	65%	N/A	N/A
	Physical Activity & Self-esteem Program for Young Girls	Youth served	124	106	90	11	45	63
		Average weekly virtual participation	80%	83%	80%	64%	80%	79%
		Parents who respond that they agree or strongly agree that their child wants to engage in more physical activity since joining the program	85%	86%	85%	80%	85%	66%
	Dental & Hearing Screening/ Referrals	Children screened through DentalFirst	350	364	350	418	175	276
		Children screened through HearingFirst	350	595	176	209	175	276
		Of children dental screened who received a referral, the percent that received and completed appropriate dental services	75%	69%	62%	86%	65%	40%
		Of children hearing screened who received a referral, the percent that received and completed appropriate hearing services	35%	36%	30%	71%	30%	76%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY MIND	**Psychotherapy for Child Abuse Victims**	Youth served (abused children)	12	12	12	12	6	6
		Services provided	120	133	120	135	60	48
		Clients completing the program who report that they have learned one new healthy coping mechanism	-	-	-	-	80%	100%
	Counseling for Cancer Patients, Survivors, Family & Caregivers	Individuals served	250	266	250	227	100	98
		Counseling sessions provided	450	499	459	459	300	411
		Clients who agree or strongly agree they experienced reduced levels of anxiety about issues related to a cancer diagnosis	85%	89%	85%	80%	80%	81%
		Clients who agree or strongly agree that they received helpful tools or resources	85%	96%	90%	90%	90%	89%
HEALTHY COMMUNITY	**Case Management & Life Skills Courses Program for Those Homeless or Near Homelessness**	Individuals served (unduplicated)	-	-	-	-	10	80
		Services provided	-	-	-	-	152	147
		Participants who report improved their self-esteem, motivation, and/or hope since joining the program	-	-	-	-	50%	55%
		Barriers removed related to housing, employment, health, and/or self-sufficiency cumulatively for all unduplicated participants	-	-	-	-	30%	89%
		Participants who report decreased quantity or improved the quality of interactions with law enforcement/the court system	-	-	-	-	N/A	N/A
	Health Education Program for Those Living in	Individuals served (unduplicated)	-	-	-	-	125	319
		Services provided (duplicated)	-	-	-	-	250	487
		Residents reported committing to eating more fruits and vegetables.	-	-	-	-	50%	91%

Health Priority Area	Agency/Program	FY22 Metrics	FY20 Yearend Target	FY20 Yearend Actual	FY21 Yearend Target	FY21 Yearend Actual	FY22 6-month Target	FY22 6-month Actual
HEALTHY COMMUNITY	Affordable Housing	Residents reported committing to doing more physical activity.	-	-	-	-	50%	82%
		Residents reported committing to reducing toxins in their home.	-	-	-	-	50%	91%
	Senior Isolation Program	Individuals served	200	148	120	200	125	281
		Services provided	-	-	715	479	2,004	1,042
		Participants who agree or strongly agree feeling less isolated as a result of the program	-	-	65%	65%	65%	65%
	Cancer Support Program	Individuals served (unduplicated)	-	-	-	-	24	42
		Services provided	-	-	-	-	490	1,472
		Patients who report feeling stronger and well-nourished through treatment as reflected in off-boarding survey	-	-	-	-	80%	86%
		Social workers who report that treatment compliance has increased by at least 20%	-	-	-	-	50%	75%
		Participants in peer support who report at least a 50% decrease in feelings of loneliness and isolation	-	-	-	-	35%	65%
	Falls Prevention Services for at-risk Older Adults	Older adults served	-	-	17	26	5	6
		Older adults who report their overall health has improved somewhat or a lot since completed repairs/modifications.	-	-	60%	96%	75%	100%
		Older adults who report a low or no chance of falling due to completed repairs/modifications.	-	-	60%	60%	65%	100%
		Older adults who report at least a 1-point increase in their ability to move around their home.	-	-	60%	60%	65%	100%