# AGENDA
## REGULAR MEETING OF THE EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

**Tuesday, June 14, 2022 – 5:30 pm**
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, THE EL CAMINO HEALTHCARE DISTRICT **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

**1-669-900-9128, MEETING CODE: 960 3840 8686#. No participant code. Just press #.**

To watch the meeting livestream, please visit: http://www.elcaminohealthcaredistrict.org/meetingstream
Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

**PURPOSE:** The purpose of the District shall be to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to do any and all other acts and things necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| **1.** | **CALL TO ORDER/ROLL CALL** | Julia Miller, Board Chair | | **5:30 – 5:31** |
| **2.** | **SALUTE TO THE FLAG** | Julia Miller, Board Chair | | **information 5:31 – 5:34** |
| **3.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Julia Miller, Board Chair | | **information 5:34 – 5:36** |
| **4.** | **PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.*<br>b. Written Correspondence | Julia Miller, Board Chair | | **information 5:36 – 5:39** |
| **5.** | **CONSENT CALENDAR**<br>*Any Board Member or member of the public may remove an item for discussion before a motion is made.*<br>***Approval***<br>a. Minutes of the Open Session of the District Board Meeting (05/17/2022)<br>b. FY23 Regular Meeting Dates: Resolution 2022-07<br>c. FY23 Operating Budget – ECHD and ECH & Affiliates<br>d. FY23 Pacing Plan<br>***Information***<br>e. Community Benefits Sponsorship | Julia Miller, Board Chair | *public comment* | **motion required 5:39 – 5:42** |
| **6.** | **APPOINTMENT OF LIAISON TO THE COMMUNITY BENEFIT ADVISORY COUNCIL** | Julia Miller, Board Chair | *public comment* | **motion required 5:42 – 5:47** |
| **7.** | **APPOINTMENT OF FY23 HOSPITAL BOARD MEMBER REAPPOINTMENT AD HOC COMMITTEE**<br>*Resolution 2022-08* | Julia Miller, Board Chair | *public comment* | **motion required 5:47 – 5:57** |

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-8254** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|
| **8.** **EL CAMINO HEALTH DISTRICT MISSION STATEMENT REVIEW AD HOC COMMITTEE RECOMMENDATION** | Julia Miller, Board Chair<br>Carol Somersille, MD, Ad Hoc Committee Chair | *public comment* | **motion required 5:57 – 6:07** |
| **9.** **REQUESTING FOR AND CONSENTING TO CONSOLIDATION FOR ELECTION**<br>*Resolution 2022-09* | Julia Miller, Board Chair | *public comment* | **motion required 6:07 – 6:12** |
| **10.** **FY22 YTD ECHD FINANCIAL REPORT** | Carlos Bohorquez, CFO | *public comment* | **motion required 6:12 – 6:22** |
| **11.** **ESTABLISHING TAX APPROPRIATION LIMIT FOR FY23 (GANN LIMIT)**<br>*Resolution 2022-10* | Michael Walsh, Controller | *public comment* | **motion required 6:22 – 6:32** |
| **12.** **DISTRICT CAPITAL OUTLAY FUNDS** | Ken King, CASO | *public comment* | **motion required 6:32 – 6:42** |
| **13.** **FY22 COMMUNITY BENEFIT PLAN** | Jonathan Cowan, Senior Director, Relations and Community Partnerships | *public comment* | **motion required 6:42 – 6:57** |
| **14. ADJOURN TO CLOSED SESSION** | Julia Miller, Board Chair | *public comment* | **motion required 6:57 – 6:58** |
| **15. CONSENT CALENDAR**<br>*Any Board Member or member of the public may remove an item for discussion before a motion is made.*<br>***Approval***<br>*Gov't Code Section 54957.2:*<br>– Minutes of the Closed Session of the District Board Meeting (05/17/2022) | Julia Miller, Board Chair | | **motion required 6:58 – 6:59** |
| **16.** *Health & Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets:*<br>**DISTRICT REAL ESTATE STRATEGY** | Ken King, Chief Administrative Services Officer | | **discussion 6:59 – 7:19** |
| **17.** Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management:<br>– Executive Session | Julia Miller, Board Chair | | **discussion 7:19 – 7:29** |
| **18. ADJOURN TO OPEN SESSION** | Julia Miller, Board Chair | | **motion required 7:29 – 7:30** |
| **19. RECONVENE OPEN SESSION/ REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Julia Miller, Board Chair | | **information 7:30 – 7:31** |
| **20. BOARD COMMENTS** | Julia Miller, Board Chair | | **discussion 7:31– 7:33** |
| **21. ADJOURNMENT** | Julia Miller, Board Chair | *public comment* | **motion required 7:33 – 7:35pm** |

**Upcoming Meetings (*Subject to Board Approval*):** October 18, 2022; December 13, 2022; February 8, 2023; March 28, 2023; June 20, 2023

**Education Session:** May 16, 2023

**Minutes of the Open Session of the**
**El Camino Healthcare District Board of Directors**
**Tuesday, May 17, 2022**

**Pursuant to Government code section 54953(e)(1), El Camino Health will not be providing a physical location to the public for this meeting. Instead, the public is invited to join the open session meeting via teleconference at:**

| Board Members Present | Board Members Absent | Members Excused |
|---|---|---|
| **Peter C. Fung, MD** Vice-Chair<br>**Julia E. Miller**, Chair<br>**Carol A. Somersille, MD** Secretary/Treasurer<br>**George O. Ting, MD**<br>**John Zoglin** | | None |

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | Chair Miller called to order the open session of the Regular Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 5:31 pm and reviewed the logistics for the meeting. A verbal roll call was taken; all Board members were present at the roll call, and a quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020. | ***Call to Order at 5:31 pm.*** |
| **2. SALUTE TO THE FLAG** | Chair Miller asked Vice-Chair, Dr. Peter Fung, to lead all present in the Pledge of Allegiance. | |
| **3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Miller asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted. | |
| **4. PUBLIC COMMUNICATION** | There was no public communication. | |
| **5. SPOTLIGHT: RESOLUTION 2022-06** | Chair Miller invited Jon Cowan, Senior Director, Relations and Community Partnerships, to introduce Karen Scussel, Women SV Board. Mr. Cowan introduced Ms. Scussel, and she provided a brief overview of Women SV, a local non-profit in Los Altos serving people of intimate partner abuse, and the impact of the El Camino Healthcare District Grant on the program in FY21 and FY22.<br><br>**Motion:** To approve the Resolution 2022-06 recognizing Womens SV.<br><br>**Movant:** Zoglin<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Resolution 2022-06 was approved*** |
| **6. CONSENT CALENDAR** | Chair Miller asked if any member of the Board or the public wished to remove an item from the consent calendar.<br><br>Director Zoglin requested to remove 6c – Community Benefits Mid-Year Update for discussion.<br><br>**Motion:** To approve the consent calendar excluding item 6c to include:<br><br>a. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings<br>b. Minutes of the Open Session of the El Camino Healthcare District Board Meeting (03/15/2021)<br>d. FY22 Pacing Plan | ***The consent calendar was approved.*** |

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| | e. Community Benefits Sponsorship Report<br><br>**Movant:** Somersille<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None<br><br>Director Zoglin asked for further clarification on the following items:<br><br>• How the programs are doing compared to the pre-Covid year and overall as the numbers reported seem lower than pre-Covid years.<br>• Why the cost per student/session in similar programs have a higher variance for similar services delivered.<br><br>Mr. Cowan responded that the numbers are lower than pre-Covid, yet trending in the right direction. He further disclosed the following degrees of variations:<br><br>• Fiscal Year 20: 65% of the programs met 80% of their metrics, and 92% of them met 80% of their metrics for the largest grants.<br>• Fiscal Year 19: 72% of the programs met 80% of their metrics, and 73% met 80% of their metrics for the largest grants.<br><br>Mr. Cowan reported that some programs were faced with staffing challenges due to Covid, and some of the services were more intensive than expected.<br><br>**Motion:** To approve item 6c - Community Benefits Mid-Year Update<br><br>**Movant:** Zoglin<br>**Second**: Somersille<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | |
| **7. FY23 COMMUNITY BENEFIT PLAN STUDY SESSION** | Mr. Cowan reported that the grants utilized the guiding principles and approved percentages that the Board approved at the end of last year. There was an increase of 6% from 2022 to 2023 in diabetes and obesity, a 2% increase for behavioral health, and a decrease in healthcare access and delivery.<br><br>Mr. Cowan highlighted the FY23 strategies for Diabetes and Obesity, School Behavioral Health, Community Service Agencies, and Staff Innovation Grants. He explained the recommended funding to 9 out of the 15 applications for new programs. In addition, more recognition will be requested from the grantees such as building signage for programs receiving grants ≥$200,000 and mobile van signage for programs receiving grants ≥$50,000.<br><br>Director Fung asked how many of the grants or programs came from staff recommendations and why some were not funded.<br><br>Mr. Cowan reported that a few programs were recommended by staff based on gaps identified within our Behavior Health department. Specifically, Caminar – LGBTQ, Behavioral Health Navigator, and Post Discharge Navigator.<br><br>Director Somersille requested details regarding the analysis on Road Runners and the outreach changes, including utilizing our services. | |

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| | Mr. Cowan explained reaching out to Santa Clara Family Health Plan, Senior Centers, and Clinical Practices to help connect vulnerable and underserved individuals to get to their appointments and identify other options to help. Furthermore, staff works with those who express concern about being able to afford the rates.<br><br>Director Somersille stated that she would like to extend the time of the grant to 2 years for the nursing programs in various school districts.<br><br>Mr. Cowan responded that extending the time of the grant is an excellent idea to reduce the burden on the grantee and provide more focus on newer grants, and will try to implement in the following fiscal year.<br><br>Director Zoglin wanted to know what total percentage the new organizations represent.<br><br>Mr. Cowan stated roughly 6% of funds go to new organizations.<br><br>Director Ting inquired about the correlation with the community health needs assessment and whether it is valuable enough to guide us to a better understanding of the community needs.<br><br>Mr. Cowan stated that the assessment does help identify the community and broad health needs. The El Camino Healthcare District and El Camino Hospital have historically had a comprehensive approach of wanting to reach many different organizations.<br><br>Director Miller would like to challenge the process and have staff consider the following recommendations:<br>• Remove dual funding<br>• If possible, fund hospital programs out of the hospital funds and district programs out of district funds<br>• If appropriate, increase the hospital funds | |
| **8. ECHD FY22 YTD FINANCIALS** | Carlos Bohorquez, Chief Financial Officer, presented the FY22 YTD Financials and highlighted the following:<br><br>• $91.098B in total Assets as of March 31, 2022<br>• $59.072B in total Fund Balance as of March 31, 2022<br>• Deferred Revenue decreased from 67M to 37M dollars<br>• Year over Year, increased by about 20%, mainly driven by a strong rebound in volume.<br>• Unrealized loss on our portfolio in our non-operating income (investment income)<br><br>Mr. Bohorquez concluded that we are unfavorable to budget with investment income by $1.7M, net income at $12.6M versus $13.1M but overall revenue and expenses are consistent with the projected budget. A brief discussion ensued.<br><br>Director Somersille requested a range of percentages of our assets when reporting the financials to the District Board. | |
| **9. REPORT ON COVID-19 COMMUNITY PROGRAM** | Omar Chughtai, VP of Operations, provided a brief update on the El Camino Healthcare District funds allocation to cover testing and vaccinations. He reviewed El Camino Health's efforts to help the community by providing at-home kits, N95 masks, and vaccine clinics. Mr. Chughtai reported a remaining balance of $1.2M and requested allocating the remaining balance to FY23.<br><br>**Motion:** To approve rolling over the existing funds to fiscal FY23 to continue our testing and vaccination program. | ***Motion to approve allocating remaining 1.2M funds to FY23.*** |

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| | **Movant:** Miller<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | |
| **10. FY23 PACING PLAN** | Chair Miller asked for a discussion regarding the FY23 pacing plan. She requested that the January meeting be moved to February to remain dark to align with the Hospital Board pacing and hold a December meeting during the election year.<br><br>There was consensus from the Board of Directors to remain dark in January and hold a meeting in December during the election year.<br><br>A revised pacing plan will be paced for review, discussion, and possible motion at the June Meeting. | ***Deferred to 6/14 Board Meeting*** |
| **11. EL CAMINO HEALTH DISTRICT MISSION STATEMENT REVIEW AD HOC COMMITTEE FORMATION**<br>***Resolution 2022-04*** | Chair Miller called for a motion to appoint Director John Zoglin to the District Mission Statement Review Ad Hoc Committee.<br><br>**Motion:** To approve Resolution 2022-04, Appointment of Director John Zoglin to the District Mission Statement Review Ad Hoc Committee.<br><br>**Movant:** Somersille<br>**Second**: Fung<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Resolution 2022-04 was approved.*** |
| **12. DISTRICT BOARD MEMBER HEALTH BENEFITS DISCUSSION** | Dan Woods, Chief Executive Officer, provided a brief update on District Board Member Health Benefit and introduced outside counsel Allison Bassett and Shauna Amon to explain aspects of the health and safety code of the districts and employment law regarding providing health care benefits to district board members.<br><br>Shauna Amon stated while it is legal for the district to offer health-related benefits, providing and implementing coverage may be more difficult. She further detailed the following requirements:<br><br>• Hourly requirements that employees need to work to qualify for benefits<br>  ○ 20 hours a week for part-time employees and 32 hours per week for full-time employees<br>• Compared to Sequoia Healthcare District, Sequoia likely has a pre-existing contract with Calipers to provide benefits to their active members and extend coverage to their board members<br>  ○ ECH can reach out to Calipers to see if there are similar coverage plans that can be made<br>  ○ Might not be cost-effective<br><br>Director Fung asked whether the board members were interested in health care benefits.<br><br>Chair Miller asked each board member for their interest in the process of discovery and discussion. Directors Fung, Miller, Somersille, and Ting responded yes. Director Zoglin responded no.<br><br>Director Ting asked if the health care benefit was individual or family coverage.<br><br>Chair Miller stated that would be a decision for Board approval. | |

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| | Chair Miller asked for further explanation on the general counsel's opinion of special district board members receiving benefits. Ms. Bassett explained there are no specific procedures for providing benefits, but a government code allows approval in an open meeting subject to the Brown Act.<br><br>Chair Miller requested additional information regarding insurance coverage that Calipers can provide. | |
| **13. FY23 EL CAMINO HEALTHCARE DISTRICT POLICY BYLAW REVIEW AD-HOC COMMITTEE RECOMMENDATION P.2 Compliance Review Process** | Chair Miller referred to the revised P.2 Compliance Review Process as detailed in the packet materials and asked the Board of Directors for feedback.<br><br>Director Zoglin asked if there was a limit to the hourly rate for legal fees.<br><br>Alison Bassett stated the Board has control over the legal fees as the Board would engage the counsel for the board member and negotiate the engagement letter to define the cap amount, set the number of hours, and so forth. A personal attorney would not be permitted to submit bills to the District.<br><br>**Motion:** To approve P.2 Compliance Review Process.<br><br>**Movant:** Fung<br>**Second**: Ting<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***P.2 Compliance Review Process was approved*** |
| **14. FY23 EL CAMINO HEALTHCARE DISTRICT POLICY BYLAW REVIEW AD-HOC COMMITTEE RECOMMENDATION P.3 Director Compensation Policy** | Chair Miller referred to the revised P.3 Director Compensation Policy as detailed in the packet materials and asked the Board of Directors for feedback.<br><br>Director Zoglin asked for clarification on meeting compensation definitions (i.e., what constitutes $100 compensation and the maximum allowance)<br><br>Mr. Shiraz Ali noted that meetings are defined in section 1.2 on page 205 of the packet and the maximum is 6 meetings equaling $630 a month. Ms. Bassett added that the Health and Safety government code regulates the compensation.<br><br>**Motion:** To approve P.3 Director Compensation Policy.<br><br>**Movant:** Fung<br>**Second**: Somersille<br>**Ayes:** Fung, Miller, Somersille, Ting<br>**Noes**: Zoglin<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***P.3 Director Compensation Policy was approved*** |
| **15. FY23 EL CAMINO HEALTHCARE DISTRICT POLICY BYLAW REVIEW AD-HOC COMMITTEE RECOMMENDATION P.6 Appointment of Board Members to El Camino Hospital Board** | Chair Miller referred to the revised P.6 Appointment of Board Members to El Camino Hospital Board Policy as detailed in the packet materials and asked the Board of Directors for feedback.<br><br>Director Zoglin asked to remove the bullet under Item 2: Appropriate business attire at ECH meetings and functions. There was no second to the motion.<br><br>**Motion:** To approve P.6 Appointment of Board Members to El Camino Hospital Board.<br><br>**Movant:** Fung<br>**Second**: Somersille<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin | ***P.6 Appointment of Board Members to El Camino Hospital Board Policy was approved*** |

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| | **Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | |
| **16. ADJOURN TO CLOSED SESSION** | To adjourn to closed session at 7:34 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the District Board Meeting (01/25/22), pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO.<br><br>**Motion:** To approve to adjourn to closed session at 7:34 pm.<br><br>**Movant:** Ting<br>**Second**: Fung<br>**Ayes**: Fung, Miller, Somersille, Ting**,** Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Adjourned to closed session at 7:34 pm.*** |
| **17. AGENDA ITEM 22: RECONVENE TO OPEN SESSION/ REPORT OUT** | The open session of the El Camino Healthcare District Board of Directors was reconvened at 8:36 pm. Agenda items 17-21 were addressed in the closed session.<br><br>During the closed session, the Board approved the closed session minutes of the 03/15/22 El Camino Healthcare District Board of Directors by all Board Members present. (Directors Fung, Miller, Somersille, Ting, and Zoglin). | ***Open Session reconvened at 8:36 pm.*** |
| **18. AGENDA ITEM 23: BOARD COMMENTS** | None were noted. | |
| **19. AGENDA ITEM 24: ADJOURNMENT** | **Motion**: To adjourn at 8:37 pm.<br><br>**Movant:** Somersille<br>**Second**: Ting<br>**Ayes:** Fung, Miller, Somersille, Ting, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Meeting adjourned at 8:37 pm.*** |

**Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Healthcare District:**

_____
Julia E. Miller
Chair, ECHD Board

_____
Carol Somersille, MD
Secretary/Treasurer, ECHD Board

Prepared by: Stephanie Iljin, Manager, Administration
Michele Collaco, Executive Assistant II

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING MEMO**

**To:** El Camino Healthcare District ("District") Board of Directors
**From:** Julia E. Miller, District Board Chair
**Date:** June 14,2022
**Subject:** Proposed Resolution 2022-07: Setting Regular Meeting Dates for FY23

**Recommendation**:

To approve Proposed Resolution 2022-07: Setting Regular Meeting Dates for FY23

**Summary:**

**1.** Situation: Pursuant to California Government Code Section 54954(a) "Each legislative body of a local agency, except for advisory committees or standing committees, shall provide, by ordinance, resolution, bylaws or by whatever other rule is required for the conduct of business by that body, the time and place for holding regular meetings. "

**2.** Authority: Article VI (3)(a) of the District Bylaws state: "Regular meetings of the District Board shall be held without call on the date and at the time and place established, from time-to-time, by resolution of the District Board. The District Board may establish the date, time, and place of one (1) or more regular meetings in any such resolution."

**3.** Background: The District has routinely approved a Resolution adopting an annual meeting schedule. For the last several years, the Board has scheduled quarterly meetings in October, January, March, and June to conduct the District Board's usual business and a May meeting primarily for the purpose of reviewing the annual Proposed Community Benefit Plan. In election years, the District Board also schedules a December meeting for the purpose of administering the Oath of Office to Board members elected or re-elected in the November Election.

**4.** Assessment: Adoption of the Proposed Resolution will meet statutory requirements as well as those set forth in the District Bylaws.

**5.** Outcomes: Regular Meeting Schedule for FY23 established and provided to the public.

**List of Attachments:** Proposed Resolution 2022-07

**Suggested Board Discussion Questions:**

**1.** Does the proposed meeting schedule provide adequate meeting time for us to achieve our statutory obligations as well as our mission?

# EL CAMINO HEALTHCARE DISTRICT BOARD
# RESOLUTION 2022-07
# ESTABLISHING REGULAR MEETING DATES AND TIME

**RESOLVED**, Article VI, Section 3(a) of the Bylaws of El Camino Healthcare District requires the Board to adopt a resolution setting meeting dates; be it further,

**RESOLVED**, that the regular meeting dates of the District Board for FY 2023 shall be October 18, 2022; December 13, 2022; February 8, 2023; March 28, 2023; May 16, 2023, and June 20, 2023, at 5:30 PM; be it further,

**RESOLVED**, all meetings of the District Board shall be held at El Camino Hospital, 2500 Grant Road, Mountain View, California 94040, unless another location is identified on the meeting notice, which shall be posted at least 72 hours before the meeting or telephonically in accordance with State of California Executive Orders that may, from time to time, temporarily suspend specific provisions of the Ralph M. Brown Act requiring a physical meeting location.

**RESOLVED**, the regular meeting dates shall be posted at El Camino Hospital, on the El Camino Healthcare District website, and mailed or e-mailed to all persons who have requested notice of EL Camino Healthcare District meetings in writing as of January 1 each year.

**DULY PASSED AND ADOPTED** at a Regular Meeting held on the 14th day of June, 2022 by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

By: _____
Carol A. Somersille, MD
Secretary, ECHD Board of Directors

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Carlos Bohorquez, Chief Financial Officer
**Date:** June 14, 2022
**Subject:** FY2023 Operating Budget - El Camino Healthcare District and El Camino Hospital & Affiliates

## Purpose:

To approve the FY2023 Operating Budget

## Summary

### 1. Situation:

- The FY2023 ECH District Budget includes the Community Benefit Support fee based on the cost of services as follows:

| Community Partnerships Staff FY2023 | Total Paid FTEs | |
|---|---|---|
| Community Benefit Program Manager | | 1.00 |
| Director Community Benefit | | 1.00 |
| Administrative Assistant | | 1.00 |
| Sr Community Benefit Spec | | 1.00 |
| Business Coordinator | | - |
| Total | | 4.00 |
| Total Salaries, Wages & Benefits | $ | 687,657 |
| Estimated allocation of time at 52% | $ | 357,582 |

- The following is a comparative summary of the FY2023 operating budget vs. actual FY2021 & projected FY2022:

| | Revenues | FY2021 Actual | FY2022 Projected | FY 2023 Budget | Change Favorable / (Unfavorable) | % Change |
|---|---|---|---|---|---|---|
| (A) | Other Operating Revenue | 101 | 104 | 106 | 2 | 2.2% |
| (B) | Unrestricted M&O Property Taxes | 9,221 | 9,804 | 10,601 | 797 | 8.1% |
| (B) | Restricted M&O Taxes | 11,129 | 10,500 | 9,833 | (667) | -6.4% |
| (B) | Taxes Levied for Debt Service | 11,803 | 11,505 | 11,200 | (305) | -2.6% |
| (B) | Investment Income (net) | (2,697) | (1,470) | 1,034 | 2,503 | -29.7% |
| (B) | Other - Redevelopment Agency | 310 | 254 | 300 | 46 | 18.1% |
| (B) | IGT Medi-Cal Program Expense | (4,460) | (3,047) | (3,000) | 47 | -1.6% |
| | **Total Net Revenue** | 25,408 | 27,650 | 30,074 | 2,424 | 8.8% |
| | **Expenses** | | | | | |
| (A) | Community Benefit Support | 417 | 381 | 358 | 23 | -6.1% |
| (A) | Fees & Purchased Services | 368 | 16 | 362 | (346) | -95.6% |
| (A) | Supplies & Other Expenses | 146 | 189 | 122 | 67 | 54.6% |
| (A) | Depreciation/Amortization/Interest Expense | 53 | 10 | 4 | 6 | 161.3% |
| (B) | G.O. Interest Expense (net) | 415 | 3,091 | 6,580 | (3,489) | -53.0% |
| (B) | Community Benefit Program | 7,189 | 8,772 | 7,665 | 1,108 | 14.5% |
| | **Total Expenses** | 8,588 | 12,459 | 15,090 | (2,631) | -17.4% |
| | **NET INCOME** | 16,820 | 15,191 | 14,984 | (207) | -1.4% |

| **FY23 BUDGET RECAP STATEMENT OF REVENUES & EXPENSE** | |
|---|---|
| (A) Net Operating Revenues & Expenses | (739) |
| (B) Net Non-Operating Revenues & Expenses | 15,724 |
| **NET INCOME** | 14,984 |

- Total anticipated tax receipts of $31.6M for FY2023 will be deployed in the following manner:

| | | |
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| **Sources of District Taxes** | | |
| (1) Maintenance and Operation and Government Obligation Taxes | $31,634 | |
| (2) Redevelopment Agency Taxes | $300 | |
| **Total District Tax Receipts** | | $31,934 |
| **Uses Required Obligations / Operations** | | |
| (3) Government Obligation Bond (Principal & Interest & Surplus) | $11,200 | |
| **Total Cash Available for Operations, CB Programs, & Capital Appropriations** | | 20,734 |
| (4) Capital Appropriation Fund – Excess Gann Initiative Restricted* | 10,901 | |
| **Subtotal** | | 9,833 |
| (5) Operating Expenses (net) | 739 | |
| **Subtotal** | | 9,094 |
| (6) Capital Replacement Fund (Park Pavilion) | 5 | |
| **Funds Available for Community Benefit Program** | | $9,089 |

- Consolidated FY2023 Budget including ECHD, El Camino Hospital and Affiliates anticipates total net revenue of $1.41B.

| | ECHD | El Camino Hospital | El Camino Hospital Affiliates | Total |
|---|---|---|---|---|
| **REVENUES** | | | | |
| Net Patient Service Revenue | $0 | $1,315,164 | $42,754 | $1,357,918 |
| Other Operating Revenue | 106 | 24,921 | 24,815 | 49,842 |
| Total Net Revenue | 106 | 1,340,084 | 67,569 | 1,407,760 |
| **EXPENSES** | | | | |
| Salaries & Benefits | 0 | 681,400 | 33,917 | 715,317 |
| Supplies & Other Expenses | 841 | 387,571 | 71,550 | 459,962 |
| Interest | 0 | 16,678 | 0 | 16,678 |
| Depreciation/Amortization | 4 | 69,448 | 3,304 | 72,756 |
| TOTAL EXPENSES | 845 | 1,155,097 | 108,771 | 1,264,713 |
| **OPERATING INCOME** | **($739)** | **$184,987** | **($41,202)** | **$143,046** |
| Non Operating Income | 15,724 | 31,166 | 3,739 | 50,629 |
| **NET INCOME** | **$14,984** | **$216,154** | **($37,461)** | **$193,676** |
| *Operating EBIDA* | *(735)* | *271,114* | *(37,898)* | *232,480* |
| *EBIDA Margin Percentage* | *(693.9%)* | *20.2%* | *(56.1%)* | *16.5%* |
| *Operating Margin Percentage* | *(697.6%)* | *13.8%* | *(61.0%)* | *10.2%* |

2. **Assessment:** N/A
3. **Other Reviews:** None
4. **Outcomes:** N/A

**List of Attachments:**

1. ECHD FY203 Budget Presentation

**Suggested Board Discussion Questions:** None.

*Dedicated to improving the health and well being of the people in our community.*

# El Camino Healthcare District
# Fiscal Year 2023 Budget

Carlos Bohorquez, Chief Financial Officer
June 14, 2022

# Basis of the El Camino Healthcare District FY 2023 Budget

- ***The District budget is first shown in "stand-alone" format, including those transactions which occur at the District level.***

  - This presentation will cover the assumptions driving the District's budget and will provide information on District–level revenues and expenditures.

  - The preliminary budget for El Camino Hospital and its affiliates was reviewed at the May joint finance and board meeting. Additional information on the budget for El Camino Hospital and its affiliates is available on the hospital's website (www.elcaminohospital.org).

- ***The District budget is also shown in consolidated format in this presentation as it is the District's responsibility to approve the consolidated budget.***

# Major Assumptions – El Camino Healthcare District

## *Excludes El Camino Hospital & its affiliates*

- Other Operating Revenue is based on the existing ground lease agreement.
- The Unrestricted M&O Property Taxes are budgeted based upon the Tax Appropriation Limit (Gann Limit).
- This year the Redevelopment Agency revenues were once again budgeted as they continue to be distributed by the County without any lapse in payments in the past years. The increase in expenses is attributable, in a large part, that in fiscal year 2023 it has a projected budget of $325,000 for the November 2023 District Board election.
- Operating Expenses are based on historical payment information with adjustments made for non-recurring expenses.
- Community Benefit Support fee based on the cost of services as follows:

| Community Partnerships Staff FY2023 | Total Paid FTEs |
|---|---|
| Community Benefit Program Manager | 1.00 |
| Director Community Benefit | 1.00 |
| Administrative Assistant | 1.00 |
| Sr Community Benefit Spec | 1.00 |
| Business Coordinator | - |
| Total | 4.00 |
| Total Salaries, Wages & Benefits | $ 687,657 |
| Estimated allocation of time at 52% | $ 357,582 |

- Supplies and Other Expenses includes modest increases for Direct Mail material, website development, advertising and postage. The District's budgeted dues are expected to remain a constant of LAFCO at an amount of $25,000 and $7,000 for California Special Districts Association.
- Expenses related to the G.O. bonds are based on the 2006 and 2017 G.O. amortization schedules.
- Investment income is based on the expected return rate provided by our Investment Consultant of on an average cash balance of $40M.
- Community Benefit expenditures are based on the Community Benefit plan.
- IGT – Medi-Cal (PRIME) program - It is expected that the District/Hospital will participate in the program again this year.

# El Camino Healthcare District

## *Information excludes El Camino Hospital & its affiliates*

**(in $000s)**

| | Revenues | FY2021 Actual | FY2022 Projected | FY 2023 Budget | Change Favorable / (Unfavorable) | % Change |
|---|---|---|---|---|---|---|
| (A) | Other Operating Revenue | 101 | 104 | 106 | 2 | 2.2% |
| (B) | Unrestricted M&O Property Taxes | 9,221 | 9,804 | 10,601 | 797 | 8.1% |
| (B) | Restricted M&O Taxes | 11,129 | 10,500 | 9,833 | (667) | -6.4% |
| (B) | Taxes Levied for Debt Service | 11,803 | 11,505 | 11,200 | (305) | -2.6% |
| (B) | Investment Income (net) | (2,697) | (1,470) | 1,034 | 2,503 | -29.7% |
| (B) | Other - Redevelopment Agency | 310 | 254 | 300 | 46 | 18.1% |
| (B) | IGT Medi-Cal Program Expense | (4,460) | (3,047) | (3,000) | 47 | -1.6% |
| | **Total Net Revenue** | 25,408 | 27,650 | 30,074 | 2,424 | 8.8% |
| | **Expenses** | | | | | |
| (A) | Community Benefit Support | 417 | 381 | 358 | 23 | -6.1% |
| (A) | Fees & Purchased Services | 368 | 16 | 362 | (346) | -95.6% |
| (A) | Supplies & Other Expenses | 146 | 189 | 122 | 67 | 54.6% |
| (A) | Depreciation/Amortization/Interest Expense | 53 | 10 | 4 | 6 | 161.3% |
| (B) | G.O. Interest Expense (net) | 415 | 3,091 | 6,580 | (3,489) | -53.0% |
| (B) | Community Benefit Program | 7,189 | 8,772 | 7,665 | 1,108 | 14.5% |
| | **Total Expenses** | 8,588 | 12,459 | 15,090 | (2,631) | -17.4% |
| | **NET INCOME** | 16,820 | 15,191 | 14,984 | (207) | -1.4% |

| | **FY23 BUDGET RECAP STATEMENT OF REVENUES & EXPENSE** | |
|---|---|---|
| (A) | Net Operating Revenues & Expenses | (739) |
| (B) | Net Non-Operating Revenues & Expenses | 15,724 |
| | **NET INCOME** | 14,984 |

# El Camino Healthcare District

## Statement of Fund Balance Activity for Budget FY2023

*Information excludes El Camino Hospital & its affiliates*

**(in $000s)**

**UNRESTRICTED FUND ACTIVITY BALANCE**

| | |
|---|---|
| Opening Balance at 7/1/2022 | $58,637 |
| Transfer (to) / from ECH: IGT Prime Funding | 3,000 |
| Budgeted Net Income for FY2023 | 14,984 |
| Projected Transfer to ECH for Capital Outlay Projects (MV Campus Completion Project) | (9,706) |
| **FISCAL YEAR 2023 ENDING BALANCE** | **$66,915** |

# El Camino Healthcare District

## Sources & Uses of Tax Receipts (in $000s)

## Budget FY2023

| | | |
|---|---|---|
| **Sources of District Taxes** | | |
| (1) Maintenance and Operation and Government Obligation Taxes | $31,634 | |
| (2) Redevelopment Agency Taxes | $300 | |
| **Total District Tax Receipts** | | $31,934 |
| **Uses Required Obligations / Operations** | | |
| (3) Government Obligation Bond (Principal & Interest & Surplus) | $11,200 | |
| **Total Cash Available for Operations, CB Programs, & Capital Appropriations** | | 20,734 |
| (4) Capital Appropriation Fund – Excess Gann Initiative Restricted* | 10,901 | |
| **Subtotal** | | 9,833 |
| (5) Operating Expenses (net) | 739 | |
| **Subtotal** | | 9,094 |
| (6) Capital Replacement Fund (Park Pavilion) | 5 | |
| **Funds Available for Community Benefit Program** | | $9,089 |

| | |
|---|---|
| (1) M&O and G.O. Taxes | • Cash receipts from the 1% ad valorem property taxes and Measure D taxes |
| (2) Redevelopment Agency Taxes | • Cash receipts from dissolution of redevelopment agencies |
| (3) Government Obligation Bond | • Levied for debt service |
| (4) Capital Appropriation Fund | • Excess amounts over the Gann Limit are restricted for use as capital |
| (5) Operating Expenses | • Expenses incurred in carrying out the District's day-to-day activities |
| (6) Capital Replacement Fund | • Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion at 130% of original cost) |

# El Camino Healthcare District – CONSOLIDATED FY2023 Budget

**(in $000s)**

| | ECHD | El Camino Hospital | El Camino Hospital Affiliates | Total |
|---|---|---|---|---|
| **REVENUES** | | | | |
| Net Patient Service Revenue | $0 | $1,315,164 | $42,754 | $1,357,918 |
| Other Operating Revenue | 106 | 24,921 | 24,815 | 49,842 |
| Total Net Revenue | 106 | 1,340,084 | 67,569 | 1,407,760 |
| **EXPENSES** | | | | |
| Salaries & Benefits | 0 | 681,400 | 33,917 | 715,317 |
| Supplies & Other Expenses | 841 | 387,571 | 71,550 | 459,962 |
| Interest | 0 | 16,678 | 0 | 16,678 |
| Depreciation/Amortization | 4 | 69,448 | 3,304 | 72,756 |
| TOTAL EXPENSES | 845 | 1,155,097 | 108,771 | 1,264,713 |
| **OPERATING INCOME** | **($739)** | **$184,987** | **($41,202)** | **$143,046** |
| Non Operating Income | 15,724 | 31,166 | 3,739 | 50,629 |
| **NET INCOME** | **$14,984** | **$216,154** | **($37,461)** | **$193,676** |
| *Operating EBIDA* | *(735)* | *271,114* | *(37,898)* | *232,480* |
| *EBIDA Margin Percentage* | *(693.9%)* | *20.2%* | *(56.1%)* | *16.5%* |
| *Operating Margin Percentage* | *(697.6%)* | *13.8%* | *(61.0%)* | *10.2%* |

# El Camino Healthcare District - CONSOLIDATED

**(in $000s)**

| | FY2021 Actual | FY2022 Projected | FY2023 Budget | Change Favorable/ (Unfavorable) | % Change |
|---|---|---|---|---|---|
| **REVENUES** | | | | | |
| Net Patient Service Revenue | 1,107,911 | 1,297,478 | 1,357,918 | 60,440 | 4.7% |
| Other Operating Revenue | 48,532 | 44,072 | 49,842 | 5,770 | 13.1% |
| Total Net Revenue | 1,156,443 | 1,341,549 | 1,407,760 | 66,210 | 4.9% |
| **EXPENSES** | | | | | |
| Salaries & Benefits | 588,470 | 669,929 | 715,317 | (45,388) | (6.8%) |
| Supplies & Other Expenses | 398,113 | 413,071 | 459,962 | (46,891) | (11.4%) |
| Interest | 16,960 | 16,908 | 16,678 | 230 | 1.4% |
| Depreciation/Amortization | 66,539 | 73,494 | 72,756 | 738 | 1.0% |
| TOTAL EXPENSES | 1,070,082 | 1,173,403 | 1,264,713 | (91,311) | (7.8%) |
| **OPERATING INCOME** | **86,362** | **168,147** | **143,046** | **(25,100)** | **(14.9%)** |
| Non Operating Income | 258,542 | (111,091) | 50,629 | 161,720 | (145.6%) |
| **NET INCOME** | **344,904** | **57,056** | **193,676** | **136,620** | **239.5%** |
| *Operating EBIDA* | *169,860* | *258,549* | *232,480* | *(26,069)* | (10.1%) |
| *EBIDA Margin Percentage* | *14.7%* | *19.3%* | *16.5%* | | |
| *Operating Margin Percentage* | *7.5%* | *12.5%* | *10.2%* | | |

# Proposed Motion

- To approve and adopt the Fiscal Year 2023 operating budget and allocation of M&O tax funds as recommended by management

**EL CAMINO HEALTHCARE DISTRICT**
**PACING PLAN / MASTER CALENDAR**

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | 10/18 | NOV | 12/13 | JAN | 2/8 | 3/28 | APR | 5/16 | 6/20 |
| **STANDARD** | | | | | | | | | | | | |
| Public Communication | | | | ✓ | | | | ✓ | ✓ | | ✓ | ✓ |
| Spotlight Recognition | | | | ✓ | | | | ✓ | | | ✓ | |
| **FINANCE[4]** | | | | | | | | | | | | |
| Financials | | | | ✓ | | | | ✓ | ✓ | | | ✓ |
| Budget | | | | | | | | | | | ✓ | ✓ |
| Tax Appropriation | | | | | | | | | | | | ✓ |
| **COMPLIANCE** | | | | | | | | | | | | |
| Financial Audit – Consolidated ECH District Financials | | | | ✓ | | | | | | | | |
| Approve Hospital Audit | | | | ✓ | | | | | | | | |
| **COMMUNITY BENEFIT** | | | | | | | | | | | | |
| CB Year-End Report | | | | ✓ | | | | | | | | |
| CBAC Policy – Annual Approval | | | | ✓ | | | | | | | | |
| CB Plan Study Session | | | | | | | | | | | ✓ | |
| CB Mid-Year Metrics | | | | | | | | | | | ✓ | |
| Approval of CB Plan | | | | | | | | | | | | ✓ |
| **GOVERNANCE** | | | | | | | | | | | | |
| Appointment of El Camino Hospital Board Member Election Ad Hoc Committee & Advisors | | | | ✓ | | | | | | | | |
| El Camino Hospital Board Member Election Ad Hoc Committee Update | | | | | | | | ✓ | ✓ | | | |
| Possible Election of El Camino Hospital Board Member | | | | | | | | | ✓ | | | |
| Review Process for Board Officer Election | | | | | | | | | | | ✓ | |
| Appointment of Liaison to the Community Benefit Advisory Council | | | | | | | | | | | | ✓ |
| Approval of Pacing Plan & Meeting Dates | | | | | | | | | | | | ✓ |
| Acceptance of Election Results | | | | | | ✓ | | | | | | |
| Administration of Oath | | | | | | ✓ | | | | | | |
| **EXECUTIVE PERFORMANCE** | | | | | | | | | | | | |
| CEO Performance Review | | | | ✓ | | | | | | | | |

Revised: 6/4/2022

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Jon Cowan, Senior Director Government Relations & Community Partnerships
**Date:** June 14, 2022
**Subject:** Community Benefit Sponsorships

**Purpose:**

To provide the Board with FY22 ECHD Sponsorships in June 2022.

**Summary:**

**1.** Situation: Community Benefit Staff was asked to keep the Board informed regarding Community Benefit Sponsorships YTD.

**2.** Authority: Board reviewed and approved $85,000 for Sponsorships in the FY22 Community Benefit Plan in June 2021.

**3.** Background:

- Sponsorship information and instructions are available on the District website.
- Requests include sponsorship packets that outline event date, purpose, levels of sponsorship and requirements for sponsor acknowledgement. These requests are reviewed throughout the year as they come in by Community Benefit Staff and the other designated departments that provide community sponsorships (*e.g.*, Marketing & Communications and Government & Community Relations).
- Community Benefit-funded Sponsorships provide general support for health-related agencies improving the well-being of the community.
- Community Benefit Sponsorships from **June 1, 2022 - June 30, 2022** totaled **$0.**

**4.** Assessment: The last FY22 ECHD Sponsorships update to the District Board on May 17 detailed the **$17,000** in Community Benefit Sponsorships from **April 1, 2022 - May 31, 2022**

**5.** Other Reviews: N/A

**6.** Outcomes: N/A

**List of Attachments:** N/A

**Suggested Board Discussion Questions:** None. This is an informational consent item.

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Julia E. Miller, Board Chair
**Date:** June 14, 2022
**Subject:** Appointment of Liaison to Community Benefit Advisory Council (CBAC)

**Recommendation(s):**

To appoint Director Carol Somersille to serve as the District's non-voting liaison to the CBAC for FY23.

**Summary:**

**1.** Situation: Each year the District Board appoints one of its members to serve as a non-voting liaison to the CBAC.

**2.** Authority: Community Benefit Policy

**3.** Background: This assignment requires attendance at between one (1) and three (3) meetings each year.

**4.** Outcomes: Appointment of liaison to the CBAC for FY23.

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Julia E. Miller, Board Chair
**Date:** June 14, 2022
**Subject:** Draft Resolution 2022-08 Appointment of FY23 El Camino Hospital Board Member Reappointment Ad Hoc Committee Chair, Member, and Advisors.

**Recommendation(s):** To approve Draft Resolution 2022-08

**Summary:**

**1.** Situation: Two of the current El Camino Hospital ("ECH") Board Members (Julie Kliger and Bob Rebitzer) have terms expiring on June 30, 2023.

**2.** Authority: Pursuant to the Board-approved "Process for Appointment and Reappointment of Non-District Board Members to the El Camino Hospital Board of Directors" (the "Process"), the District Board appoints an Ad Hoc Committee to consider the reappointment of the ECH Board members whose terms are set to expire at the end of the upcoming fiscal year.

**3.** Background: The Process provides that the Committee will consist of two members of the ECHD Board. It also provides that the ECHD Board will appoint up to two advisors:

- One Hospital Board Director who is not a member of the District Board and serving on the ECH Governance Committee; and
- One Hospital Board Director who is not a member of the District Board
- Both should be referred by the El Camino Hospital Board Chair

**A.** Article VII, Section 1 of the El Camino Healthcare District Bylaws, as further reviewed by General Counsel, provides for the Board Chair to appoint the Chairperson of the Committee and may self-appoint.
**B.** The Process provides for the Board to appoint the other member of the Committee and up to two advisors.

- Appointment of Julia E. Miller as the Chairperson of the Committee.
- Nominations from the floor for the second District Board member of the Committee.

**4.** Other Reviews: None

**5.** Outcomes: Appointment of An Ad Hoc Committee to consider the reappointment of ECH Board Members Julie Kliger and Bob Rebitzer to the ECH Board of Directors.

**List of Attachments:** None.

**Suggested Board Discussion Questions:** None.

**EL CAMINO HEALTHCARE DISTRICT**
**RESOLUTION 2022-08**
**APPOINTMENT OF SPECIAL ADVISORY COMMITTEE FOR LIMITED PURPOSE AND LIMITED DURATION**

**WHEREAS**, the Board of Directors has determined it is necessary to carefully consider and prepare for the reappointment or appointment of Directors to the El Camino Hospital Board,

**WHEREAS**, such work can be undertaken by a special advisory committee for presentation to and consideration by the Board of Directors at a future meeting; now, therefore, be it.

**RESOLVED**, that a temporary advisory special committee ("The El Camino Hospital Board Member Reappointment Ad Hoc Committee"), consisting of two members is hereby established pursuant to Article VII, Section 1 of the Bylaws of the El Camino Healthcare District, to carefully consider and prepare for the FY 2023 appointment or reappointment of one or more Directors to the El Camino Hospital Board.

**RESOLVED**, that the members of the temporary advisory special committee shall determine the time, place, date, and frequency of such committee meetings; be it further.

**RESOLVED**, that Julia E. Miller is appointed as Chair of the temporary advisory special committee; be it further

**RESOLVED**, that _____ shall also serve as a member of the committee having been appointed as Chairperson of the committee by the Board Chairperson; be it further

**RESOLVED,** that two advisors to the Committee may be recommended by the Chair of the El Camino Hospital Board of Directors.

**DULY PASSED AND ADOPTED** at a regular meeting held on June 14, 2022, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Carol A. Somersille, MD, Secretary
ECHD Board of Directors

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING MEMO**

**To:** El Camino Healthcare District Board (ECHD) of Directors
**From:** Carol A. Somersille, MD: Ad Hoc Committee Chair
**Date:** June 14, 2022
**Subject:** FY23 El Camino Healthcare District Mission Statement Review Ad Hoc Committee Recommendations

**Purpose**: To inform the Board of FY23 El Camino Healthcare District Mission Statement Review Ad Hoc Committee recommendations

**Recommendation**: To approve the proposed revisions to the El Camino Healthcare Mission Statement as detailed below and approve the request for the ad hoc committee to craft a separate purpose statement to explain the "why."

**Summary:**

**1.** Situation: The FY23 El Camino Healthcare District Mission Statement Review Ad Hoc Committee was formed on May 17, 2022, to review and revise the District's Mission Statement.

**2.** Authority: None

**3.** Background: The FY23 El Camino Healthcare District Mission Statement Review Ad Hoc Committee reviewed the current Mission Statement, as defined in Article I (Purpose) of the District Bylaws, and recommend the following revisions:

Original - El Camino Healthcare District (ECHD) Mission & Purpose
The purpose of the District shall be to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to do any and all other acts and things necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

**New - El Camino Healthcare District (ECHD) Mission**
The mission of the District shall be to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to undertake any and all other acts necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

**4.** Assessment: None

**5.** Other Reviews: None

**6.** Outcomes:

**A.** The El Camino Healthcare District Board approves the proposed mission statement.
**B.** The El Camino Healthcare District Board approves the recommendation for the ad hoc committee to craft a separate purpose statement to explain the "why."

**List of Attachments:** None

**Suggested Board Discussion Questions:** None

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Julia E. Miller, Board Chair
**Date:** June 14, 2022
**Subject:** Approval of Draft Resolution 2022-09 Requesting and Consenting to Consolidation of Election

**Recommendation**:

To approve Resolution 2022-09 Requesting and Consenting to Consolidation of Election.

**Summary:**

**1.** Situation: Two District Director seats will be filled at the election on November 8, 2022. Both seats, currently held by Directors Fung and Ting, are for 4-year terms. Staff has completed, and Legal has reviewed Resolution 2022-09 Requesting and Consenting to Consolidation of Election.

**2.** Authority: In order to participate in the November 2022 General Election, the District must approve Resolution 2022-09.

**3.** Background: Resolution 2022-09 is consistent with the District's past practice of limiting candidate statements to 400 words and requiring candidates to cover certain costs (*See*, Section 5).

**4.** Assessment: N/A

**5.** Other Reviews: N/A

**6.** Outcomes: Participation in the 2022 General Election.

**List of Attachments:**

**1.** Draft Resolution 2022-09

**Suggested Board Discussion Questions:** None.

# DRAFT
# RESOLUTION NO. 2022-09

## REQUEST FOR AND CONSENT TO CONSOLIDATION OF ELECTION

**WHEREAS,** a Biennial District General Election has been ordered to be held on Tuesday, November 8, 2022, in the El Camino Healthcare District of Santa Clara County for the purpose of electing:

| Number of Seat(s) | Length of Term | Exact Title of Each Office to be Held |
|---|---|---|
| 2 | 4 Year | Director |
| | | |
| | | |
| | | |
| | | |

of the District; and,

**WHEREAS**, pursuant to Part 3 (commencing with Section 10400) of the Elections Code of the State of California, such election may be either completely or partially consolidated; and,

**NOW, THEREFORE, BE IT RESOLVED:**

**Section 1**. That the Board of Directors of the El Camino Healthcare District calls for an election to be held on November 8, 2022 and requests the Board of Supervisors of Santa Clara County to completely consolidate the election with the statewide election.

**Section 2**. That the Board of Directors of the El Camino Healthcare District requests the Board of Supervisors of Santa Clara County to hold and conduct the election in the manner prescribed in Section 10418 of the Elections Code of the State of California and to further provide that the Registrar of Voters canvass the returns of the election. The election shall be held in all respects as if there were only one election, and only one form of ballot shall be used.

**Section 3**. That pursuant to Section 10508 of the Elections Code of the State of California, said officers are to be elected and that the divisions, if any, from which said directors are to be elected, and the number of offices to be filled from each, are:

| At Large | By Division | Number of Offices/Divisions |
|---|---|---|
| X | | 2 |
| | | |
| | | |
| | | |
| | | |

**Section 4**. That pursuant to Sections 10002 and 10520 of the Elections Code of the State of California, each district involved in a district general election in an affected county shall reimburse the county for the actual costs incurred by the county elections official in conducting the district general election for that district.

**Section 5**. That the candidates' statements of qualifications shall be limited to:

- 400 words and,
- That the cost of printing, translating and distributing said statements shall be borne by the candidates who file such statements; and,
- That each candidate who files such a statement shall be required to pay in advance his or her pro rata share of the estimated costs of printing, handling, and mailing said candidate statement, such estimated costs to be determined by the Registrar of Voters.

**Section 6**. That pursuant to Section 10522 of the Elections Code of the State of California, a current map showing the boundaries of the district and the boundaries of the divisions of the district is herewith submitted.

**Section 7**. That pursuant to Sections 10551 and 15651 of the Elections Code of the State of California, the method of determining the winner or winners in the event of a tie vote shall be by lot.

**Section 8.** That the following is listed below:

1) Names of all current Board Members; and,
2) Term: full or short; and,
3) Seats elected by: District or At Large:

| **Member Names** | **Term: Full or Short** | **Seats Elected by Division / At Large** |
|---|---|---|
| Peter C. Fung, MD | Full (ends Nov, 2022) | At Large |
| Julia E. Miller | Full (ends Nov. 2024) | At Large |
| Carol A. Somersille, MD | Full (ends Nov. 2024) | At Large |
| George O. Ting, MD | Full (ends Nov. 2022) | At Large |
| John Zoglin | Full (ends Nov. 2024) | At Large |

// **Section 9.** That the Clerk of the Board of Directors is hereby directed to forward without delay a certified copy of this resolution to both the Board of Supervisors of the County of Santa Clara and the Santa Clara County Registrar of Voters.

**Section 10.** That the Board of Supervisors of the County of Santa Clara is requested to issue instructions to the Santa Clara County Registrar of Voters to take any and all steps necessary for the holding of the consolidated election.

//

//

**PASSED AND ADOPTED** by the Board of Directors of the El Camino Healthcare District, State of California, on June 14, 2022, by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Julia E. Miller, Chair
Board of Directors of the El Camino Healthcare District

ATTEST:

_____
Shiraz Ali
Clerk of the Board of Directors of the El Camino Healthcare District

APPROVED AS TO FORM AND LEGALITY:

_____
Mary Rotunno, General Counsel

*Dedicated to improving the health and well being of the people in our community.*

**Board Finance Presentation**
**Fiscal Year 2022**
**7/1/2021-4/30/2022**

Carlos Bohorquez, CFO
El Camino Healthcare District Board of Directors Meeting
June 14, 2022

# Table of Contents

## ECHD Consolidated Financial Statements (Includes El Camino Hospital)



## ECHD Stand-Alone Financial Statements



NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

# El Camino Healthcare District

## Consolidated Comparative Balance Sheet ($ Millions)

### (Includes El Camino Hospital)

| | Apr 30, 2022 | June 30, 2021 Audited w/o Eliminations |
|---|---|---|
| **ASSETS** | | |
| **Current Assets** | | |
| Cash & Investments | $358 | $457 |
| Patient Accounts Receivable, net | 202 | 166 |
| Other Accounts and Notes Receivable | 21 | 28 |
| Inventories and Prepaids | 30 | 23 |
| **Total Current Assets** | **611** | **674** |
| **Board Designated Assets** | | |
| Foundation Reserves | 20 | 21 |
| Community Benefit Fund | 22 | 21 |
| Operational Reserve Fund [1] | 184 | 125 |
| Workers Comp, Health & PTO Reserves | 83 | 80 |
| Facilities Replacement Fund [2] | 356 | 313 |
| Catastrophic & Malpractice Reserve [3] | 28 | 27 |
| **Total Board Designated Assets** | **694** | **587** |
| **Non-Designated Assets** | | |
| Funds Held By Trustee [4] | 32 | 37 |
| Long Term Investments | 515 | 603 |
| Other Investments | 34 | 35 |
| Net Property Plant & Equipment | 1,192 | 1,160 |
| Deferred Outflows of Resources | 19 | 20 |
| Other Assets | 145 | 148 |
| **Total Non-Designated Assets** | **1,939** | **2,003** |
| **TOTAL ASSETS** | **$3,244** | **$3,264** |

| | Apr 30, 2022 | June 30, 2021 Audited w/o Eliminations |
|---|---|---|
| **LIABILITIES & FUND BALANCE** | | |
| **Current Liabilities** | | |
| Accounts Payable & Accrued Exp [5] | $145 | $154 |
| Bonds Payable - Current | 16 | 14 |
| Bond Interest Payable | 6 | 10 |
| Other Liabilities | 16 | 19 |
| **Total Current Liabilities** | **182** | **198** |
| **Deferred Revenue** | **28** | **67** |
| **Deferred Revenue Inflow of Resources** | **46** | **46** |
| **Long Term Liabilities** | | |
| Bond Payable | 575 | 595 |
| Benefit Obligations | 48 | 48 |
| Other Long-term Obligations | 7 | 6 |
| **Total Long Term Liabilities** | **630** | **649** |
| **Fund Balance** | | |
| Unrestricted | 2,183 | 2,157 |
| Board Designated & Restricted | 175 | 147 |
| Capital & Retained Earnings | 0 | 0 |
| **Total Fund Balance** | **2,358** | **2,304** |
| **TOTAL LIAB. & FUND BAL.** | **$3,244** | **$3,264** |

*Note: Totals may not agree due to rounding. See page 5 for footnotes.*

# El Camino Healthcare District

## Consolidated Comparative Statement of Revenues & Expenses ($ Millions)

## Year-to-Date through April 30, 2022

### (Includes El Camino Hospital)

| | Actual | Budget | Fav (Unfav) Variance | Prior YTD FY Actual |
|---|---|---|---|---|
| Net Patient Revenue [6] | 1,081 | 954 | 127 | 900 |
| Other Operating Revenues | 37 | 37 | 0 | 38 |
| **Total Operating Revenues** | **1,118** | **991** | **127** | **939** |
| Wages and Benefits | 558 | 522 | -36 | 492 |
| Supplies | 154 | 145 | -9 | 141 |
| Purchased Services | 152 | 144 | -8 | 146 |
| Other | 38 | 42 | 5 | 35 |
| Depreciation | 61 | 56 | -5 | 56 |
| Interest | 14 | 14 | 0 | 14 |
| Total Operating Expense [7] | **978** | **924** | **(53)** | **885** |
| **Operating Income** | **140** | **66** | **74** | **54** |
| Non-Operating Income [8] | (91) | 89 | (180) | 219 |
| **Net Income** | **49** | **156** | **(106)** | **273** |

*Note: Totals or variances may not agree due to rounding. See page 5 for footnotes.*

# El Camino Healthcare District

## Notes to Consolidated Financial Statements

### Current FY2022 Actual to Budget

### (Includes El Camino Hospital)

1) A 60 day reserve of expenses based on the current fiscal year's Hospital budget.
2) The current period Facilities Replacement Fund is comprised of ($ Millions):

| | |
|---|---|
| ECH Capital Replacement Fund (i.e. Funded Depr.) | $308 |
| ECHD Appropriation Fund (fka: Capital Outlay) | 18 |
| ECH Women's Hospital Expansion | 30 |
| | $356 |

3) The current period Catastrophic & Malpractice Fund is comprised of ($ Millions):

| | |
|---|---|
| ECH Catastrophic Fund (aka: Earthquake Fund) | $26 |
| ECH Malpractice Reserve | 2 |
| | $28 |

4) The decrease is due to the Bond Project Fund final disbursements for the IMOB and BHS construction, and most recently the Women's Hospital Expansion. This amount now reflects the GO Funds only.
5) The decrease is primarily due to construction retentions accrued at fiscal year end for the Behavioral Health and the IMOB buildings that have been subsequently paid down.
6) Strong volumes recovery from COVID-19 continues to be the primary driver to such a favorable performance to budget.
7) Higher operating expenses are due to the increased volumes and expenses associated with the COVID-19 pandemic.
8) The variance is due to decreased investment returns.

# El Camino Healthcare District

## Stand-Alone Comparative Balance Sheet ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | April 30, 2022 | June 30, 2021 | | April 30, 2022 | June 30, 2021 |
|---|---|---|---|---|---|
| **ASSETS** | | | **LIABILITIES & FUND BALANCE** | | |
| Cash & cash equiv [1] | $17,651 | $8,662 | Accounts payable | $5 | $2 |
| Short term investments [1] | 2,398 | 12,042 | Current portion of bonds | 5,760 | 5,050 |
| Due fm Retiree Health Plan [2] | 36 | 21 | Bond interest payable [10] | 788 | 1,419 |
| S.C. M&O Taxes Receivable [3] | 0 | 0 | Other Liabilities | 334 | 1,871 |
| Other current assets [3a] | 74 | 3061 | | | |
| **Total current assets** | $20,158 | $23,786 | **Total current liabilities** | $6,887 | $8,342 |
| Operational Reserve Fund [4] | 1,500 | 1,500 | | | |
| Capital Appropriation Fund [5] | 17,500 | 18,657 | | | |
| Capital Replacement Fund [6] | 4,903 | 5,646 | Deferred income | 70 | 51 |
| Community Benefit Fund [7] | 4,388 | 3,030 | Bonds payable - long term | 105,662 | 111,422 |
| **Total Board designated funds** | $28,291 | $28,834 | **Total liabilities** | **$112,619** | **$119,815** |
| **Funds held by trustee [8]** | **$32,491** | **$31,245** | **Fund balance** | | |
| **Capital assets, net [9]** | **$10,649** | **$10,657** | Unrestricted fund balance | $58,637 | $61,513 |
| | | | Restricted fund balance [11] | (79,668) | (86,806) |
| | | | **Total fund balance** | **($21,031)** | **($25,293)** |
| **TOTAL ASSETS** | **$91,588** | **$94,522** | **TOTAL LIAB & FUND BALANCE** | **$91,588** | **$94,522** |

*Note: Totals may not agree due to rounding. See page 9 for footnotes.*

# El Camino Healthcare District

## YTD Stand-Alone Stmt of Revenue and Expenses ($ Thousands)

## Comparative Year-to-Date April 30, 2022

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | | Actual | Current Year Budget | Variance | Prior Full Year Actual |
|---|---|---|---|---|---|
| | **REVENUES** | | | | |
| (A) | Ground Lease Revenue [12] | $ 86 | 85 | $ 1 | $ 101 |
| (B) | Redevelopment Taxes [13] | 212 | 150 | 62 | 310 |
| (B) | Unrestricted M&O Property Taxes [13] | 9,804 | 9,804 | - | 9,221 |
| (B) | Restricted M&O Property Taxes [13] | 7,264 | 7,264 | - | 11,129 |
| (B) | G.O. Taxes Levied for Debt Service [13] | 9,587 | 8,500 | 1,087 | 11,803 |
| (B) | IGT/PRIME Medi-Cal Program [14] | (2,540) | (4,012) | 1,472 | (4,460) |
| (B) | Investment Income (net) | (1,285) | 695 | (1,980) | (23) |
| (B) | Other income | - | 271 | (271) | 0 |
| | **TOTAL NET REVENUE** | 23,128 | 22,757 | 371 | 28,081 |
| | **EXPENSES** | | | | |
| (A) | Wages & Benefits [15] | 1 | - | - | 0 |
| (A) | Professional Fees & Purchased Svcs [16] | 390 | 453 | 63 | 849 |
| (A) | Supplies & Other Expenses [17] | 97 | 27 | (70) | 82 |
| (B) | G.O. Bond Interest Expense (net) [18] | 2,515 | 2,473 | (42) | 3,082 |
| (B) | Community Benefit Expenditures [19] | 7,310 | 7,419 | 109 | 7,196 |
| (A) | Depreciation / Amortization | 9 | 9 | - | 53 |
| | **TOTAL EXPENSES** | 10,322 | 10,381 | 60 | 11,262 |
| | **NET INCOME** | $ 12,806 | $ 12,376 | $ 430 | $ 16,820 |

(A) Operating Revenues & Expenses

(B) Non-operating Revenues & Expenses

| | **RECAP STATEMENT OF REVENUES & EXPENSE** | |
|---|---|---|
| (A) | Net Operating Revenues & Expenses | $ (410) |
| (B) | Net Non-Operating Revenues & Expenses | 13,217 |
| | **NET INCOME** | $ 12,807 |

*Note: Totals may not agree due to rounding. See page 10 for footnotes.*

# El Camino Healthcare District

## Comparative YTD Stand-Alone Stmt of Fund Balance Activity ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| | April 30, 2022 | June 30, 2021 |
|---|---|---|
| **Fiscal year beginning balance** | **$ (25,293)** | **$ (38,734)** |
| Net income year-to-date | $ 12,807 | $ 16,820 |
| Transfers (to)/from ECH: | | |
| IGT/PRIME Funding [20] | $ 434 | $ 4,460 |
| Capital Appropriation projects [21] | $ (8,979) | (7,839) |
| **Fiscal year ending balance** | **$ (21,031)** | **$ (25,293)** |

*Note: Totals may not agree due to rounding. See page 10 for footnotes.*

# El Camino Healthcare District

## Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

**(1) Cash & Short Term Investments –** The decrease is due to transfer to Community Benefit Fund for 2022.

**(2) Due from Retiree Health Plan –** The monies due from Trustee for District's Retiree Healthcare Plan.

**(3) S.C. M&O Taxes Receivable –** No change.

**(3a) Other Current Assets** – This decrease is due to Healthcare District paying for IGT refund to the State that was to be paid by the Hospital.

**(4) Operational Reserve Fund** – Starting in FY 2014, the Board established an operational reserve for unanticipated operating expenses of the District.

**(5) Capital Appropriation Fund –** Commitment to the Women's Hospital renovation project or others.

**(6) Capital Replacement Fund** – Formerly known as the Plant Facilities Fund (AKA - Funded Depreciation) which reserves monies for the major renovation or replacement of the portion of the YMCA (Park Pavilion) owned by the District.

**(7) Community Benefit Fund –** This fund retains unrestricted (Gann Limit) funds to support the District's operations and primarily to support its Community Benefit Programs

**(8) Funds Held by Trustee –** Funds from General Obligation tax monies, being held to make the debt payments when due.

**(9) Capital Net Assets -** The land on which the Mountain View Hospital resides, a portion of the YMCA building, property at the end of South Drive (currently for the Road Runners operations), and a vacant lot located at El Camino Real and Phyllis.

**(10) Bond Interest Payable –** The decrease is due to the semi-annual interest payment paid on 2/1/2022.

**(11) Fund Balance –** The negative fund balance is a result of the General Obligation bonds which assisted in funding the replacement hospital facility in Mountain View. Accounting rules required the District to recognize the obligation in full at the time the bonds were issued ; receipts from taxpayers will be recognized in the year they are levied, slowly reducing the negative fund balance over the next 15 years.

# El Camino Healthcare District

## Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

**(12) Other Operating Revenue –** Lease income from El Camino Hospital for its ground lease with the District.

**(13) Taxes: Redevelopment, M&O, G.O.** – Tax receipts (either received or to be received) during the period. Note amount for the G.O. Taxed Levied for Debt will come in less than prior year mostly due to the March 2017 G.O. Refunding that the District did that reduced the previously $12.90 of assessed property valuation per $100,000 to a current $10.00 per $100,000.

**(14) IGT/PRIME Expense** – Payments in support of the PRIME or IGT programs.

**(15) Wages & Benefits –** Due to a new IRS reg that board stipends previously paid as reportable 1099 transactions are now considered to be W-2 reportable transactions, and reported in this section, where previously reported in the "Supplies & Other Expenses." There will continue to be no other "employees" of the District. This change will start to take place in April.

**(16) Professional Fees & Services** – Actual detailed below:

| | |
|---|---|
| • Community Benefit Support from ECH (54% of SW&B) | $ 318 |
| • Legal Fees | 59 |
| • Miscellaneous | 13 |
| | $ 390 |

**(17) Supplies & Other Expenses –** Actual detailed below:

| | |
|---|---|
| • Marketing / Advertising | $ 95 |
| • Board Stipends | 2 |
| | $ 97 |

**(18) G.O. Bond Interest Expense –** It is to be noted that on March 22, 2017 the District refunded $99M of its remaining $132M 2006 G.O. bond issue. Refunding of the 2006 G.O. debt, given current interest rates, caused a net present value savings of $7M.

**(19) Community Benefit Expenditures –** Starting in FY2014, the District is directly operating its Community Benefit Program at the District level. This represents amounts expended to grantees and sponsorships thus far in this fiscal year. Note the major payments to recipients are made in August & January of the fiscal year.

**(20) IGT/PRIME Funding** – Transfers from ECH for participation in the PRIME or IGT program thus far in FY 2022.

**(21) Capital Appropriation Projects Transfer** – This years transfer is in support of MV Hospital's Campus Completion Project.

# El Camino Healthcare District

## Sources & Uses of Tax Receipts ($Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

| **Sources of District Taxes** | **04/30/22** |
|---|---|
| (1) Maintenance and Operation and Government Obligation Taxes | $26,655 |
| (2) Redevelopment Agency Taxes | 212 |
| **Total District Tax Receipts** | **$26,867** |
| **Uses Required Obligations / Operations** | |
| (3) Government Obligation Bond | 9,587 |
| **Total Cash Available for Operations, CB Programs, & Capital Appropriations** | **17,280** |
| (4) Capital Appropriation Fund – Excess Gann Initiative Restricted* | 7,264 |
| **Subtotal** | **10,016** |
| (5) Operating Expenses (Net) | 410 |
| **Subtotal** | **9,606** |
| (6) Capital Replacement Fund (Park Pavilion) | 12 |
| **Funds Available for Community Benefit Programs** | **$9,594** |
| *Gann Limit Calculation for FY2022 | $9,804 |

| | |
|---|---|
| (1) M&O and G.O. Taxes | • Cash receipts from the 1% ad valorem property taxes and Measure D taxes |
| (2) Redevelopment Agency Taxes | • Cash receipts from dissolution of redevelopment agencies |
| (3) Government Obligation Bond | • Levied for debt service |
| (4) Capital Appropriation Fund | • Excess amounts over the Gann Limit are restricted for use as capital |
| (5) Operating Expenses | • Expenses incurred in carrying out the District's day-to-day activities |
| (6) Capital Replacement Fund | • Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion) |

**Appendix**: Major Budget Assumptions for FY2022

1. Pages 13 and 14: Are the pages 6 and 7 of the FY22 ECHD Stand-Alone Budget presented to the ECHD Board and approved on June 29, 2021.

2. Page 15: Additional detail about Community Benefit SW&B allocation process

**Appendix**: General Obligation Bond of the District

1. Pages 16 and 17: Description of the Bonds and annual debt service requirements grid.

# Major Budget Assumptions – El Camino Healthcare District

## *Excludes El Camino Hospital & its affiliates*

- Other Operating Revenue is based on the existing ground lease agreement.
- The Unrestricted M&O Property Taxes are budgeted at the FY2022 Gann Limit calculation as directed by the Finance Department of the State of California.
- This year the Redevelopment Agency revenues were once again budgeted as they continue to be distributed by the County without any lapse in payments in the past years. The decrease in these expenses is attributable, in a large part, that in fiscal year 2021 it had a projected budget of $250,000 for the November 2020 District Board election.
- Operating Expenses are based on historical payment information with adjustments made for non-recurring expenses.
- Community Benefit Support fee based on the cost of services as follows:

| Community Benefit Staff FY2022 | | Total Paid FTEs | |
|---|---|---|---|
| | | | |
| VP Corp Comm Hlth Svcs | | | 0.25 |
| Director Community Benefit | | | 0.75 |
| Administrative Assistant | | | 1.00 |
| Sr Community Benefit Spec | | | 2.00 |
| Business Coordinator | | | 0.20 |
| Total | | | 4.20 |
| Total Salaries, Wages & Benefits | | $ | 705,558 |
| | | | |
| Estimated allocation of time at 54% = | | $ | 381,001 |

- Supplies and Other Expenses includes modest increases for Direct Mail material, website development, advertising and postage. The District's budgeted dues are expected to remain a constant of LAFCO at an amount of $18,000 and $7,000 for California Special Districts Association.
- Expenses related to the G.O. bonds are based on the 2017 G.O. Refunding outcomes and required payment schedules.
- Investment income is based on the expected return rate provided by our Investment Consultant of on an average cash balance of $40M.
- Community Benefit expenditures are based on the Community Benefit plan.
- IGT – Medi-Cal (PRIME) program - It is expected that the District/Hospital will participate in the program again this year.

# El Camino Healthcare District FY2022 Budget

*Information excludes El Camino Hospital & its affiliates*

**($000s)**

| | Revenues | FY2020 Actual | FY2021 Actual | FY 2022 Budget | Change Favorable / (Unfavorable) | % Change |
|---|---|---|---|---|---|---|
| (A) | Other Operating Revenue | 91 | 101 | 102 | 1 | 1.0% |
| (B) | Unrestricted M&O Property Taxes | 8,845 | 9,221 | 9,804 | 583 | 6.3% |
| (B) | Restricted M&O Taxes | 9,706 | 11,129 | 8,717 | (2,412) | -21.7% |
| (B) | Taxes Levied for Debt Service | 10,493 | 11,803 | 10,200 | (1,603) | -13.6% |
| (B) | Investment Income (net) | 1,444 | (23) | 848 | 871 | 3587.0% |
| (B) | Other - Redevelopment Agency | 325 | 310 | 300 | (10) | -3.2% |
| | **Total Net Revenue** | 30,904 | 32,541 | 29,971 | (2,570) | -7.9% |
| | | | | | | |
| | **Expenses** | | | | | |
| (A) | Community Benefit Support | 397 | 416 | 381 | 35 | -8.4% |
| (A) | Fees & Purchased Services | 156 | 432 | 162 | 270 | 166.7% |
| (A) | Supplies & Other Expenses | 90 | 82 | 32 | 50 | 156.3% |
| (A) | Depreciation/Amortization/Interest Expense | 57 | 53 | 9 | 44 | 488.9% |
| (B) | G.O. Interest Expense (net) | 2,474 | 3,082 | 2,656 | 426 | 16.0% |
| (B) | Community Benefit Program | 7,544 | 7,196 | 7,665 | (469) | -6.1% |
| (B) | IGT Medi-Cal Program Expense | 4,048 | 4,460 | 4,000 | 460 | 11.5% |
| | **Total Expenses** | 14,766 | 15,721 | 14,905 | 816 | 5.5% |
| | **NET INCOME** | 16,138 | 16,820 | 15,066 | (1,754) | -10.4% |

| | FY22 BUDGET RECAP STATEMENT OF REVENUES & EXPENSE | |
|---|---|---|
| (A) | Net Operating Revenues & Expenses | (482) |
| (B) | Net Non-Operating Revenues & Expenses | 15,548 |
| | **NET INCOME** | 15,066 |

# FY2022 Budget - Community Benefit SW&B Allocation

- Community Benefit staff are El Camino Hospital (ECH) employees who provide services to the District and to the Hospital Corporation.
- Pursuant to a Statement of Work (SOW) between El Camino Hospital and the District, Community Benefit Staff SW&B are allocated between the Hospital and the District.
- Per the SOW, the allocation is to be negotiated between the District Board Chair and the ECH Controller each spring for the coming fiscal year.
- For FY2021, the total SW&B for the Community Benefit staff is budgeted at $771,414 with 54% ($416,564) allocated to the District. The Board Chair reviewed this allocation with Controller, Michael Walsh, and approved the allocation.
- For FY2022, the total SW&B for the Community Benefit staff came in lower than FY2021 at $705,558 with no change in the allocation percentage of 54%. Thus the allocation for FY2022 will be a reduced amount of $381,001.

# El Camino Healthcare District
# General Obligation Bonds of the District

- 2006 General Obligation Bonds - Upon voter approval, in November 2003, the District issued in 2006, $148,000,000 principle amount of 2006 General Obligation Bonds, which consists of $115,665,000 of Current Interest Bonds. Interest on the Current Interest Bonds is payable semiannually at rates ranging from 4% to 5% and principal maturities ranging from $2,065,000 in 2016 to $18,050,000 in 2036 are due annually on August 1. Interest at rates ranging from 4.38% to 4.48% and principal of the Capital Appreciation Bonds are payable only at maturity. In March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the 2017 General Obligation Refunding Bonds.

- The Bonds are general obligations of the District payable from ad valorem taxes. Payment of principal, interest and maturity value of the Bonds, when due, is insured by a municipal bond insurance policy.

- 2017 General Obligation Bonds - Upon Board approval, in March 2017, the District advanced refunded a portion of the 2006 General Obligation Bonds, through the issuance of the $99,035,000 2017 General Obligation Refunding Bonds, which consists of $115,665,000 of Current Interest Bonds, and $32,335,000 of Capital Appreciation Bonds. Interest on the 2017 General Obligation Refunding Bonds is payable semiannually at rates ranging from 2% to 5% and principal maturities ranging from $3,570,000 in 2017 to $17,480,000 in 2036 are due annually on August 1. This refinancing resulted in a reduction of future interest payments with a present value of approximately $7,000,000.

# Annual Debt Service Requirements

## As of August 1, 2021

| Year Ending (August 1) | 2017 G.O Refunding Bonds Principal | 2017 G.O Refunding Bonds Interest | 2017 G.O Refunding Bonds Total Debt Service | Series 2006 Capital Appreciation Bonds (1) Principal | Series 2006 Capital Appreciation Bonds (1) Accreted Interest | Series 2006 Capital Appreciation Bonds (1) Total Debt Service | Aggregate Annual Debt Service on all general obligation bonds |
|---|---|---|---|---|---|---|---|
| 2017 | $ 3,570,000 | $ 1,428,675 | $ 4,998,675 | | | | $ 4,998,675 |
| 2018 | 3,310,000 | 3,915,600 | 7,225,600 | | | | 7,225,600 |
| 2019 | 3,800,000 | 3,816,300 | 7,616,300 | | | | 7,616,300 |
| 2020 | 4,400,000 | 3,626,300 | 8,026,300 | | | | 8,026,300 |
| 2021 | 5,050,000 | 3,406,300 | 8,456,300 | | | | 8,456,300 |
| 2022 | 5,760,000 | 3,153,800 | 8,913,800 | | | | 8,913,800 |
| 2023 | | 2,865,800 | 2,865,800 | 3,293,063 | 3,476,937 | 6,770,000 | 9,635,800 |
| 2024 | | 2,865,800 | 2,865,800 | 3,397,871 | 3,922,129 | 7,320,000 | 10,185,800 |
| 2025 | | 2,865,800 | 2,865,800 | 3,411,361 | 4,278,639 | 7,690,000 | 10,555,800 |
| 2026 | | 2,865,800 | 2,865,800 | 3,551,505 | 4,843,495 | 8,395,000 | 11,260,800 |
| 2027 | | 2,865,800 | 2,865,800 | 3,598,421 | 5,306,579 | 8,905,000 | 11,770,800 |
| 2028 | | 2,865,800 | 2,865,800 | 3,673,863 | 5,846,137 | 9,520,000 | 12,385,800 |
| 2029 | | 2,865,800 | 2,865,800 | 3,741,914 | 6,413,086 | 10,155,000 | 13,020,800 |
| 2030 | | 2,865,800 | 2,865,800 | 3,802,634 | 7,007,366 | 10,810,000 | 13,675,800 |
| 2031 | | 2,865,800 | 2,865,800 | 3,864,367 | 7,645,633 | 11,510,000 | 14,375,800 |
| 2032 | 12,000,000 | 2,865,800 | 14,865,800 | | | | 14,865,800 |
| 2033 | 13,190,000 | 2,445,800 | 15,635,800 | | | | 15,635,800 |
| 2034 | 14,525,000 | 1,918,200 | 16,443,200 | | | | 16,443,200 |
| 2035 | 15,950,000 | 1,337,200 | 17,287,200 | | | | 17,287,200 |
| 2036 | 17,480,000 | 699,200 | 18,179,200 | | | | 18,179,200 |
| **Total** | $ 99,035,000 | $ 54,405,375 | $ 153,440,375 | $ 32,335,000 | $ 48,740,000 | $ 81,075,000 | $ 234,515,375 |

Blue highlighted items are paid down

2017 Outstanding Principle $78,905,000. 2006 Outstanding Principle $32,335,000.

(1) The Series 2006 Capital Appreciation Bonds are payable only at maturity on August 1 of each year, and interest on the series 2006 Capital Appreciation Bonds is compounded semiannually on each February 1 and August 1

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Carlos Bohorquez, Chief Financial Officer
Michael Walsh, Controller
**Date:** June 14, 2022
**Subject:** Draft Resolution 2022-09 Establishing Tax Appropriation Limit for FY2023 (Gann Limit)

**Purpose:** To approve Resolution 2022-10

**Summary:**

1. **Situation:** Annually, the District Board must set the Tax Appropriation Limit (Gann Limit) for the following fiscal year.

2. **Authority:** See above.

3. **Background:** Every May 1st, the Department of Finance of the State of California sends a letter to all Fiscal officers regarding "Price and Population Information." Since FY 2008/2009, we have been required to use the California Department of Finance – Demographics website link, which provides the variables for cost-of-living factors and population changes from the prior year from which we select to calculate the Prop 13 Tax Appropriation Limit. Our selections are made to maximize the funds available for Community Benefit Programs and the operational expenses of the District.

   **A.** Cost of Living Category:
   - The change in California's per capita personal income from the preceding year was a positive 7.55%.
   - The percentage change in local assessment is due to nonresidential new construction from the previous year. This change is no longer provided.

   We selected the % change in per capita personal income of a positive 7.55% (1.0755).

   **B.** Change in Population
   - The population change within the District was a positive 0.0054%.
   - The population change within the County was a negative -0.0069%.

   We selected the District: 0.0054%.

   **C.** Calculation:
   - Change in Per Capita Income of 1.0755 x Change in the County's Population of 0.0054 = 1.0813 (multiplier): Last Year's Limit of $9,804,247.00 x multiplier of 1.0813 = FY2023 Appropriation Limit of $10,601,332.00.

**List of Attachments:**

1. Draft Resolution 2022-10

**ECHD RESOLUTION 2022 - 10**

**RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR FISCAL YEAR 2023 IN ACCORDANCE WITH ARTICLE XIIIB OF THE CONSTITUTION OF THE STATE OF CALIFORNIA**

WHEREAS, El Camino Healthcare District ("District") has completed its budget analysis and preparation for fiscal year 2023 (July 1, 2022 – June 30, 2023) and, pursuant to Article XIIIB of the California Constitution and SS7900 et seq of the California Government Code, has computed its appropriations limit for such fiscal year; and

WHEREAS, S7910 requires the District to establish by resolution its appropriations limit for the upcoming fiscal year; and

WHEREAS, Article XIIIB S8 (e)(2) directs the District to select its change in the cost of living annually by using either of the following two measurements and to record the vote of the District Board in making this choice:

a) the percentage change in California per capita personal income from the preceding year, or
b) the percentage change in the local assessment roll from the preceding year for the District due to the addition of local non-residential new construction; and

WHEREAS, Article XIII S8 (f) and S790 (b) directs the District to select its change in the population annually by using either of the following two measurement(s) and to record the vote of the District Board in making this choice:

a) change in population within the District, or
b) change in population within Santa Clara County

NOW, THEREFORE BE IT RESOLVED that:

1. For fiscal year 2023, the District hereby elects to use the following measurement to calculate the District's change in the cost of living:

The percentage change in the California per capita personal income from the preceding year (7.55%).

2. For fiscal year 2023, the District hereby elects to use the following measurement to calculate the change in population:

The change in population within the District of 0.0054%.

3. The Secretary of the District is hereby directed to include in the minutes a record of the vote of each member of the District Board as to the choices set forth in paragraphs 1 and 2.

4. For fiscal year 2023, the District's total annual appropriations subject to limitation are $10,601,332.00 calculated as follows.

   a. 1.0755 x 1.0054 = 1.0813 (multiplier)
   b. 1.0813 x $9,804,247 (FY2022 limit) = $10,601,332.00

5. As required by Article XIIIB S1, the District's total annual appropriations subject to limitation for fiscal year 2023 should not exceed the District's appropriations limit for fiscal year 2023.

   DULY PASSED AND ADOPTED at a Regular Meeting held on the 14th day of June 2022 by the following votes:

   AYES:

   NOES:

   ABSENT:

   ABSTAIN:

_____

Carol A. Somersille, MD, Secretary
El Camino Healthcare District Board of Directors

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Ken King, CAO
**Date:** June 14, 2022
**Subject:** FY-2020 District Capital Outlay Fund Request

**Purpose:** This item aims to gain approval to use the FY-2020 District Capital Outlay Funds to support the Mountain View Campus Completion Project.

**Summary:**

1. Situation: The El Camino Hospital District has $9,705,831 of Capital Outlay Funds from fiscal year 2020 that must be allocated for use within a two-year period. Note that expenditure from the Capital Outlay Fund must be for a capital land/building project or equipment that has a cost of greater than $100,000 and a useful life of 10 years or more.

2. Authority: The El Camino Healthcare District Board is required to allocate these funds for a qualifying capital project.

3. Background: The Campus Completion Project Includes the Demolition of the old main hospital building and the construction of a new service yard along with a corridor connection between the main hospital and the new Taube Pavilion. To date, the Hospital Board of Directors has approved $24.9 million for two initial phases of work, including a temporary service yard (required for the safe demolition of the old hospital building) and the actual demolition and protection of existing structures. The scope of the final phase of work, which has not yet been presented, is estimated to cost between $50 and $55 million.

4. Assessment: For reference, see below how the El Camino Healthcare District Capital Outlay Funds have been allocated since FY 2014.

**ECH District Capital Outlay Funds -Use History**

| FY | Fund Amount | Fund Allocation | Allocation Date | Fund Description |
|---|---|---|---|---|
| 2014 | 4,145,422 | 9,297,651 | June-16 | Women's Hospital Expansion |
| 2015 | 5,152,229 | | | |
| 2016 | 6,174,291 | 6,174,291 | June-18 | Women's Hospital Expansion |
| 2017 | 6,958,521 | 6,958,521 | June-19 | Women's Hospital Expansion |
| 2018 | 7,830,671 | 7,830,671 | June-19 | Women's Hospital Expansion |
| | **Total** | **30,261,134** | | |
| 2019 | 8,988,967 | 8,988,967 | June-21 | Campus Completion Project |

5. Other Reviews: The Executive Capital Committee has reviewed this item and recommends that the FY-2020 Capital Outlay Funds totaling $9,988,967 be allocated to the MV Campus Completion Project. This will bring the total Fund for the MV Campus Completion Project to $18,694,798

**6.** Outcomes: The initial two phases of the project are in process, with the Phase 1 Receiving and Service Yard to be completed in July and the demolition of the old main hospital to be completed by March 2023. The Phase 3 scope of work is being finalized and will be presented in the coming months.

**List of Attachments:**

None.

**EL CAMINO HEALTHCARE DISTRICT**
**BOARD MEETING COVER MEMO**

**To:** El Camino Healthcare District Board of Directors
**From:** Jon Cowan, Senior Director, Government Relations & Community Partnerships
**Date:** June 14, 2022
**Subject:** FY23 Community Benefit Plan

**Purpose:** To approve the FY23 El Camino Healthcare District Implementation Strategy Report and Community Benefit Plan (Community Benefit Plan)

**Summary:**

1. Situation: FY23 Community Benefit Plan totals $7.85 million and includes funding recommendations for 57 proposals, sponsorships, and placeholder

2. Authority: Board approval of the FY23 Community Benefit Plan

3. Background:

**FY23 Community Benefit Plan Summary**

- **Grant Proposals:**
  - 68 proposals requested: $10,669,165
  - 57 proposals recommended for funding: $7,640,000
    - Total unfunded: $3,029,165
- **Sponsorships:** $85,000
- **Placeholder:** $125,000

**FY23 ECHD Total Plan Request: $7,850,000**

**Community Benefit Plan**
Drawing from the 2022 Community Health Needs Assessment (CHNA) findings, the FY23 Implementation Strategy Report and Community Benefit Plan outlines goals and initiatives that address our community's most pressing health needs. In FY23, the Community Partnerships team will work with grant partners to encourage alignment with these initiatives when selecting metrics. Starting in FY24, grant partners will be asked to align their program proposals with the Implementation Strategy Report and Community Benefit Plan, and data will be tracked to demonstrate the collective impact of services provided under each initiative.

**CHNA**
Per the Affordable Care Act, El Camino Hospital conducted a community health needs assessment (CHNA) from January 2021 through March 2022. 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.

The CHNA informs five priority focus areas:

- Health Care Access & Delivery
- Behavioral Health
- Diabetes & Obesity
- Chronic Conditions
- Economic Stability

**4.** Assessment: N/A

**5.** Other Reviews:

a. On April 13, 2022, the Community Benefit Advisory Council (CBAC) provided funding recommendation consensus reflected in the FY23 Proposal Index and Summaries.

b**.** On May 17, 2022, **the** El Camino Healthcare District Board of Directors conducted a study session to review the FY23 funding recommendations.

**6.** Outcomes: Approve the plan as recommended or approve the plan with amendments.

**List of Attachments:**

1. FY23 ECHD Implementation Strategy Report and Community Benefit Plan
2. Dual Funding Request Summary
3. Community Benefit Plan Appendix: FY23 Index and Proposal Summaries (see Appendix)
4. 2022 Community Health Needs Assessment (see Appendix)


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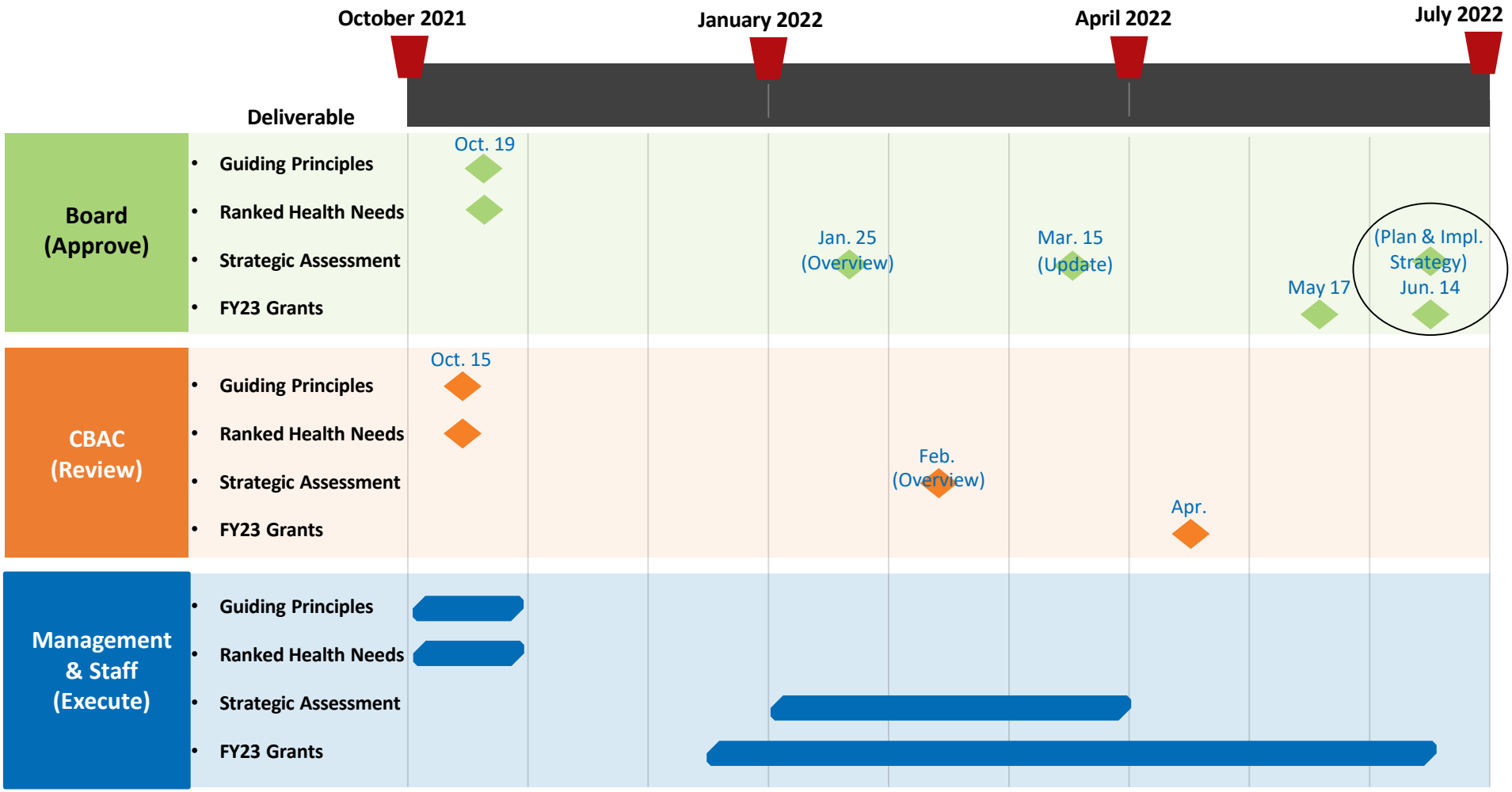
# FY23 ECHD Community Benefit Plan

Jon Cowan
Senior Director, Government Relations & Community Partnerships
June 14, 2022

# Timeline for District Community Benefit



# Feedback from May Study Session and Proposed Action to Address

| Item | Proposed Action |
|---|---|
| FY23 grant decisions | Offer technical assistance to grant applicants who were not recommended for funding this year, so that they have the opportunity to write a stronger application in FY24 |
| FY23 metrics reporting | In addition to the metric dashboard, include more narrative about the performance of the largest grants and trends within the grant portfolio in future memos to the District Board |
| FY24 multi-year grants | Evaluate the feasibility of a multi-year grant cycle, develop criteria, bring back a proposal for board approval in FY23 |
| FY24 dual funding | Look for opportunities to reduce dual funding |
| FY24 portfolio planning | Determine whether ECHD should continue funding health programs offered by Stanford and other health systems |
| Analyze economic need of individuals using Road Runners | Add a question on income range and insurance type to next survey of Road Runners participants |

# FY23 Summary of Proposal Portfolio

**68** **Proposals**

**Requested** **$10.7M**

*14% increase*

**$7.6M** **Available**

# FY23 Proposals by Health Need

| | Health Need | FY22 Approved | FY22 % | FY23 Proposed | FY23 % |
|---|---|---|---|---|---|
| Healthcare Access & Delivery (including oral health) | Healthcare Access & Delivery | $3.378 million | 45% | $3.124 million | 41% |
| | Oral Health | $850,000 | 11% | $756,200 | 10% |
| Behavioral Health (including domestic violence trauma) | Behavioral Health | $1.524 million | 20% | $1.635 million | 22% |
| | Domestic Violence | $215,000 | 3% | $245,000 | 3% |
| Diabetes & Obesity | Diabetes & Obesity | $694,000 | 9% | $1.089 million | 14% |
| Chronic Conditions (other than Diabetes & Obesity) | Chronic Conditions (other than Diabetes & Obesity) | $394,000 | 5% | $393,000 | 5% |
| Economic Stability (including housing & food) | Economic Stability | $386,000 | 5% | $397,000 | 5% |
| | **Total** | **$7.546 million** | | **$7.640 million** | |

* Percentages do not sum to 100% due to rounding. Total approved presented is rounded total.

# Recommendation

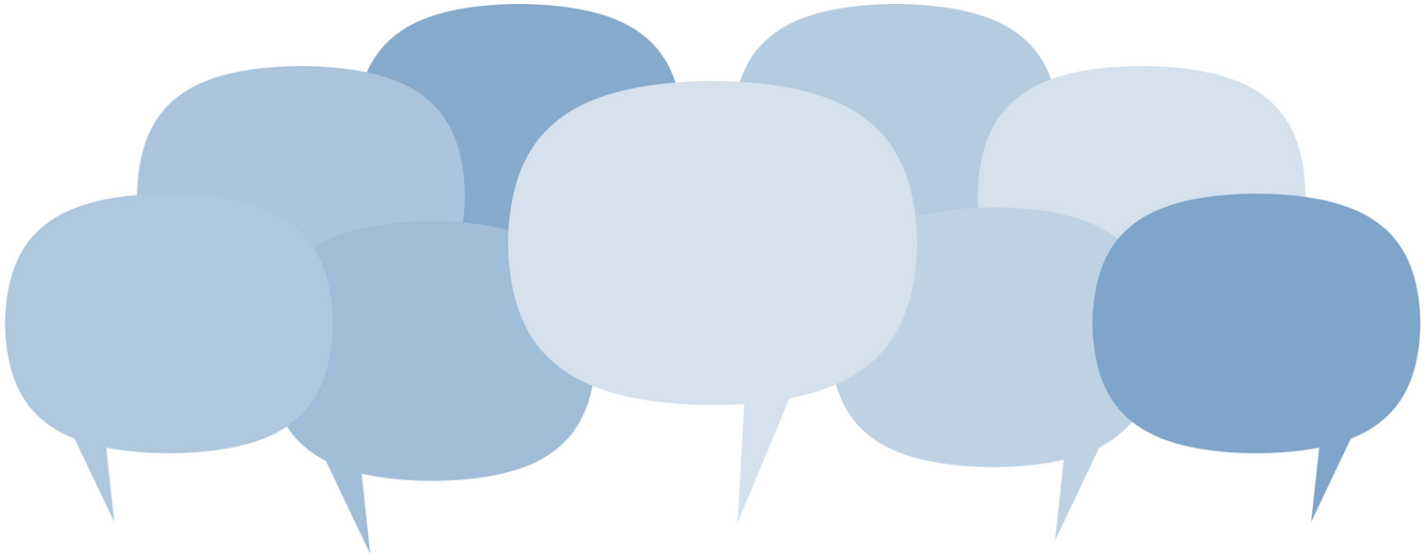
**Action Item**: to approve the FY23 El Camino Healthcare District Implementation Strategy Report and Community Benefit Plan (Community Benefit Plan)

- **Approve Community Benefit Plan as is:** total $7,850,000 including grants ($7,640,000), sponsorships ($85,000), and placeholder ($125,000)

  **or**

- **Approve Plan w/amendments**

# Board Discussion



# Appendix

# Guiding Principles for Evaluating and Prioritizing Appropriateness of Grant Proposals

**Required**

1. Serve those who live, work or go to school in El Camino Healthcare District's targeted geography
2. Demonstrate a competence and capacity to address at least one of the identified health needs
3. Focus primarily, but not exclusively, on the results of increasing access to healthcare services, behavioral health services, as well as the management of rising risk chronic health conditions (diabetes, obesity, cardiovascular disease, cancer, and respiratory conditions)
4. Have an emphasis on populations that are underserved, experiencing health disparities, and/or facing health challenges

**Preferred**

5. Aim to reflect the diversity of El Camino Healthcare District's targeted geography
6. Focus on operational programmatic costs for service delivery, over capital campaigns. Do not fund drives or political initiatives
7. Emphasize locally focused vs. national organizations
8. Emphasize the most effective and impactful programs while welcoming new and innovative applicants

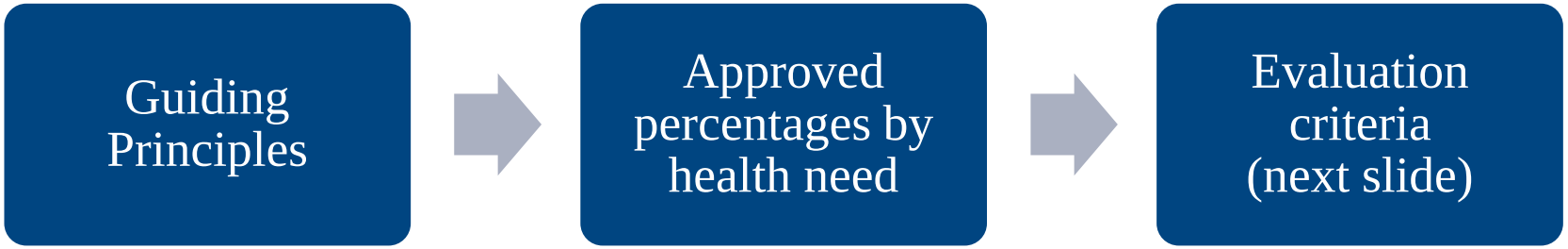
# ECHD Ranked & Prioritized Health Needs

| Health Need | FY21 Approved | FY22 Approved | FY23 Approved |
|---|---|---|---|
| Healthcare Access & Delivery (including oral health) | 56% | 56% | ~50% |
| Behavioral Health (including domestic violence trauma) | 23% | 23% | ~25% |
| Diabetes & Obesity | 8% | 9% | ~15% |
| Chronic Conditions (other than Diabetes & Obesity) | 5% | 5% | ~5% |
| Economic Stability (including food insecurity, housing & homelessness) | 5% | 5% | ~5% |

*Dropped health needs include cognitive decline, unintended injury prevention (1% each in FY21 and FY22)

# Proposal Evaluation Process

Top three factors that are referenced during the grant evaluation process



# Proposal Evaluation Criteria

Proposals are evaluated by:

- Alignment with ECHD priorities
- Addressing community needs
- Applicant capability
- Proposal quality
- Impact and evaluation plan
- Budget request
- Evidence-based programming
- Financial need of applicant
- Brand alignment (i.e. will not reflect negatively on reputation, brand)

Proposals are also evaluated in context of those in each health need, then grouped by their proximity to the median for review in the grant index.

# Implementation Strategy Report and Community Benefit Plan, FY2023



*Dedicated to improving the health and well-being of the people in our community.*

# TABLE OF CONTENTS

## II. ABOUT EL CAMINO HEALTHCARE DISTRICT

El Camino Healthcare District was formed to provide healthcare services that foster good physical and mental health. The District is governed by a five-member publicly elected Board and provides oversight of El Camino Health[1]. The District also administers a Community Benefit Program, which addresses unmet health needs through grants and collaborations with local schools, nonprofits and social and health service providers.

### MISSION

It is the purpose of the Healthcare District to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to do any and all other acts and things necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

### COMMUNITY BENEFIT PROGRAM

El Camino Healthcare District utilizes El Camino Health's Community Health Needs Assessment (CHNA) as a framework for Community Benefit funding. The CHNA is developed in compliance with IRS requirements. The District invests in programs addressing the identified health needs for community members who live, work or go to school in the District's boundaries. El Camino Healthcare District cities include most of Mountain View, Los Altos and Los Altos Hills; a large portion of Sunnyvale, and small sections of Cupertino, Santa Clara and Palo Alto.

El Camino Healthcare District, in partnership with El Camino Health, 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, the Community Benefit Annual Report informs 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.[2]

## III. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Healthcare District's planned response to the needs identified through the 2022 CHNA process.

This 2023 IS Report and CB Plan is based on the 2022 CHNA and outlines El Camino Healthcare District's funding for fiscal year 2023. It will be updated annually and the update will be based on the most recently conducted CHNA.

### Financial Summary

FY23 El Camino Healthcare District Community Benefit Plan:

- 57 Grants: $7,640,000
    - Requested Grant Funding: $10,669,165
- Sponsorships: $85,000
- Placeholder: $125,000
- Plan Total: $7,850,000

## IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.

To be considered a health need for the purposes of the 2022 CHNA, the need had to fit a standard definition, be present in at least two data sources, and either prioritized by key informants or focus groups, or suggested by direct statistical indicators that fail benchmarks or exhibit documented inequities by race.[3] A total of 12 health needs were identified in the 2022 CHNA. The health need selection process is described in Section VI of this report.

**2022 Community Health Needs List**

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

## V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) & COMMUNITY BENEFIT PLAN DEVELOPMENT

El Camino Health selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health initiative. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

# VI. HEALTH NEEDS THAT EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

## PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In October 2021, the Hospital Community Benefit Committee met to review the information collected for the 2022 CHNA. The purpose of the meeting was to help select the needs El Camino Health would address, which would form the basis for its FY23 community benefit plan and implementation strategies. El Camino Health, by consensus, selected the following needs to address:

- Health Care Access & Delivery (including oral health)
- Behavioral Health (including domestic violence and trauma)
- Diabetes & Obesity
- Other Chronic Conditions (other than Diabetes & Obesity)
- Economic Stability (including food insecurity, housing, and homelessness)

El Camino Healthcare District utilizes El Camino Health's CHNA and selected health needs as a framework for its Community Benefit funding.

## DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

### Health Care Access & Delivery (including oral health)

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%.[4] 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).[4] 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[5]) 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%).[6] 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%)[6], but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).[6]

Many key informants and focus group participants connected healthcare access with economic instability. For example, some mentioned that low-income residents may be required to prioritize rent and food over 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.

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.[6] 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.[6] 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.

### Behavioral Health (including domestic violence and trauma)

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).[7] 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).[8] 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)[9] 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).[10] 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).[11] 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).[12] 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 more likely to receive poor quality care when treated."[13] 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."[14] 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).[15]

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.[16] It was stated that services for people without health insurance can be expensive and difficult to access.

## 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.[17] 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%).[18]

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.[19] 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.

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).[20] 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%).[21] Multiple residents 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."[22]

## Other Chronic Conditions (other than Diabetes & 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.

However, health conditions such as cardiovascular disease, cancer, and respiratory problems are among the top 10 causes of death in the county. With regard to cancer, 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).[23] 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%).[24] Our previous (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. With regard to respiratory problems, the level of asthma prevalence for people of all ages is higher for Santa Clara County (10%) than the state (9%).[25] One key informant noted that asthma rates have been worsening.

An expert in chronic disease mentioned a rise in dementia-related issues. Additionally, 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.

There are also racial/ethnic disparities and inequities with respect to chronic conditions: Heart disease and stroke were identified as two of the chronic conditions that are often seen in data on ethnic health disparities. An expert in Black health cautioned about high rates of asthma in areas with poor air quality. There are also persistent disparities in cancer incidence rates and other cancer statistics. The rate of cancer incidence among children ages 0-19 is highest among Santa Clara County's white children (21.2 per 100,000) and Asian/Pacific Islander children (20.2 per 100,000).[23] 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."[26]

## Economic Stability (including food insecurity, housing, and homelessness)

Nearly all focus groups and almost three-quarters of key informants identified economic stability, including education and food insecurity, 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."[27]

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.[28] 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).[29] In addition, the East San José area experiences higher levels of Neighborhood Deprivation[30] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0).[29] 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.[31] 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).[29]

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%).[32] Also, a smaller percentage of local Latinx 11th graders met or exceeded math standards (28%) versus California's 11th-graders (32%).[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%).[33] 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 school diploma is much higher (East San José, 31%; 94040 in Mountain View, approximately 28%) than the state average (18%).[29] Educational inequities, often related to neighborhood segregation[34], lead to educational disparities that begin at an early age: the elementary school proficiency index, which measures the academic performance of 4$^{th}$-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).[35]

Data available on economically precarious households shows that 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.[36] Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards.[36] 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).[28] In our 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic precariousness 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.

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.[37] 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. Similarly, pre-K child care (age 3-5) cost $15,315 in Santa Clara County versus $12,168 on average in California overall.[38] Economic insecurity affects single-parent households more than dual-parent households[39]; in East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).[29]

# VII. EL CAMINO HEALTHCARE DISTRICT'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Healthcare District's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, our community health investment for FY23 will be directed to improve health care access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

This plan represents the revamping of a multi-year strategic investment in community health. El Camino Healthcare District believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2022 CHNA process.

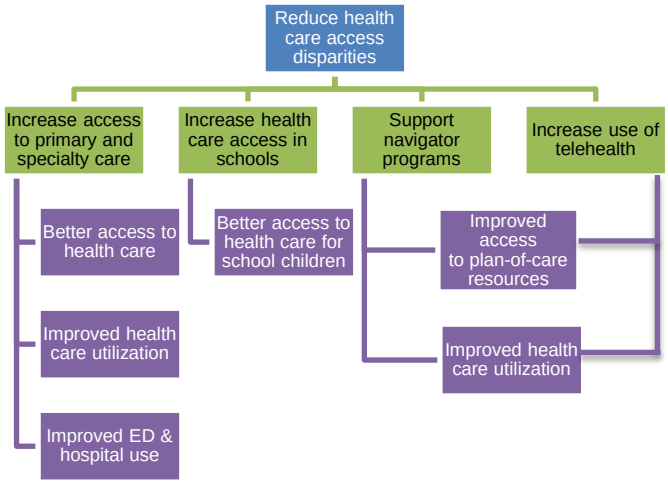
## HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

El Camino Healthcare District views efforts to ensure equitable access to high-quality health care and respectful, compassionate, culturally competent delivery of health care services as a top priority for its community benefit investments. Given the community's strong focus on issues of health care access and delivery during the 2022 CHNA, El Camino Healthcare District chose goals that support initiatives to reduce disparities in access to and delivery of primary and specialty care for community members in its service area. The goals also include improvements in access to and delivery of oral health care and maternal/infant health care, based on statistical data and information provided by experts interviewed during the CHNA. The hospital expects to make a positive impact by improving health care access and utilization, reducing unnecessary emergency department visits and hospitalizations, and reducing disparities in health outcomes.

GOAL

INITIATIVES

ANTICIPATED IMPACTS

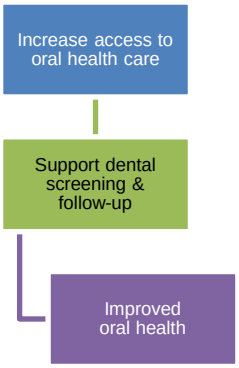



| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Reduce disparities in access to high-quality care | A. Support increased access to primary care and specialty care services for vulnerable individuals[40, 41, 42, 43, 44, 45, 46, 47, 48, 49] | (i) Individuals experience better access to health care<br>(ii) Improved health care utilization<br>(iii) Reduced unnecessary ED visits and hospitalizations |
| | B. Support greater access to healthcare in schools[50] | (i) Improved access to health care for school-aged children and youth |
| | C. Support clinical and community health navigator programs[51, 52, 53] | (i) Community members access clinical and community resources that support their plan of care |
| | D. Support increased use of telehealth and other technology solutions[54, 55, 56] | |

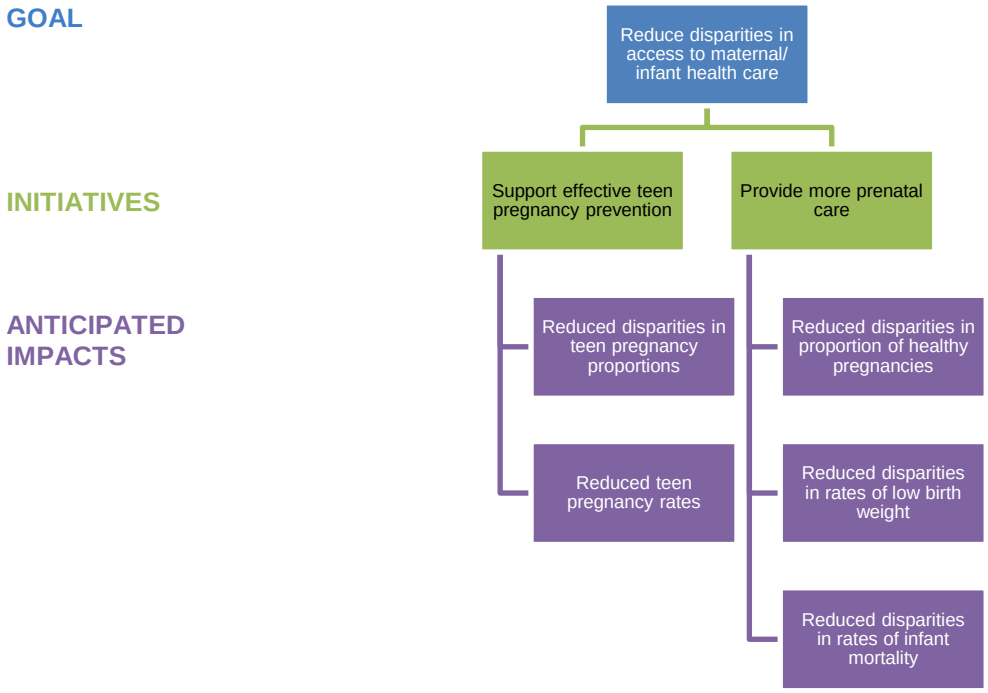
GOAL

INITIATIVE

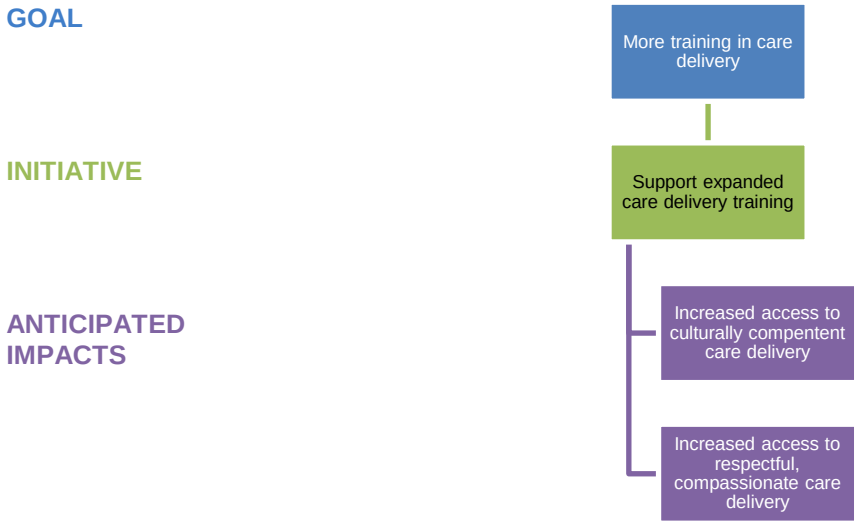
ANTICIPATED IMPACT




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Increase access to oral health care for underserved community members | A. Support school- and community-based programs that offer dental screenings and care, including tele-dentistry[57, 58, 59, 60] | (i) Improved oral health among community members |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 3. Reduce disparities and inequitable access to maternal/ infant health care for community members | A. Support effective teen pregnancy prevention programs[61, 62, 63] | (i) Reduced disparities in the proportion of teens who are pregnant<br>(ii) Reduced proportions of teens who are pregnant |
| | B. Increase access to and utilization of adequate prenatal care[64, 65, 66, 67, 68] | Reduced disparities in:<br>(i) Proportions of women with healthy pregnancies<br>(ii) Rates of low birth weight<br>(iii) Rates of infant mortality |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 4. Provide/ expand workforce training in cultural competence, and compassionate and respectful care delivery | A. Support workforce training in cultural competence, and compassionate and respectful care delivery[69, 70, 71, 72] | (i) Increased access to culturally competent health care services among underserved community members, including LGBTQ+ and community members with limited English proficiency<br>(ii) Increased access to compassionate and respectful health care among underserved community members, including LGBTQ+ and community members with limited English proficiency |

## HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH) PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|
| El Camino Health - Post Discharge Care Navigator | X | | | $150,000 | N/A | $150,000 |
| LifeMoves Mountain View Homeless Shelter | | | X | $160,000 | $160,000 | $160,000 |
| Lucile Packard Foundation for Children's Health - Teen Health Van | | | | $115,206 | $98,000 | $98,000 |
| New Directions - A Program of Peninsula Healthcare Connection | | | | $284,767 | $220,000 | $220,000 |
| Pathways Home Health and Hospice | | | | $60,000 | $60,000 | $60,000 |
| Planned Parenthood Mar Monte - Mountain View Health Center | | | | $225,000 | $225,000 | $225,000 |
| Ravenswood Family Health Network | | | | $1,300,000 | $1,300,000 | $1,250,000 |
| County of Santa Clara Health System | | | | $1,041,074 | $530,000 | $440,000 |
| Cupertino Union School District - School Nurse Program | | | X | $120,367 | $100,000 | $100,000 |
| El Camino Health - RoadRunners | | | | $240,000 | $200,000 | $165,000 |
| Mountain View Whisman School District - School Nurse Program | | | | $410,807 | $280,000 | $290,000 |
| On-Site Dental Care Foundation | | | | $200,000 | $200,000 | $200,000 |
| Sunnyvale School District - School Nurse Program | | | | $287,000 | $287,000 | $287,000 |
| Vista Center for the Blind and Visually Impaired | | X | X | $48,057 | $30,000 | $ - |
| El Camino Hospital - Health Library & Resource Center Mountain View | | | | $210,000 | $200,000 | $175,000 |
| Health Mobile | X | X | X | $150,000 | N/A | $ - |
| Law Foundation of Silicon Valley | | | | $93,000 | $60,000 | $60,000 |
| Lucile Packard Foundation for Children's Health - Virtual PrEP | | X | | $79,113 | $20,000 | $ - |

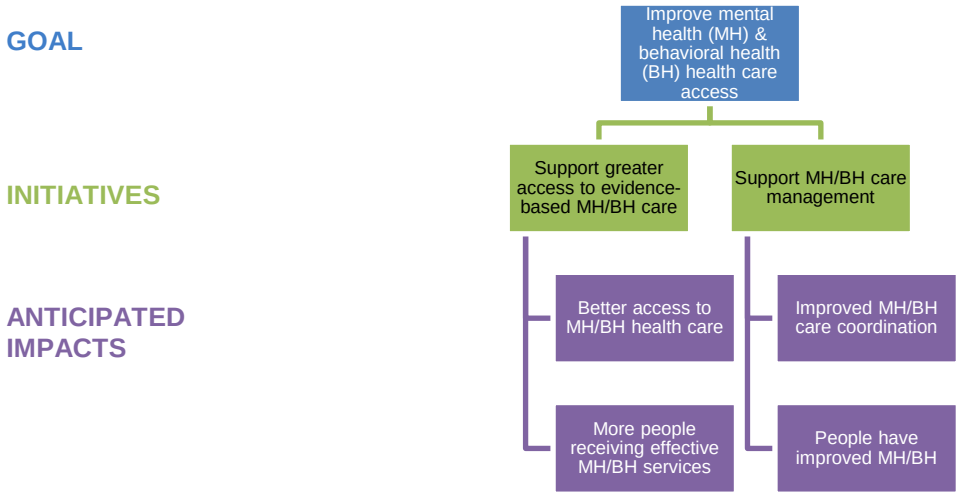
*Green represents higher proposal strength, Blue represents medium proposal strength, and Grey represents lower proposal strength

**Proposals within each color grants are organized alphabetically

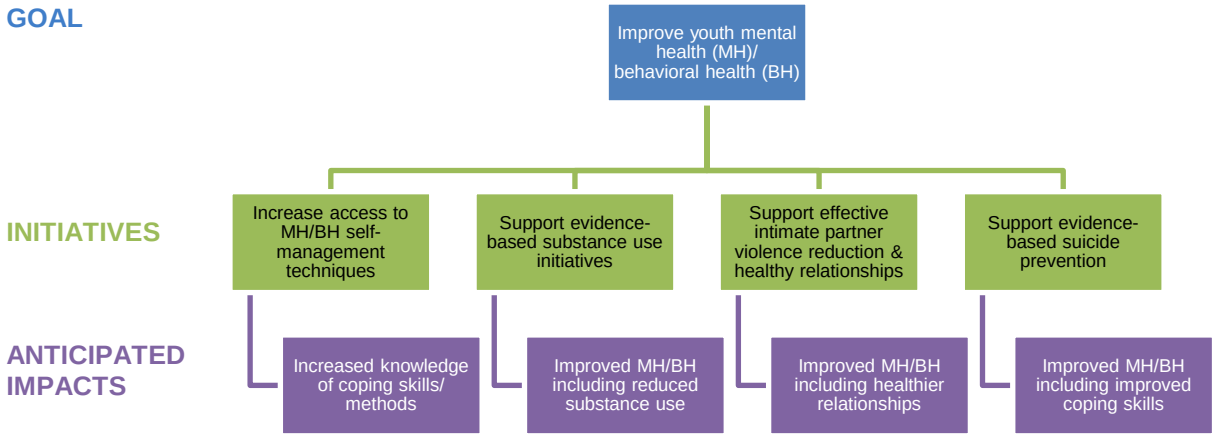
***CBAC is the Community Benefit Advisory Council

## BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

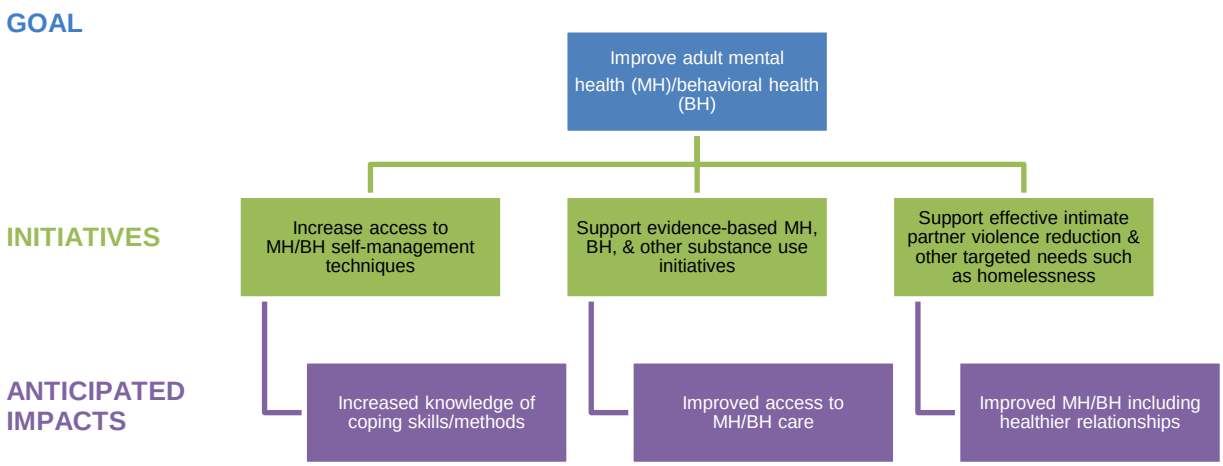
Even prior to the pandemic, data indicated that behavioral health (including mental health, trauma, and substance use) was a significant health need, especially with respect to the supply of providers. Community input during the 2022 CHNA emphasized how much worse and more widespread behavioral health issues have become due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral health care, El Camino Healthcare District chose goals that support more direct approaches to improving the mental and behavioral health of both youth and adult community members. By using a two-pronged approach, addressing access to care and care itself, El Camino Healthcare District expects to be able to make a positive impact by improving community members' mental and behavioral health, including contributing to improved coping skills, healthier relationships, and reduced substance use.




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Improve mental/ behavioral health care access for community members | A. Support in-person and virtual expanded access to evidence-based counseling, addiction treatment, behavioral health case management, etc. [73, 74, 75, 76, 77] | (i) Improved access to mental/behavioral health programs and services<br>(ii) More community members receiving effective mental/ behavioral health services |
| | B. Care management to support community members' self-management and mental health[78, 79] | (i) Improved coordination of mental/behavioral services<br>(ii) Improved mental/behavioral health among those served |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Improve mental/ behavioral health of youth in the community | A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[80 , 81] | (i) Increased knowledge among youth served about methods of coping with stress and depression |
| | B. Support for substance abuse initiatives with evidence of effectiveness[82, 83, 84] | (i) Improved mental health among those served, including reduced substance use |
| | C. Programs that prevent or reduce youth and young adult intimate partner and sexual violence and promote healthier relationships[85, 86] | (i) Improved mental health among those served, including healthier relationships |
| | D. Programs that reduce or prevent suicide with evidence of effectiveness[87, 88] | (i) Improved mental health among those served, including improved coping skills |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 3. Improve mental/ behavioral health of adults in the community | A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[89, 90, 91] | (i) Increased knowledge among those served about methods of coping with depression, anxiety, and stress |
| | B. Support for screening, accurate diagnosis, effective treatment, and follow-up for mental/ behavioral health and substance use/ addiction treatment services[92, 93, 94] | (i) Improved access to mental and behavioral health services among those served |
| | C. Programs that support targeted unmet needs such as supporting individuals experiencing or at risk of homelessness or intimate partner violence[95, 96] | (i) Improved mental health among those served<br><br>(ii) Improved utilization of clinical and community resources among those served |

## BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA) PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|
| Avenidas | | | | $60,000 | $60,000 | $60,000 |
| Caminar - Dometic Violence Suppport Services | | | | $100,000 | $60,000 | $80,000 |
| Cupertino Union School District - Mental Health Program | | | X | $93,000 | $90,000 | $93,000 |
| El Camino Health - Behavioral Health Navigator Program | X | | | $150,000 | N/A | $150,000 |
| Maitri | | | | $50,000 | $50,000 | $50,000 |
| YWCA of Silicon Valley | | | | $85,000 | $75,000 | $85,000 |
| Acknowledge Alliance | | | | $60,000 | $50,000 | $50,000 |
| Caminar - LGBTQ+ Youth Space Awareness & Outreach Program | X | | | $100,000 | N/A | $75,000 |
| CHAC at Sunnyvale School District | | | | $405,107 | $280,000 | $280,000 |
| City of Sunnyvale/Sunnyvale Senior Center | X | | | $42,014 | N/A | $25,000 |
| Eating Disorders Resource Center | | | X | $22,500 | $25,000 | $22,500 |
| Friends for Youth | X | | | $30,000 | N/A | $30,000 |
| Los Altos School District - Mental Health Program | | | | $150,000 | $100,000 | $130,000 |
| Momentum for Health | | | X | $290,000 | $290,000 | $290,000 |
| Mountain View-Los Altos High School District - Mental Health Program | | | | $381,187 | $160,000 | $210,000 |
| NAMI Santa Clara County | | | | $120,000 | $100,000 | $100,000 |
| Emotions in Harmony | X | X | | $30,000 | N/A | $ - |
| Family Alliance for Counseling Tools & Resolution | X | X | | $30,000 | N/A | $ - |
| Kara | | | | $30,000 | $20,000 | $20,000 |
| My Digital TAT2 | X | | | $40,000 | N/A | $30,000 |
| Parents Helping Parents | | | | $62,971 | $35,000 | $35,000 |
| Project Safety Net | | | | $174,023 | $20,000 | $35,000 |
| Sunnyvale Police & Fire Foundation | X | X | | $25,000 | N/A | $ - |
| WomenSV | | | | $30,000 | $30,000 | $30,000 |

*Green represents higher proposal strength, Blue represents medium proposal strength, and Grey represents lower proposal strength

**Proposals within each color are organized alphabetically

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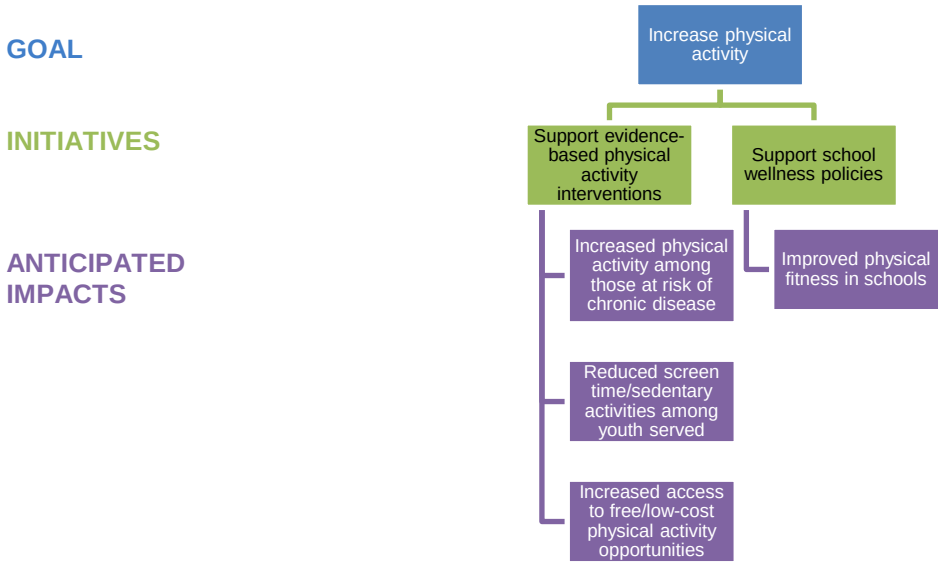
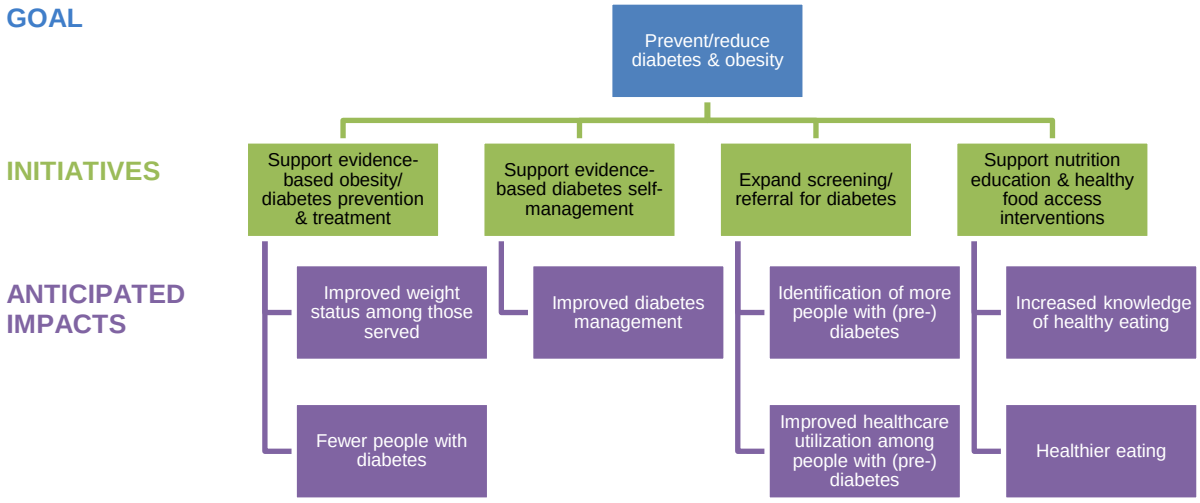
## DIABETES & OBESITY

During the 2022 CHNA, community members provided input on poor food access and the lack of physical activity, both of which are drivers of diabetes and obesity. Additionally, CHNA data indicated issues with the food environment, geographic disparities in walkability, and ethnic disparities in youth fitness, among other things. Experts also indicated that diabetes rates are trending up in Santa Clara County. Therefore, El Camino Healthcare District chose goals that support initiatives that prevent or reduce obesity and diabetes, as well as those that increase physical activity, reduce food insecurity, and increase healthy food access among community members. The hospital expects these efforts will make a positive impact by contributing to improved weight status, improved diabetes management, and reduced rates of obesity & diabetes in the community.




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Increase physical activity among community members | A. Support physical activity interventions shown to contribute to weight loss and reduced screen time among youth and adults[97, 98, 99, 100] | (i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions<br>(ii) Reduced screen time & time on sedentary activities among youth served<br>(iii) Increased access to and utilization of free/low-cost opportunities for physical activity |
| | B. Support implementation of school wellness policies for promoting physical activity[101] | (i) Improved physical fitness among students in schools served |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Prevent/ reduce obesity & diabetes among community members | A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[102, 103, 104, 105, 106, 107, 108, 109, 110] | (i) Improved weight status in youth and adults served<br>(ii) Long-term reduction in the number of community members with diabetes |
| | B. Support diabetes treatment/self-management programs with evidence of effectiveness[111, 112, 113, 114, 115] | (i) Improved diabetes management in participants served |
| | C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[116, 117] | (i) Identification of more individuals with diabetes and pre-diabetes<br>(ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes |
| | D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[118, 119, 120, 121] | (i) Increased knowledge and understanding about healthy eating among people served<br>(ii) Healthier eating among community members receiving interventions |

## DIABETES & OBESITY PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|
| Chinese Health Initiative | | | X | $280,000 | $267,000 | $267,000 |
| Playworks | | | X | $231,000 | $200,000 | $200,000 |
| Silicon Valley Bicycle Coalition | | | | $30,000 | $25,000 | $30,000 |
| Bay Area Women's Sports Initiative - Girls Program | | | X | $60,000 | $17,000 | $26,000 |
| City of Sunnyvale - Columbia Neighborhood Center | | | | $45,745 | $35,000 | $45,000 |
| El Camino Hospital - Prenatal Diagnostic Center | X | X | | $300,000 | N/A | $ - |
| Fresh Approach | | | | $73,803 | $93,000 | $73,500 |
| South Asian Heart Center | | | X | $330,000 | $300,000 | $300,000 |
| YMCA of Silicon Valley | | | | $67,562 | $65,000 | $67,000 |
| AbilityPath | X | X | | $45,000 | N/A | $ - |
| Bay Area Women's Sports Initiative - Rollers Program | | | | $53,000 | $18,000 | $21,000 |
| Living Classroom | | | | $84,740 | $60,000 | $60,000 |
| Palo Alto Medical Foundation - 5210 Program | | X | X | $30,000 | $25,000 | $ - |

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**Proposals within each color are organized alphabetically

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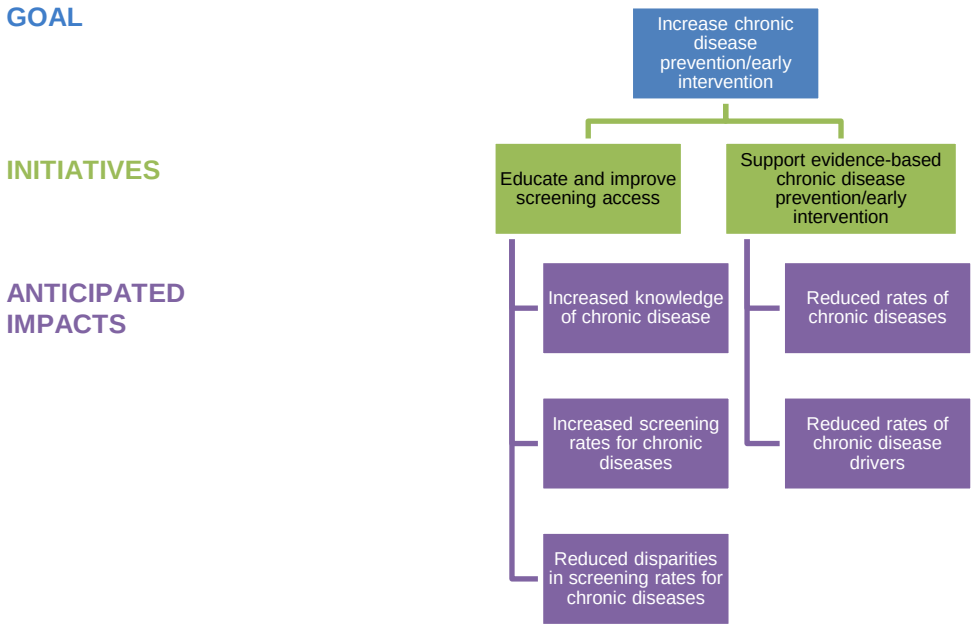
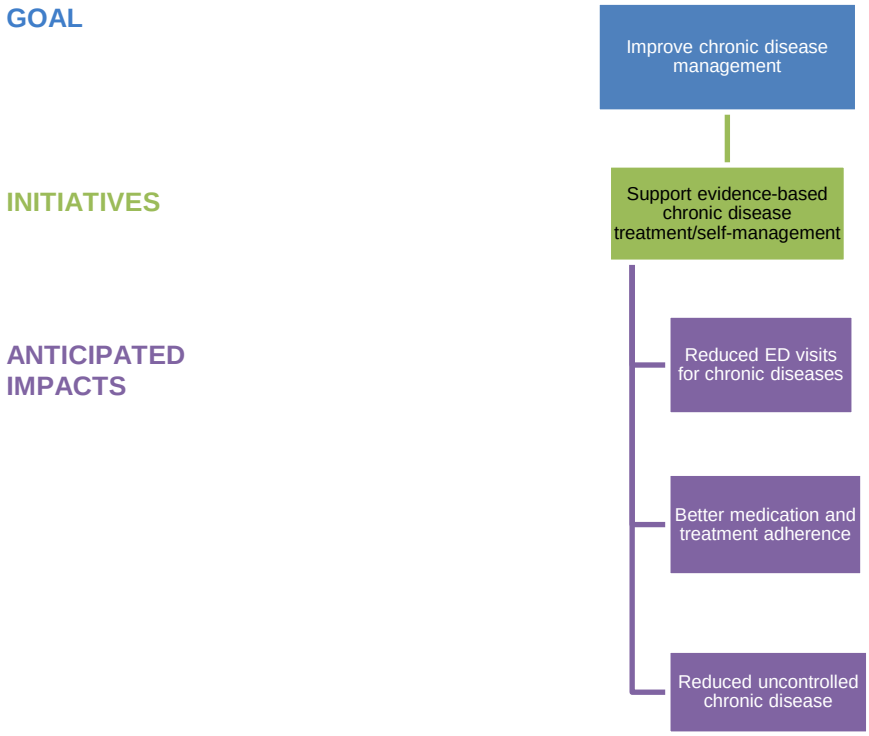
## OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

Many chronic diseases are among the top causes of death in Santa Clara County. CHNA data show there are disparities in chronic conditions such as cancer, asthma, heart disease, and stroke. Therefore, El Camino Healthcare District chose goals that support initiatives to increase prevention and early intervention of chronic diseases and to improve chronic disease management among community members. By addressing these issues, El Camino Healthcare District believes it will make a positive impact through improved screening for chronic conditions, reduced rates of uncontrolled chronic diseases, lower levels of the drivers of chronic conditions, and, in the long term, reduced rates of chronic diseases.




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Increase prevention and early intervention of chronic diseases in the community | A. Provide education and improve access to screenings[122, 123, 124, 125, 126, 127, 128] | (i) Increased knowledge of chronic disease among community members<br>(ii) Increased rates of screening for chronic disease<br>(iii) Reduced disparities in chronic disease screening rates |
| | B. Support evidence-based chronic disease prevention and early intervention programs[129, 130, 131] | (i) Reduced rates of chronic diseases<br>(ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc. |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Improve chronic disease management among community members | A. Support evidence-based chronic disease treatment and self-management programs[132, 133, 134] | (i) Reduced rates of ER/ED visits for chronic diseases<br>(ii) Improved medication and treatment adherence<br>(iii) Reduced rates of uncontrolled chronic disease |

## OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY) PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|
| Breathe California | | | | $25,000 | $25,000 | $25,000 |
| The Health Trust | X | X | | $101,760 | N/A | $ - |
| American Heart Association | | | X | $110,000 | $110,000 | $100,000 |
| Community Services Agency of Mountain View and Los Altos | | | | $258,811 | $228,000 | $228,000 |
| Stanford Health Care - Falls Prevention Program | | | | $52,000 | $46,100 | $20,000 |
| Via Services | X | | | $73,524 | N/A | $20,000 |

*Green represents higher proposal strength, Blue represents medium proposal strength, and Grey represents lower proposal strength

**Proposals within each color are organized alphabetically

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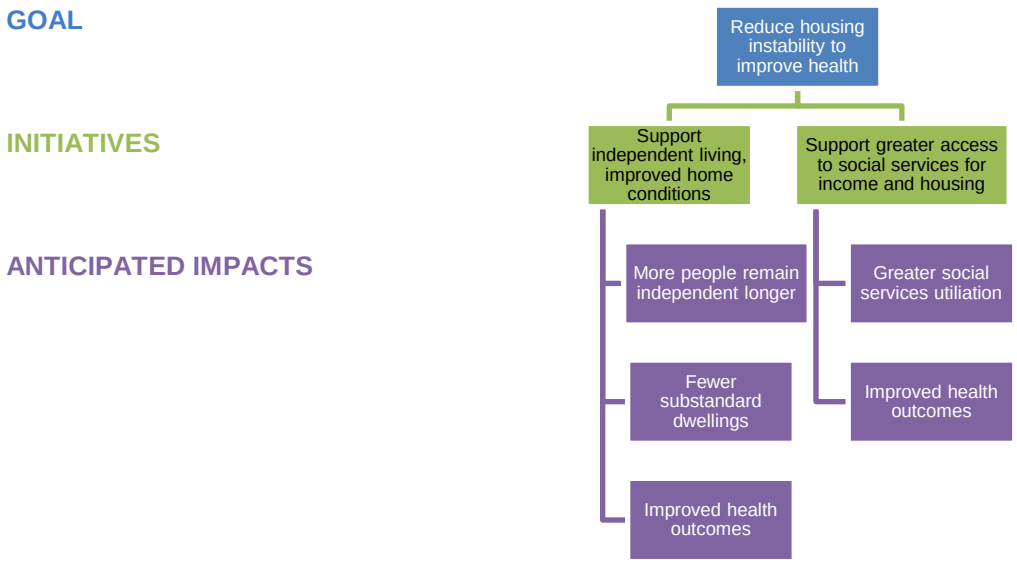
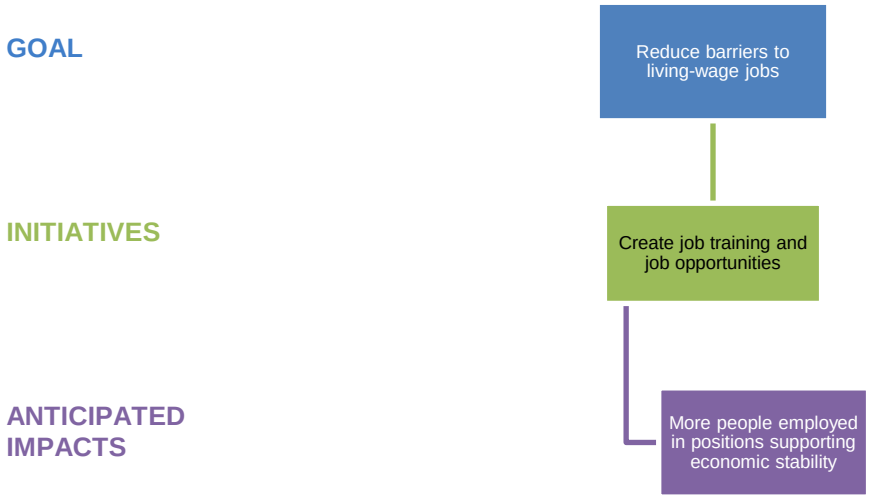
## ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS)

Economic stability was a top priority for the community in the 2022 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and health care are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Healthcare District chose goals that support initiatives to reduce housing instability, food insecurity, and barriers to living-wage employment. Through efforts to address community members' basic needs, El Camino Healthcare District believes it will make a positive impact via increased utilization of social services and improved well-being and health outcomes among community members.




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Reduce housing instability among community members | A. Support independent living and efforts to improve substandard living conditions[135, 136, 137] | (i) More community members remain independent longer<br>(ii) Reduced number of sub-standard dwellings<br>(iii) Improved health outcomes for those at-risk of and/or experiencing homelessness |
| | B. Support efforts to improve access to social services that address income and housing insecurity[138, 139, 140] | (i) Increase in social services utilization<br>(ii) Improved health outcomes for those at-risk of and/or experiencing homelessness |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Reduce barriers to employment/ careers that provide community members with a living wage | A. Create workforce training and employment opportunities for underrepresented populations[141, 142, 143, 144] | (i) More community members employed in positions that support economic stability |

**GOAL**

**INITIATIVE**

**ANTICIPATED IMPACTS**


| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 3. Reduce food insecurity and increase healthy food access for low-income community members | A. Support increased utilization of healthy/ culturally appropriate food through CalFresh/SNAP enrollment, existing food banks, and other sites[145, 146] | (i) Improved access to healthy food options<br>(ii) Reduced food insecurity |

## ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS) PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|
| Hope's Corner | | | | $30,000 | $30,000 | $30,000 |
| Sunnyvale Community Services - Comprehensive Safety Net Services | | | | $75,000 | $75,000 | $75,000 |
| Day Worker Center of Mountain View | | | | $30,000 | $30,000 | $30,000 |
| Sunnyvale Community Services - Social Work & Homebound Case Mgt | | | | $332,027 | $187,000 | $197,000 |
| Second Harvest of Silicon Valley | | | | $90,000 | $90,000 | $40,000 |
| Mountain View Police Department's Youth Services Unit | | | | $25,000 | $25,000 | $25,000 |
| Senior Inclusion and Participation Project | X | X | | $100,000 | N/A | $ - |

*Green represents higher proposal strength, Blue represents medium proposal strength, and Grey represents lower proposal strength

**Proposals within each color are organized alphabetically

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## VIII. EVALUATION PLANS

As part of El Camino Healthcare District's ongoing community health improvement efforts, we partner with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through El Camino Health's triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

El Camino Healthcare District will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, El Camino Healthcare District will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report mid-year and year-end performance on annual outcomes metrics, which are shared broadly with the public as well as state and federal regulatory bodies.

The Board of Directors' support of this Implementation Strategy Report and Community Benefit Plan will allow El Camino Healthcare District to continue responding to the most pressing needs faced by vulnerable residents in our communities.

The premise — and the promise — of community benefit investments is the chance to extend the reach of resources beyond the patient community, and address the suffering of underserved, at-risk community members. These annual community grants provide direct and preventive services throughout the service area. Community Benefit support addresses gaps by funding critical, innovative services that would otherwise not likely be supported. The Implementation Strategy Report and Community Benefit Plan aims to improve the health and wellness of the El Camino Healthcare District.

# ENDNOTES

[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.

[2] https://www.elcaminohealthcaredistrict.org/community-benefit

[3] The definition of a health need is 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. Further definitions of terms and specific criteria for health needs identification may be found in El Camino Health's 2022 CHNA report.

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# El Camino Health and El Camino Healthcare District Dual-Funded Community Benefit Programs: FY21, FY22 & FY23

**El Camino Health** FY21: $800,000 *(23% of ECH grants)* | FY22: $907,000 *(28% of ECH grants)*
FY23 (Recommended): $610,000 *(18% of ECH grants)*

**El Camino Healthcare District** FY21: $1,667,530 *(23% of ECHD grants)* | FY22: $1,714,000 *(23% of ECHD grants)*
FY23 (Recommended): $1,579,500 *(21% of ECHD grants)*

**Combined Total** FY21: $2,467,530 *(23% of all grants)* | FY22: $2,621,000 *(24% of all grants)*
FY23 (Recommended): $2,189,500 *(20% of all grants)*

**5210 Health Awareness Program**
FY21 - $55,000
ECH - $25,000
ECHD - $30,000
FY22 – $45,000
ECH - $20,000
ECHD -$25,000
FY23 – DNF (Recommended)
ECH - DNF
ECHD - DNF

**American Heart Association**
FY21 - $160,000
ECH - $50,000
ECHD - $110,000
FY22 – $160,000
ECH – $50,000
ECHD - $110,000
FY23 – $160,000 (Recommended)
ECH - $60,000
ECHD -$100,000

**Bay Area Women's Sports Initiative Program (BAWSI)**
FY21 - $49,500
ECH - $15,000 (BAWSI Girls)
ECH - DNF (BAWSI Rollers)
ECHD - $19,500 (BAWSI Girls)
ECHD - $15,000 (BAWSI Rollers)
FY22 – $32,000 (BAWSI Girls)
ECH - $15,000 (BAWSI Girls)
ECHD - $17,000 (BAWSI Girls)
*(BAWSI Rollers - Not a Dual Applicant)*
FY23 – $41,000 (BAWSI Girls - Recommended)
ECH - $15,000 (BAWSI Girls)
ECHD -$26,000 (BAWSI Girls)
*(BAWSI Rollers - Not a Dual Applicant)*

**Chinese Health Initiative (ECH)**
FY21 - $269,030
ECH - DNF
ECHD - $269,030
FY22 – $309,000
ECH - $42,000
ECHD - $267,00
FY23 – $287,000 (Recommended)
ECH - $20,000
ECHD -$267,000

**Cupertino Union School District – School Nurse Program**
FY21 - $190,000
ECH - $90,000
ECHD - $100,000
FY22 – $200,000
ECH - $100,000
ECHD - $100,000
FY23 – $200,000 (Recommended)
ECH - $100,000
ECHD -$100,000

**Cupertino Union School District – Mental Health Counseling**
FY21 - $210,000
ECH - $120,000
ECHD - $90,000
FY22 – $210,000
ECH - $120,000
ECHD - $90,000
FY23 – $213,000 (Recommended)
ECH - $120,000
ECHD -$93,000

**GoNoodle**
FY21 - $149,000
ECH - $113,000
ECHD - $36,000
FY22 – $113,000
ECH - $113,000
ECHD - DNF
FY23 – Not a Dual Applicant

**Health Mobile**
FY21 - $150,000
ECH - $75,000
ECHD - $75,000
FY22 – $55,000
ECH - $55,000
ECHD – DNF
FY23 – $75,000 (Recommended)
ECH - $75,000
ECHD -DNF

**Healthier Kids Foundation**
FY21 - $70,000
ECH - $30,000
ECHD - $40,000
FY22 – $70,000 (Recommended)
ECH - $30,000
ECHD - $40,000
FY23 – Not a Dual Applicant

**LifeMoves**
FY21 – Not a Dual Applicant
FY22 - $220,000
ECH - $60,000
ECHD - $160,000
FY23 – $210,000 (Recommended)
ECH - $50,000
ECHD -$160,000

**Medical Respite**
FY21 - $80,000
ECH - DNF
ECHD - $80,000
FY22 – Not a Dual Applicant
FY23 – Did not Apply

**Momentum for Mental Health**
FY21 - $321,000
ECH - $51,000
ECHD - $270,000
FY22 – $336,000
ECH - $46,000
ECHD - $290,000
FY23 – $330,000 (Recommended)
ECH - $40,000
ECHD -$290,000

EL CAMINO HEALTHCARE DISTRICT

El Camino Health

**Playworks**
FY21 - $304,000
ECH - $86,000
ECHD - $218,000
FY22 – $286,000
ECH - $86,000
ECHD - $200,000
FY23 – $240,000 (Recommended)
ECH - $40,000
ECHD -$200,000
**Rebuilding Together**
FY21 - $105,000
ECH - $30,000 (Silicon Valley)
ECHD - $75,000 (Peninsula)
FY22 – $30,000
ECH - $30,000 (Silicon Valley)
ECHD – DNF (Peninsula)
FY23 – Not a Dual Applicant
**South Asian Heart Center**
FY21 - $285,000
ECH - $75,000
ECHD - $210,000
FY22 – $400,000
ECH - $100,000
ECHD - $300,000
FY23 – $350,000 (Recommended)
ECH - $50,000
ECHD -$300,000
**Vista Center for the Blind**
FY21 - $70,000
ECH - $40,000
ECHD - $30,000
FY22 – $70,000
ECH - $40,000
ECHD - $30,000
FY23 – $40,000 (Recommended)
ECH - $40,000
ECHD -DNF

# Community Benefit Plan Appendix: FY23 Proposal Summaries

**Plan Appendix includes:**

- FY23 Proposal Index: reflects an overview of each proposal including requested/recommended amounts, current funding, if applicable, and page numbers for corresponding Summaries.

- Proposal Summaries for submitted applications containing:
    - Program title
    - Grant goal
    - Agency description & address
    - Program delivery site(s)
    - Services funded by grant/how funds will be spent
    - FY23 funding requested and Community Benefit Advisory Council (CBAC) recommendation
    - Funding history and metric performance, if applicable
    - Dual funding information, if applicable
    - FY23 proposed metrics

# FY23 Grant Application Index

**Total Requested: $10,669,165 | Total Funded: $7,640,000 | Total Unfunded: $3,029,165**

| Health Need | Agency | Page # | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|---|---|
| Health Care Access<br>Goal % = 50%<br>Recommended % = 51% | El Camino Health - Post Discharge Care Navigator | 6 | X | | | $ 150,000 | N/A | $ 150,000 |
| | LifeMoves Mountain View Homeless Shelter | 13 | | | X | $ 160,000 | $ 160,000 | $ 160,000 |
| | Lucile Packard Foundation for Children's Health - Teen Health Van | 15 | | | | $ 115,206 | $ 98,000 | $ 98,000 |
| | New Directions - A Program of Peninsula Healthcare Connection | 21 | | | | $ 284,767 | $ 220,000 | $ 220,000 |
| | Pathways Home Health and Hospice | 25 | | | | $ 60,000 | $ 60,000 | $ 60,000 |
| | Planned Parenthood Mar Monte - Mountain View Health Center | 27 | | | | $ 225,000 | $ 225,000 | $ 225,000 |
| | Ravenswood Family Health Network | 29 | | | | $ 1,300,000 | $ 1,300,000 | $ 1,250,000 |
| | County of Santa Clara Health System | 3 | | | | $ 1,041,074 | $ 530,000 | $ 440,000 |
| | Cupertino Union School District - School Nurse Program | 4 | | | X | $ 120,367 | $ 100,000 | $ 100,000 |
| | El Camino Health - RoadRunners | 8 | | | | $ 240,000 | $ 200,000 | $ 165,000 |
| | Mountain View Whisman School District - School Nurse Program | 19 | | | | $ 410,807 | $ 280,000 | $ 290,000 |
| | On-Site Dental Care Foundation | 23 | | | | $ 200,000 | $ 200,000 | $ 200,000 |
| | Sunnyvale School District - School Nurse Program | 31 | | | | $ 287,000 | $ 287,000 | $ 287,000 |
| | Vista Center for the Blind and Visually Impaired | 33 | | X | X | $ 48,057 | $ 30,000 | $ - |
| | El Camino Hospital - Health Library & Resource Center Mountain View | 9 | | | | $ 210,000 | $ 200,000 | $ 175,000 |
| | Health Mobile | 10 | X | X | X | $ 150,000 | N/A | $ - |
| | Law Foundation of Silicon Valley | 11 | | | | $ 93,000 | $ 60,000 | $ 60,000 |
| | Lucile Packard Foundation for Children's Health - Virtual PrEP | 17 | | X | | $ 79,113 | $ 20,000 | $ - |
| | | | | | TOTALS: | $ 5,174,391 | | $ 3,880,000 |
| Behavioral Health<br>Goal % = 25%<br>Recommended % = 25% | Avenidas | 37 | | | | $ 60,000 | $ 60,000 | $ 60,000 |
| | Caminar - Dometic Violence Suppport Services | 38 | | | | $ 100,000 | $ 60,000 | $ 80,000 |
| | Cupertino Union School District - Mental Health Program | 44 | | | X | $ 93,000 | $ 90,000 | $ 93,000 |
| | El Camino Health - Behavioral Health Navigator Program | 47 | X | | | $ 150,000 | N/A | $ 150,000 |
| | Maitri | 54 | | | | $ 50,000 | $ 50,000 | $ 50,000 |
| | YWCA Golden Gate Silicon Valley | 65 | | | | $ 85,000 | $ 75,000 | $ 85,000 |
| | Acknowledge Alliance | 35 | | | | $ 60,000 | $ 50,000 | $ 50,000 |
| | Caminar - LGBTQ+ Youth Space Awareness & Outreach Program | 40 | X | | | $ 100,000 | N/A | $ 75,000 |
| | CHAC at Sunnyvale School District | 41 | | | | $ 405,107 | $ 280,000 | $ 280,000 |
| | City of Sunnyvale/Sunnyvale Senior Center | 43 | X | | | $ 42,014 | $ - | $ 25,000 |
| | Eating Disorders Resource Center | 46 | | | X | $ 22,500 | $ 25,000 | $ 22,500 |
| | Friends for Youth | 50 | X | | | $ 30,000 | N/A | $ 30,000 |
| | Los Altos School District - Mental Health Program | 52 | | | | $ 150,000 | $ 100,000 | $ 130,000 |
| | Momentum for Health | 56 | | | X | $ 290,000 | $ 290,000 | $ 290,000 |
| | Mountain View-Los Altos High School District - Mental Health Program | 58 | | | | $ 381,187 | $ 160,000 | $ 210,000 |
| | NAMI Santa Clara County | 60 | | | | $ 120,000 | $ 100,000 | $ 100,000 |
| | Emotions in Harmony | 48 | X | X | | $ 30,000 | N/A | $ - |

DNF: Do Not Fund recommendation
New: New program to Community Benefit in FY23
Dual Request: Program requested dual funding from ECH + ECHD

Green represents higher proposal strength
Blue represents medium proposal strength
Grey represents lower proposal strength

Proposal summary sheets are organized alphabetically within each health need and do not necessarily correspond with the index order.

# FY23 Grant Application Index

**Total Requested: $10,669,165 | Total Funded: $7,640,000 | Total Unfunded: $3,029,165**

| Health Need | Agency | Page # | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | CBAC Rec. |
|---|---|---|---|---|---|---|---|---|
|  | Family Alliance for Counseling Tools & Resolution | 49 | X | X | | $ 30,000 | N/A | $ - |
| | Kara | 51 | | | | $ 30,000 | $ 20,000 | $ 20,000 |
| | My Digital TAT2 | 59 | X | | | $ 40,000 | N/A | $ 30,000 |
| | Parents Helping Parents | 61 | | | | $ 62,971 | $ 35,000 | $ 35,000 |
| | Project Safety Net | 62 | | | | $ 174,023 | $ 20,000 | $ 35,000 |
| | Sunnyvale Police & Fire Foundation | 63 | X | X | | $ 25,000 | N/A | $ - |
| | WomenSV | 64 | | | | $ 30,000 | $ 30,000 | $ 30,000 |
| | | | | | **TOTALS:** | **$ 2,560,802** | | **$ 1,880,500** |
|  **Diabetes & Obesity** **Goal % = 15%** **Recommended % = 14%** | Chinese Health Initiative | 70 | | | X | $ 280,000 | $ 267,000 | $ 267,000 |
| | Playworks | 79 | | | X | $ 231,000 | $ 200,000 | $ 200,000 |
| | Silicon Valley Bicycle Coalition | 81 | | | | $ 30,000 | $ 25,000 | $ 30,000 |
| | Bay Area Women's Sports Initiative - Girls Program | 68 | | | X | $ 60,000 | $ 17,000 | $ 26,000 |
| | City of Sunnyvale - Columbia Neighborhood Center | 72 | | | | $ 45,745 | $ 35,000 | $ 45,000 |
| | El Camino Hospital - Prenatal Diagnostic Center | 74 | X | X | | $ 300,000 | N/A | $ - |
| | Fresh Approach | 75 | | | | $ 73,803 | $ 93,000 | $ 73,500 |
| | South Asian Heart Center | 82 | | | X | $ 330,000 | $ 300,000 | $ 300,000 |
| | YMCA of Silicon Valley | 84 | | | | $ 67,562 | $ 65,000 | $ 67,000 |
| | AbilityPath | 66 | X | X | | $ 45,000 | $ - | $ - |
| | Bay Area Women's Sports Initiative - Rollers Program | 69 | | | | $ 53,000 | $ 18,000 | $ 21,000 |
| | Living Classroom | 76 | | | | $ 84,740 | $ 60,000 | $ 60,000 |
| | Palo Alto Medical Foundation - 5210 Program | 77 | | X | X | $ 30,000 | $ 25,000 | $ - |
| | | | | | **TOTALS:** | **$ 1,630,850** | | **$ 1,089,500** |
|  **Chronic Conditions** **Goal % = 5%** **Recommended % = 5%** | Breathe California | 87 | | | | $ 25,000 | $ 25,000 | $ 25,000 |
| | The Health Trust | 90 | X | X | | $ 101,760 | N/A | $ - |
| | American Heart Association | 85 | | | X | $ 110,000 | $ 110,000 | $ 100,000 |
| | Community Services Agency of Mountain View and Los Altos | 88 | | | | $ 258,811 | $ 228,000 | $ 228,000 |
| | Stanford Health Care - Falls Prevention Program | 89 | | | | $ 52,000 | $ 46,100 | $ 20,000 |
| | Via Services | 92 | X | | | $ 73,524 | N/A | $ 20,000 |
| | | | | | **TOTALS:** | **$ 621,095** | | **$ 393,000** |
|  **Economic Stability** **Goal % = 5%** **Recommended % = 5%** | Hope's Corner | 94 | | | | $ 30,000 | $ 30,000 | $ 30,000 |
| | Sunnyvale Community Services - Comprehensive Safety Net Services | 98 | | | | $ 75,000 | $ 75,000 | $ 75,000 |
| | Day Worker Center of Mountain View | 93 | | | | $ 30,000 | $ 30,000 | $ 30,000 |
| | Sunnyvale Community Services - Social Work & Homebound Case Mgt | 99 | | | | $ 332,027 | $ 187,000 | $ 197,000 |
| | Second Harvest of Silicon Valley | 96 | | | | $ 90,000 | $ 90,000 | $ 40,000 |
| | Mountain View Police Department's Youth Services Unit | 95 | | | | $ 25,000 | $ 25,000 | $ 25,000 |
| | Senior Inclusion and Participation Project | 97 | X | X | | $ 100,000 | N/A | $ - |
| | | | | | **TOTALS:** | **$ 682,027** | | **$ 397,000** |

DNF: Do Not Fund recommendation
New: New program to Community Benefit in FY23
Dual Request: Program requested dual funding from ECH + ECHD

Green represents higher proposal strength
Blue represents medium proposal strength
Grey represents lower proposal strength

Proposal summary sheets are organized alphabetically within each health need and do not necessarily correspond with the index order.

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## County of Santa Clara Health System

| | | |
|---|---|---|
| ***Program Title*** | Dental Services in Sunnyvale and Mountain View | ***Recommended Amount:*** $440,000 |
| ***Program Abstract & Goal*** | To provide routine, preventive dental services to underserved individuals, including children, in Sunnyvale and Mountain View. Santa Clara Valley Medical Center (SCVMC) has seen increased patient need and demand through the pandemic. Routine, preventive dental services will be provided along with referral coordination between dental and medical teams, such as when a dental patient is experiencing COVID-19 symptoms. Education will be provided to parents on oral health and preventive dental techniques to increase oral health screenings and maintenance among children. It is expected that by bolstering education, early access, and referral coordination efforts, appointment adherence will increase, thereby reducing the frequency of emergency dental visits in North County. | |
| ***Agency Description & Address*** | 777 Turner Drive, Suite 220, San Jose<br>http://www.betterhealthrx.org<br>The Santa Clara County Public Health Department (SCCPHD) focuses on protecting and improving the health of the community through education, promotion of healthy lifestyles, disease and injury prevention, and the promotion of sound health policy. The department is comprised of a highly diverse work force that encompasses many professional disciplines and several main areas of focus. The department includes over 30 programs and services organized across seven divisions and centers | |
| ***Program Delivery Site(s)*** | • Valley Health Center Sunnyvale<br>• Santa Clara Valley Dentalcare El Camino, Mountain View | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Routine dental appointments (5 days/week)<br>• Reminder calls to patients about dental appointments (5 days/week)<br>• Scheduling for COVID related testing as needed and rescheduling of routine dental appointments (5 days/week)<br>Full requested amount funds partial time of a dentist, a dental assistant, a referral coordinator, and a health service representative. | |
| ***FY23 Funding*** | FY23 Requested: $1,041,074 | FY23 Recommended: $440,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $1,398,673<br>FY22 Approved: $530,000<br>FY22 6-month metrics met: 80% | FY21 Approved: $750,000<br>FY21 Spent: $750,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 60% | FY20 Approved: $700,000<br>FY20 Spent: $700,000<br>FY20 6-month metrics met: 80%<br>FY20 Annual metrics met: 38% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 1,008 | 1,865 |
| | Dental encounters | 2,182 | 4,165 |
| | Increase percentage of patients who receive prophylactic cleaning | 20% | 25% |
| | Reduce percentage of patients who have emergency dental visits | 21% | 20% |
| | Reduce no show rate of dental patients | 8% | 7% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Cupertino Union School District

| | | |
|---|---|---|
| ***Program Title*** | Student Health Services | ***Recommended Amount:*** $100,000 |
| ***Program Abstract & Goal*** | This program aims to support the Student Health Services program for five schools in the El Camino Healthcare District. Services will provide extensive follow-up for health screening failures and assistance with access to healthcare services through community resources as well as on-site medical care for students grades K-8. Many of the children require a licensed medical professional for management of health issues such as type 1 diabetes, seizure disorder, life-threatening allergy, asthma, and cerebral palsy. Additionally, the health services staff will provide health trainings to staff and health education to students and families. | |
| ***Agency Description & Address*** | 1309 S. Mary Avenue, Sunnyvale<br>http://www.cusdk8.org<br>The Cupertino Union School District (CUSD) is a Local Education Agency that provides public education to students in preschool through eighth grade. The largest elementary school district in northern California, CUSD is comprised of nearly 1,500 employees serving approximately 14,000 students in 17 elementary schools, one K-8 school, and five middle schools located throughout Cupertino and parts of Sunnyvale, San Jose, Saratoga, Los Altos, and Santa Clara. The mission of CUSD is to provide a child-centered environment that cultivates character, fosters academic excellence, and embraces diversity. District families, communities, and staff join as partners to develop creative, exemplary learners with the skills and enthusiasm to contribute a constantly changing global society. | |
| ***Program Delivery Site(s)*** | • Chester Nimitz Elementary, Sunnyvale<br>• Louis Stocklmeir Elementary, Sunnyvale<br>• Montclaire Elementary, Los Altos<br>• West Valley Elementary, Sunnyvale<br>• Cupertino Middle School, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Day to day nursing assessment, care, and documentation of illness and injury<br>• Ongoing recording and monitoring of students with special medical needs at school<br>• Collaboration with primary and specialty care providers to determine specialized needs<br>• Ongoing administration of medications and procedures for students requiring them at school (i.e. insulin, urinary catheterization)<br>• Screening/follow-up for undiagnosed vision and hearing Impairments<br>• Oral health screenings/follow-ups<br>• Identification of non-compliant TB testing, required immunizations and physical exams<br>• Annual and ongoing confirmation of physical health assessments for all first grade students<br>• Individual health assessment for student evaluated for Special Education<br>• Identification of students with medical conditions and creation of Individualized Student Healthcare Plans (ISHP) to meet their unique needs at school<br>• Development/implementation of health and safety protocols and trainings for a variety of situations and settings, including COVID-19<br>• Supervision of COVID-19 isolation areas and assistance with contact tracing<br>• Training of unlicensed personnel to perform scope-appropriate medical care<br>Full requested amount funds five health clerks (0.438 FTE) and 0.5 FTE LVN, and office supplies. | |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Cupertino Union School District

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $120,367 | FY23 Recommended: $100,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $280,743<br>FY22 Approved: $100,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $100,00<br>FY21 Spent: $100,000<br>FY21 6-month metrics met: 80%<br>FY21 Annual metrics met: 100% | FY20 Approved: $81,921<br>FY20 Spent: $81,921<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |
| ***FY23 Dual Funding*** | FY23 Requested: $120,367 | FY23 Recommended: $100,000 | |
| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $294,792<br>FY22 Approved: $100,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $90,000<br>FY21 Spent: $90,000<br>FY21 6-month metrics met: 75%<br>FY21 Annual metrics met: 100% | FY20 Approved: $81,921<br>FY20 Spent: $81,921<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 50% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 1,499 | 2,997 |
| | Hearing and Vision Screenings Provided | 1,297 | 2,547 |
| | Percentage of students who saw an eye care provider after failing a vision screening at school as a result of the nurse's referral. | 55% | 85% |
| | Percentage of students who receive a flu vaccine as a result of SHS community education and advice to get flu shot. | 40% | 55% |
| | Percentage of staff members who received training on food allergies and administration of life-saving Epi-Pen. | 20% | 25% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## El Camino Health

| | | |
|---|---|---|
| ***Program Title*** | Post Discharge Care Navigator | ***Recommended Amount:*** $150,000 |
| ***Program Abstract & Goal*** | The El Camino Health (ECH) care coordination department is requesting funds to develop a post-discharge navigator program to support vulnerable and underserved patients in their transition from an inpatient stay to the outpatient setting. Post-discharge support was identified as a gap in the ECH patient experience, and the care navigator concept is based on industry best practice. Care navigation is especially critical for patients with limited access to financial and social resources. These patients often have more difficulty transitioning into the community and are more likely to be readmitted to the hospital when their basic needs are not being met. The care coordination department plans to add a 1.0 FTE LVN care navigator, who will serve patients at El Camino Hospital Mountain View. The care navigator will work as part of interdisciplinary team including Dr. Pezzani, UM Director, Grace Benlice, Director of Care Coordination, and an outpatient pharmacist. The primary goals of the program are to reduce readmissions, increase referrals to our local network of community health organizations, and ensure that patients thrive after discharge. The LVN care navigator will use existing reports and risk stratification tools in Epic to identify recently discharged patients who are in need of support. Patients will be prioritized based on risk for readmission with a focus on vulnerable populations such as Medi-Cal beneficiaries, the uninsured, and the unhoused. Clinicians will also be able to refer directly to the care navigator as needed. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>http://https://www.elcaminohealth.org/<br>The El Camino Health goal is to assure that patients have the care they need once they leave the hospital. El Camino Health draws from in-home, community and family resources to help patients or thier loved ones return to as independent and productive a role as possible. | |
| ***Program Delivery Site(s)*** | El Camino Health - Mountain View Campus | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Risk stratification based on probability of readmission and access to resources<br>• At least 4 phone calls in the 30-day window post-discharge<br>• Initial phone call 48-72 hours post-discharge<br>• The care navigator will perform the following interventions:<br>• After Visit Summary Support/Education- Ensure that patients understand the AVS and have access to the resources necessary to complete any follow-up recommended by the inpatient care team.<br>• Chronic Condition Red Flags Education- Teach patients about the red flags of their chronic condition, create action plans for when and where to seek care for escalating symptoms.<br>• Chronic Disease Self-Management Education- Assess the patient's level of health literacy, provide education and support for self-management of the condition(s), provide resources that support self-management as appropriate (i.e. glucometer, scale, healthy food, etc.).<br>• Care Coordination- Ensure that patients are able to schedule and attend follow-up appointments with their care team, connect to support services offered through the health plan as appropriate, and connect to community resources as needed.<br>Full requested amount funds 1.0 FTE navigator. | |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## El Camino Health

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $150,000 | FY23 Recommended: $150,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | New Applicant in FY23 | New Applicant in FY23 | New Applicant in FY23 |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 150 | 400 |
| | Patients served that were referred to community partners | 70% | 80% |
| | Patients identified that were served | 20% | 25% |
| | Decreased readmission rates of those who met with the post discharge care navigator | 10% | 10% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## El Camino Health

| | | |
|---|---|---|
| ***Program Title*** | MV RoadRunners Transportation | ***Recommended Amount:*** $165,000 |
| ***Program Abstract & Goal*** | This program ensures seniors and disabled community members have access to medical care by providing safe, timely and compassionate transport while helping older adults maintain independence. RoadRunners is a community-based transportation service that is available to ambulatory clients and patients, specializing in seniors and the disabled who are unable to drive. RoadRunners serves a growing number of seniors who are no longer able to drive and may face isolation and loneliness in addition to limited access to medical care. The service takes community members to and from vital community services, programs, and places that support their health. Financial assistance is available for clients that have limited income and that have continuous, regular, and on-going appointments such as dialysis, physical therapy, cancer treatments and the Behavioral Health Programs. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>http://elcaminohealth.org<br>The El Camino Health RoadRunners Transportaion program is a community-based transportation service that is available to ambulatory clients and patients, specializing in seniors and the disabled who are unable to drive. The RoadRunners program has a close working relationship with community physicians, community clinics, Peninsula Eye Surgery Center, local area Community Services agencies, as well as other medical facilities within our district. Unfortunately, a growing number of seniors who are no longer able to drive may face isolation and loneliness in addition to limited access to medical care, and may not even know what community services and resources are available. | |
| ***Program Delivery Site(s)*** | Delivery sites within El Camino Healthcare District | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Transporting individuals to medical appointments and other necessary services (i.e. COVID testing/vaccinations, pharmacy etc.)<br>• Volunteer recruitment and coordination<br>• Outreach to local senior centers, community services agencies and other senior focused programs about available services<br>Full requested amount funds a transportation supervisor, two department assistants, supplies, purchased services, repairs/maintenance, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $240,000 | FY23 Recommended: $165,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $240,000<br>FY22 Approved: $200,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $240,000<br>FY21 Spent: $199,629<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 75% | FY20 Approved: $230,000<br>FY20 Spent: $204,760<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 75% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 300 | 600 |
| | RoadRunners client rides | 3,500 | 5,500 |
| | Older adults who strongly agree or agree services helped in maintaining their independence | 91% | 91% |
| | Older adults who strongly agree or agree services made it possible to get to their medical appointments. | 95% | 95% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## El Camino Hospital

| | | |
|---|---|---|
| ***Program Title*** | Health Library & Resource Center Mountain View | ***Recommended Amount:*** $175,000 |
| ***Program Abstract & Goal*** | The Health Library and Resource Center (HLRC) serves to improve health literacy and knowledge of care options for patients, families and caregivers. The HLRC is open to all community members. Individuals seek accurate and up-to-date health information to assist them in making healthy lifestyle choices and to aid them in effectively partnering with their healthcare providers and connect them to community resources. The HLRC directs community members to information sources suitable to their needs, interests and abilities. The services are provided at the HLRC in Mountain View, by telephone, online and at senior centers or community centers. Additionally in FY23, the HLRC will support activities related to the ECHD Community Health & Wellness Initiative. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>https://www.elcaminohealth.org/services/health-library-resource-center<br>The Health Library & Resource Center (HLRC) provides access to high quality vetted information tailored to the information needs of each individual patron. Information is available in various formats including consumer books, medical textbooks, newsletters, journals, and medical subscription databases. The HLRC provides research assistance, advance healthcare directive counseling, eldercare counseling, Medicare counseling and appointments with the dietitian and pharmacist. Many patrons receive information by telephone or email. Prior to COVID 19 they would also come into the HLRC. | |
| ***Program Delivery Site(s)*** | Services will be provided virtually, by phone and at the Health Library and Resource Center at El Camino Hospital, Mountain View and open to all members of the local community. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Providing access to vetted print, electronic, and online information sources coupled with professional assistance in selecting appropriate resources<br>• Providing resources to local senior centers<br>• Providing no-cost access to blood pressure screenings, consultations with a dietitian and pharmacist, advance healthcare directive assistance, Medicare counselor and eldercare consultations<br>• Supporting the ECHD Community Health & Wellness Initiative with project administration and other related activities<br>Full requested amount funds 0.6 FTE Medical Librarian, 0.5 FTE HLRC Coordinator, a consultant, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $210,000 | FY23 Recommended: $175,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $210,000<br>FY22 Approved: $200,00<br>FY22 6-month metrics met: 100% | FY21 Approved: $210,000<br>FY21 Spent: $211,853<br>FY21 6-month metrics met: 75%<br>FY21 Annual metrics met: 75% | FY20 Approved: $210,000<br>FY20 Spent: $159,286<br>FY20 6-month metrics met: %100<br>FY20 Annual metrics met: %100 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 3,000 | 6,000 |
| | Each individual receives at least one service | 3,000 | 6,000 |
| | Library services have been valuable in helping me manage my health or that of a friend or family member | 65% | 65% |
| | Library information is appropriate to my needs | 80% | 80% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Health Mobile

| | | |
|---|---|---|
| ***Program Title*** | Free dental care for under served children, adult, seniors and homeless of Sunnyvale and Mountain View | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | This program will provide free, comprehensive dental care services to low-income older adults, children, pregnant women and the homeless population in Mountain View and Sunnyvale. | |
| ***Agency Description & Address*** | 1659 Scott Boulevard, #4, Santa Clara<br>http://www.healthmobile.org<br>Due to high cost of living in the Bay Area, it is not feasible for Medi-Cal (Medicaid) providers to provide care to Medi-Cal members with Medi-Cal dental rates. Hence the low utilization rate. Additionally, low-income families can not afford to take a day off to take their children and senior parents to dentists. Accessibility is second barriers after affordability in utilizing healthcare system. If funded, for $100 per visit the program will provide, 1500 free, comprehensive (A-Z), accessible (onsite) dental treatments to 400 under served children, adults, seniors of Sunnyvale and Mountain View. The program will provide free dental care to children (at school), to adults (at school after hours), to seniors at seniors centers and to homeless and pregnant woman at homeless service agencies (CSA). | |
| ***Program Delivery Site(s)*** | Schools and senior centers in Mountain View and Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Dental Exams<br>• X-rays, cleanings and fillings<br>• Other comprehensive dental treatments such as root canals and extractions<br>• Oral Cancer Screenings<br>• Smoking cessation and oral hygiene education<br>Full requested amount funds partial time for a dentist, clinic manager, two assistants, a receptionist, and a driver. Funds will also cover supplies, gas and auto expenses, lab expenses and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $150,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | Not funded in FY22 | FY21 Approved: $75,000<br>FY21 Spent: $75,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 100% | FY20 Approved: $150,000<br>FY20 Spent: $150,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 50% |

| ***FY23 Dual Funding*** | FY23 Requested: $150,000 | FY23 Recommended: $75,000 |
|---|---|---|

| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $150,000<br>FY22 Approved: $55,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $75,000<br>FY21 Spent: $75,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 100% | New in FY21 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 150 | 400 |
| | Dental procedures including;<br>Exam, X-Ray, Cleaning, Fillings, Root Canals, Extractions | 600 | 1,500 |
| | Patients who report increased knowledge about their oral health | 85% | 85% |
| | Patients who report no pain after their first visit | 90% | 90% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Law Foundation of Silicon Valley

| | | |
|---|---|---|
| ***Program Title*** | Removing Barriers to Mental Health Access | ***Recommended Amount:*** $60,000 |
| ***Program Abstract & Goal*** | This program helps people living with mental health disabilities gain access to healthcare and other support they need to improve their overall quality of life. Attorneys provide legal counsel and advice, extended legal representation, referrals to other community-based organizations and more, in an effort to ensure that people with mental health or developmental disabilities have access to services and public benefits that are critical to their health and well-being. The program collaborates with, gets referrals from and provides services at clinics, hospitals and safety net institutions including El Camino Health and Community Services Agency Mountain View. The Law Foundation will also conduct outreach and educational presentations to providers at medical and safety-net facilities in an effort to expand services for people with mental health disabilities. | |
| ***Agency Description & Address*** | 4 N. 2nd Street, Suite 1300, San Jose<br>http://www.lawfoundation.org<br>The Law Foundation of Silicon Valley advances the rights of under-represented individuals and families in our diverse community through legal services, strategic advocacy, and educational outreach. Their Health Program takes an approach where we serve communities who are historically excluded from health systems including Black, Indigenous, Latinx, AAPI, other people of color, LGBTQIA individuals and people experiencing homelessness. They incorporate community/movement lawyering and grassroots advocacy to help our clients based on their direct legal services work. | |
| ***Program Delivery Site(s)*** | • The Law Foundation holds monthly clinics at Community Services Agency (CSA) in Mountain View as well as virtually until offices re-open. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Outreach and advocacy services for residents to improve access to mental health care and other safety-net benefits<br>• Legal counsel and advise on healthcare-related matters<br>• Provide patients' rights advocacy and other legal information from on-site legal advisors<br>• Training health care providers about benefits eligibility and other legal issues commonly faced by mental health consumers and people living in poverty<br>• Coordination with medical staff, social workers and case managers at community partner agencies throughout the El Camino Healthcare District to help identify and resolve legal barrier that negatively impact patients' health<br>Full requested amount funds partial salaries of three staff attorneys, other staff and some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $93,000 | FY23 Recommended: $60,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $65,000<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 50% | FY21 Approved: $60,000<br>FY21 Spent: $60,000<br>FY21 6-month metrics met: 60%<br>FY21 Annual metrics met: 40% | FY20 Approved: $60,000<br>FY20 Spent: $60,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Law Foundation of Silicon Valley

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served (providers trained and community members served through representation) | 72 | 145 |
| | Individuals served through representation | 27 | 55 |
| | Clients receiving services for benefits issues who increase their knowledge regarding available health and income benefits | 95% | 95% |
| | Providers receiving training who increase their understanding of their patients' rights to medical benefits and other forms of public assistance | 90% | 90% |
| | Clients receiving extensive representation services for benefits issues who successfully access or maintain health benefits or other safety-net benefits | 90% | 90% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## LifeMoves

| | | | |
|---|---|---|---|
| ***Program Title*** | LifeMoves – Supportive Services at Mountain View Shelter | ***Recommended Amount:*** | $160,000 |
| ***Program Abstract & Goal*** | To support LifeMoves on-site behavioral health program and a licensed vocational nurse (LVN) to assist older clients with medical management and other health care needs at the Mountain View homeless shelter. El Camino Health has supported LifeMoves behavioral health services at three shelters in San Jose for four years. The Mountain View shelter will prioritize serving seniors; most older homeless individuals have one or more chronic health conditions and may be taking multiple medications. The LVN will conduct health screenings and assessments, connect clients to primary care services, accompany clients to appointments, assist clients with managing their medications, and otherwise ensures that clients are making and keeping primary care appointments, rather than using hospital emergency rooms for care that can be better addressed in other settings. The LVN will also assist clients with getting the COVID vaccine. The objectives of the Behavioral Health services are (1) to screen homeless clients for behavioral health conditions, and (2) to connect those needing services to on-site services. This continued behavioral health support has proven to be very useful in helping clients successfully transition out of homelessness and into stable housing and self-sufficiency. | | |
| ***Agency Description & Address*** | 181 Constitution Drive, Menlo Park<br>http://www.lifemoves.org<br>LifeMoves is the largest and most innovative provider of interim housing and supportive services for individuals, couples, and families experiencing homelessness in Silicon Valley and the Bay Area Peninsula. For more than 30 years, LifeMoves has given our neighbors experiencing homelessness a temporary place to call home while providing intensive, customized case management through both site-based programs and community outreach. On any given night, we feed, clothe, and house about 1,250 individuals across our 23 shelter and service sites, providing intensive case management and a broad range of supportive services. In our most recent fiscal year, LifeMoves provided more than 237,500 nights of shelter, and returned more than 1,800 clients to stable housing. | | |
| ***Program Delivery Site(s)*** | At agency's Mountain View Interim Housing Community | | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>BehavioralMoves services:<br>• Screening adult clients for behavioral health needs at program entry<br>• Individual one-hour behavioral health therapy sessions<br>• Milieu therapy sessions on-site<br>• Group counseling sessions on-site<br>LVN services:<br>• Screening in-coming clients for medical issues or conditions needing treatment<br>• Managing medications for clients<br>• Facilitating primary care appointments<br>• Facilitating return appointments and other follow-up care<br>Full requested amount funds an LVN and partial salaries for the Director of Behavioral Health, Director of Clinical Services and other staff positions as well as some program support costs. | | |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## LifeMoves

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $160,000 | FY23 Recommended: $160,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $160,000<br>FY22 Approved: $160,000<br>FY22 6-month metrics met: 100% | New in FY22 | New in FY22 |
| ***FY23 Dual Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $50,000 | |
| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $60,000<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $60,000<br>FY21 Spent: $60,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $50,000<br>FY20 Spent: $50,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 125 | 285 |
| | Combined LVN and BH services provided | 365 | 820 |
| | BH clients report improved mood & function | N/A | 85% |
| | BH clients report understanding of BH issues | N/A | 75% |
| | LVN clients report improved health | N/A | 75% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Lucile Packard Foundation for Children's Health - Teen Health Van

| | | |
|---|---|---|
| ***Program Title*** | Stanford Children's Health Teen Van at High Schools in the El Camino Healthcare District | ***Recommended Amount:*** $98,000 |
| ***Program Abstract & Goal*** | The Teen Health Van consists of a medical team and mobile clinic designed to address the unmet health needs of the most underserved pediatric population in the community: at-risk, uninsured, underinsured, and homeless patients aged 12-25 years. Most of the Van's patients suffer from multiple health-related problems, including mental health issues such as anxiety and depression, and require ongoing care. The Van's multi-disciplinary staff provides comprehensive primary health care services, nutrition counseling, and psychosocial and mental health counseling. Additionally, the social worker and dietitian offer group sessions on a variety of adolescent issues, including self-esteem, mental health, substance use, healthy nutrition for teens and acculturation issues for new refugees/immigrants. Patients who require specialty, dental or vision care are provided a referral and often have their costs covered by the Van program. COVID-19 testing and vaccinations have been ongoing and will continue as needed. Social determinants of health affected by the pandemic, especially food and financial insecurity, are also addressed by the Van's staff, who provide care packages with non-perishable food, arrange for free home grocery deliveries (especially during isolation/quarantine situations), and help cover some housing-related costs (e.g., utility bills) for our most highly impacted patients and families. For many of these patients, the Van is their single point of healthcare access. It is estimated that every dollar invested in the Van leads to a savings of $10 because of its success in prevention and early treatment. | |
| ***Agency Description & Address*** | 400 Hamilton Avenue, Suite 340, Palo Alto<br>http://www.lpfch.org<br>Lucile Packard Children's Hospital Stanford is a nonprofit hospital in Palo Alto, devoted exclusively to the health care needs of children and expectant mothers throughout Northern California and around the world. The mission of Packard Children's is to serve our communities as an internationally recognized pediatric and obstetric hospital that advances family-centered care, fosters innovation, translates discoveries, educates health care providers and leaders, and advocates on behalf of children and expectant mothers. Lucile Packard Foundation for Children's Health is the fundraising entity for the hospital; philanthropy supports clinical care, research, and education to improve the health of children and expectant mothers, locally and worldwide. Our hospital serves as a vital safety net hospital for low-income families throughout the Bay Area and California. | |
| ***Program Delivery Site(s)*** | Mountain View-Los Altos Union High School District; students from Mountain View High School are provided with transportation to one of these sites:<br>• Los Altos High School<br>• Alta Vista High School | |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Lucile Packard Foundation for Children's Health

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| | |
|---|---|
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Staffing of a doctor, nurse practitioner, social worker, and dietitian<br>• Comprehensive medical care including complete physicals & sports physicals<br>• Social services assessments<br>• Immunizations<br>• Referrals for substance abuse, mental health and HIV<br>• Nutrition counseling<br>• Medications<br>• Lab tests onsite<br>• Mental health counseling<br>• Risk behavior reduction and wellness events<br>• Mindfulness training afor stress reduction and ongoing group sessions<br>• Smoking/vaping counseling and education and use of nicotine replacement therapy<br>• Referrals to community groups that offer housing, education, and job training<br>Full requested amount funds partial salaries of the Medical Director, Dietitian, Nurse Practitioner, Social Worker, Medical Assistant, Clinical Assistant, Registrar/Driver, medications and supplies. |
| ***FY23 Funding*** | FY23 Requested: $115,206 FY23 Recommended: $98,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $105,194<br>FY22 Approved: $98,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $97,000<br>FY21 Spent: $97,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $95,000<br>FY20 Spent: $95,000<br>FY20 6-month metrics met: 67%<br>FY20 Annual metrics met: 75% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 50 | 100 |
| | Total number of services provided/encounters | 200 | 400 |
| | Youth receiving catch up vaccinations to be able to enroll in school | 35% | 75% |
| | Patients who receive recommended vaccinations (including but not limited to influenza and HPV) | 30% | 60% |
| | Patients who receive social worker consultation, treatment by the medical team, including a Packard Children's Hospital psychiatrist, and/or medications, after screening positive for depression | 90% | 90% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Lucile Packard Foundation for Children's Health - PrEP

| | | |
|---|---|---|
| ***Program Title*** | Virtual PrEP: Connecting adolescents and young adults with pre-exposure prophylaxis (PrEP) for HIV prevention | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | The Virtual Pre-Exposure Prophylaxis (PrEP) Program for Adolescents and Young Adults at Stanford was developed to improve access to quality PrEP care for adolescents and young adults. Patients must be 25 and younger and at risk of HIV infection. The program connects patients with a Stanford pediatric or adolescent provider to provide PrEP counseling and initiation services specifically designed for and focused on youth to reduce their chance of contracting HIV. PrEP Navigators will provide frequent check-ins, adherence support, and navigate medication payment assistance programs. Both patient and provider outreach is conducted. Direct patient outreach is primarily through social media and online advertisements that focus messaging to a relevant audience. Most providers caring for adolescents are not familiar with PrEP and were not trained provide PrEP.<br>In 2019, about 40% of new HIV diagnoses in California were among adolescents and young adults under the age of 30 years, with over half of those occurring in youth under the age of 25 years. In 2018, patients aged 13-24 accounted for 15% of new HIV infections in Santa Clara County. | |
| ***Agency Description & Address*** | 400 Hamilton Avenue, Suite 340, Palo Alto<br>http://www.lpfch.org<br>Lucile Packard Children's Hospital Stanford is a nonprofit hospital in Palo Alto, devoted exclusively to the health care needs of children and expectant mothers throughout Northern California and around the world. The mission of Packard Children's is to serve our communities as an internationally recognized pediatric and obstetric hospital that advances family-centered care, fosters innovation, translates discoveries, educates health care providers and leaders, and advocates on behalf of children and expectant mothers. Lucile Packard Foundation for Children's Health is the fundraising entity for the hospital; philanthropy supports clinical care, research, and education to improve the health of children and expectant mothers, locally and worldwide. Our hospital serves as a vital safety net hospital for low-income families throughout the Bay Area and California. | |
| ***Program Delivery Site(s)*** | • Program is virtual and will target within the El Camino Healthcare District, however the providers are primarily based at the Center for Adolescent Health at Stanford | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>Increasing the number of patients who are prescribed PrEP through:<br>• Providing direct clinical care to patients interested in receiving PrEP through the Virtual PrEP Program for Adolescents and Young Adults at Stanford<br>• Providing live and recorded training to pediatric clinical providers to increase their PrEP awareness and their willingness to prescribe PrEP<br>Full requested funding would support the partial salaries of a Medical Director, an Associate Medical Director of Operations and Outreach, an Associate Medical Director of Research and Education as well as costs for patient outreach on social media and provider outreach through virtual training. | |
| ***FY23 Funding*** | FY23 Requested: $79,113 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $80,000<br>FY22 Approved: $20,000<br>FY22 6-month metrics met: 0% | New in FY22 | New in FY22 |

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# FY23 Healthcare Access & Delivery Application Summary


## Lucile Packard Foundation for Children's Health

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 12 | 24 |
| | number of virtual patient visits | 12 | 40 |
| | HIV infections among patients who are continuously participating in the program (zero/low percent desired) | 0% | 0% |
| | Patients in the Virtual PrEP program who are supported by a PrEP Navigator | 80% | 80% |
| | Patients offered mail-in laboratory monitoring | 80% | 80% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Mountain View Whisman School District – School Nurse Program

| | | |
|---|---|---|
| ***Program Title*** | Health Services Grant | ***Recommended Amount:*** $290,000 |
| ***Program Abstract & Goal*** | Mountain View Whisman School District requests support for two registered nurses and an LVN to provide health services students from preschool through 8th grade. Students will receive direct healthcare services through treatment of minor illnesses and injuries occurring at school, management of chronic illnesses requiring direct nursing intervention, assessment of health histories, and state mandated health screenings. Students requiring medical follow-up with a provider will receive assistance in accessing appropriate healthcare services. The program also addresses prevention of acute illness concerns through screenings, review of vaccination records, and implementation of preventative measures to prevent the spread of communicable diseases. Due to the Covid pandemic, the health services program has the added responsibility of COVID testing and reporting for staff and students, as well as increased involvement in managing school safety measures, including providing education, overseeing testing, and reporting vaccination status and positive cases. | |
| ***Agency Description & Address*** | 1400 Montecito Drive, Mountain View<br>http://mvwsd.org<br>Mountain View Whisman School District (MVWSD) is located in Mountain View, CA, in the heart of Silicon Valley. MVWSD serves a diverse student population from preschool through eighth grade representing a wide range of ethnicities, languages, cultures, and economic status. Mountain View Whisman School District's mission is to demonstrate a relentless commitment to the success of every child on a daily basis. Our priorities are academic excellence, strong community, and a broad worldview. We prepare our students for the world ahead by challenging, inspiring, and supporting them to thrive in a world of constant change. | |
| ***Program Delivery Site(s)*** | At all 12 sites in the Mountain View Whisman School District | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Vision and hearing screenings<br>• Oral Health Exam<br>• Child Health and Disability Prevention Exam<br>• One on one health care for students with chronic health conditions such as Diabetes, G-tube feedings, tracheotomy care, chronic cardiac conditions, daily medication administration, etc.<br>• Emergency responses to injured and ill students. Provide telehealth support as needed and on call for health concerns.<br>• GoNoodle (breathing, yoga, mindfulness)<br>• Staff Training/Education (i.e. CPR, First Aid, Medication Administration, GoNoodle)<br>• Health assessments for students requiring specialized education plans<br>• COVID contact tracing<br>• Create educational resources (i.e. videos, presentations, etc.)<br>Full requested amount funds two School Nurses and two Licensed Vocational Nurses. | |
| ***FY23 Funding*** | FY23 Requested: $410,807 | FY23 Recommended: $290,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $300,628<br>FY22 Approved: $280,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $275,000<br>FY21 Spent: $275,000<br>FY21 6-month metrics met: 67%<br>FY21 Annual metrics met: 100% | FY20 Approved: $240,000<br>FY20 Spent: $227,614<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 25% |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Mountain View Whisman School District

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 1,950 | 3,900 |
| | Services provided | 5,500 | 8,000 |
| | Students who failed a hearing or vision screening who saw a provider. | N/A | 45% |
| | Students needing a oral health exam who saw a provider. | 30% | 60% |
| | Students needing a CHDP exam who saw a provider. | 40% | 60% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## New Directions – a program of Peninsula Healthcare Connection

| | | |
|---|---|---|
| ***Program Title*** | New Directions Intensive Case Management | ***Recommended Amount:*** $220,000 |
| ***Program Abstract & Goal*** | To provide intensive, community-based case management services by MSW/LCSW level Social Work Case Managers to individuals with complex medical and psychosocial needs. Intensive case management has been shown to be an effective intervention for addressing social determinants of health, reducing health disparities, reducing Emergency Department visits, hospital admissions and length of stay, and improving health outcomes and overall quality of life. Services are provided wherever a patient is located in the District, at a frequency and duration appropriate for each individual. New Directions supports the most high-need, vulnerable individuals in our community who have been unsuccessful linking to supports and services independently, to connect and engage with health, behavioral health and basic needs services. | |
| ***Agency Description & Address*** | Opportunity Center, 33 Encina Avenue, #103, Palo Alto<br>http://www.peninsulahcc.org/newdirections<br>Peninsula Healthcare Connection (PHC) provides individuals experiencing homelessness, at risk for homelessness and low income individuals, comprehensive health and behavioral health services regardless of ability to pay. Our patients present with complex medical, behavioral health and social needs, and can have difficulty engaging with traditional healthcare settings. PHC's dedicated clinic professionals administer compassionate, person-centered care tailored to the unique needs of the population we serve. | |
| ***Program Delivery Site(s)*** | Services are provided at locations throughout the community where clients are located, as well as at agency site. Agency receives referrals from ECH Care Coordination. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Bilingual services include:<br>• Comprehensive biopsychosocial assessment to evaluate needs and create appropriate care plan<br>• Primary and specialty care, including mental health and substance abuse treatment<br>• Crisis intervention for immediate housing needs, medical, mental health and substance use issues<br>• Care coordination and communication between providers<br>• Recommendations and referrals to governmental or community-based programs as appropriate<br>• Assistance with, application, renewal and coordination of benefits such as Social Security, SSI, Medi-Cal and Medicare<br>• Advocate for clients with social service, medical and behavioral health agencies<br>• Financial and transportation assistance as needed<br>Full requested amount funds 2.5 FTE Social Work Case Managers along with partial salaries of a Clinical Supervisor and Coordinator as well as some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $284,767 | FY23 Recommended: $220,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $220,000<br>FY22 Approved: $220,000<br>FY22 6-month metrics met: 75% | FY21 Approved: $220,000<br>FY21 Spent: $220,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 80% | FY20 Approved: $180,000<br>FY20 Spent: $180,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Peninsula Healthcare Connection

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 65 | 102 |
| | Services provided | 900 | 1,950 |
| | Enrolled patients in need of mental health or substance use treatment or services will be referred to and seen by a treatment provider. | 70% | 75% |
| | Enrolled patients will be connected to and establish services with a minimum of one basic needs benefits program. | 80% | 95% |
| | Enrolled patients will be screened for depression utilizing the PHQ-9. | 60% | 70% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## On-Site Dental Care Foundation

| | | |
|---|---|---|
| ***Program Title*** | Oral Health & Education - North County | ***Recommended Amount:*** $200,000 |
| ***Program Abstract & Goal*** | This program will provide comprehensive, bilingual oral health services and education in Mountain View and Sunnyvale for uninsured low-income community members including homeless, undocumented immigrants, low income seniors, and low income families. In Santa Clara County, 1/3 of adults do not have dental insurance and 45% have dental decay and/or gum disease. Furthermore, disparities exist where 25.3% white, 30.3% Asian, and 32.1% of Latinx have no dental insurance; 31% white, 50% African American, 61% Asian, and 60% Latinx have dental decay and/or gum disease. | |
| ***Agency Description & Address*** | P.O. Box 41111, San Jose<br>http://https://www.osdcf.org<br>On-Site Dental Care Foundation provides comprehensive oral health services and education to homeless, undocumented immigrants, low income seniors and low income families. Services are provided via a mobile dental practice that locates in neighborhoods or other locations familiar to target populations. The comprehensive services include, exams, periodontal, blood pressure and oral cancer screenings, x-rays, cleanings (including deep cleanings), fillings, extractions (both surgical and regular), root canals (both molar and anterior), crowns, and dentures (stayplates, partials, and full). In addition to providing services, On-Site establishes a dental home for these patients that generally have limited access to oral health services, and recall exams are scheduled when treatment plans are completed, at 3, 4 or 6 months depending on patient's periodontal status. | |
| ***Program Delivery Site(s)*** | Mobile services will be delivered in Mountain View and Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Conducting new patient exams, including x-rays, periodontal and cancer screenings, as well as treatment plan development<br>• Providing cleanings, including deep root cleaning, and fluoride varnish to help prevent dental caries<br>• Providing dental procedures including fillings, extractions, root canals, restorative, crowns, dentures<br>• Delivering education on proper maintenance, importance of oral health on overall health<br>Full requested amount funds partial time of two dentists, two dental assistants, a health educator, dental supplies/equipment, lab costs, fuel, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $200,000 | FY23 Recommended: $200,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $200,000<br>FY22 Approved: $200,000<br>FY22 6-month metrics met: 75% | FY21 Approved: $90,000<br>FY21 Spent: $90,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | New in FY21 |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## On-Site Dental Care Foundation

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 175 | 285 |
| | Number of visits provided to patients for treatment | 575 | 1,325 |
| | Patients who are retained in care and continue to come to regular checkups and cleanings. | 50% | 65% |
| | Treatment completion rate. | 50% | 85% |
| | Patients with improved oral hygiene after receiving treatment and education | 50% | 65% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Pathways Home Health and Hospice

| | | |
|---|---|---|
| ***Program Title*** | Pathways Un and Underinsured Care Program | ***Recommended Amount:*** $60,000 |
| ***Program Abstract & Goal*** | To provide high-quality home health and hospice services to un/under-insured individuals living in the El Camino Healthcare District. This program will provide health care services (home health and/or hospice) to individuals who are recovering from illness or surgery, managing a chronic disease, or coping with life-threatening conditions. The program's goal is to ensure that this vulnerable population receives the home health or hospice care prescribed by their doctors which allows them to remain in their homes as healthy as possible, to avoid re-hospitalization and emergency room visits, and to reconnect patients back to their primary care physicians for ongoing health management. Service are provided by physicians, licensed RN's, physical, speech and occupational therapists, social workers, bereavement counselors, and home health aides. | |
| ***Agency Description & Address*** | 585 N. Mary Avenue, Sunnyvale<br>http://www.pathwayshealth.org<br>Pathways provides high-quality home health, hospice, and palliative care with kindness and respect, promoting comfort, independence and dignity. Non-profit, community-based Pathways has been a pioneer in home health, hospice and palliative care since 1977. With offices in Sunnyvale, South San Francisco and Oakland, Pathways serves more than 4,000 families annually in five Bay Area counties. Pathways cares for patients wherever they live – at home, in nursing homes, hospitals and assisted living communities. | |
| ***Program Delivery Site(s)*** | At patient's residence in the El Camino Healthcare District or in an inpatient health care setting such as a hospital or skilled nursing facility | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Nursing visits<br>• Physical, occupational and other therapies<br>• Medical social workers<br>• Home health aides for personal care<br>• 24-hour on-call nursing service<br>• Spiritual and bereavement counselors<br>• Medication management with pharmacy oversight and consultation<br>• Uncompensated room and board for MediCal recipients on hospice<br>Full requested amount funds 0.58 FTE nurse, 0.23 FTE physical therapist, 0.07 FTE occupational and speech therapist, 0.01 FTE social worker, 0.05 FTE program manager, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $60,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $60,000<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $60,000<br>FY21 Spent: $60,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $60,000<br>FY20 Spent: $60,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Pathways Home Health and Hospice

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 30 | 45 |
| | Units of Service provded | 300 | 450 |
| | Home Health 60 Day re hospitalization rate | 14% | 14% |
| | Percentage of hospice patients who got as much help with pain as needed | 73% | 73% |
| | Hospice family caregivers likely to recommend this hospice to friends and family | 82% | 82% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Planned Parenthood Mar Monte - Mountain View Health Center

| | | |
|---|---|---|
| ***Program Title*** | Increasing Access to Primary Care and Family Medicine | ***Recommended Amount:*** $225,000 |
| ***Program Abstract & Goal*** | To continuing providing access to Primary Care and Family Medicine for primarily underserved high-poverty patients at the Mountain View Health Center. Health center staff will provide a range of family medicine services, including Well Child and Well Woman checks, immunizations, preventive screenings, episodic illness care for both children and adults, management of chronic conditions and COVID-19 testing. Referrals to specialists will be provided as appropriate. In addition, the Mountain View Health Center will provide reproductive health care to patients, including cancer screenings, diagnosis and treatment of STIs and gender affirming care. The Mountain View Health Center serves adults and teens of all genders. The majority of patients are low-income, un- or underinsured and come from populations which have been hardest hit by the pandemic- low-income, essential workers, and communities of color. For many, the Mountain View Health Center is their only source for healthcare. | |
| ***Agency Description & Address*** | 1691 The Alameda, San Jose<br>http://ppmarmonte.org<br>The Mountain View Health Center is one of Planned Parenthood Mar Monte's (PPMM) affiliate health centers. Planned Parenthood Mar Monte invests in communities by providing health care and education, and by expanding rights and access for all. We are committed to providing accessible, affordable and compassionate reproductive health care, family medicine, integrated behavioral health care, and gender affirming care to the communities in which we serve. We are also committed advocates for increased access to that care. | |
| ***Program Delivery Site(s)*** | Services will be provided at the agency's Mountain View Health Center | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include a broad spectrum of Primary Care and Family Medicine:<br>• Well Child and Well Women exams<br>• Annual preventive visits<br>• Immunizations, including flu vaccines and vaccines for children<br>• Preventive screenings for disease risk (diabetes, high cholesterol, hypertension, Hepatitis C, among other medical issues)<br>• Episodic illness care for pediatric and adult patients<br>• Management of complex chronic medical conditions such as hypertension, diabetes<br>• Preventive screenings, as appropriate, for cancer risk (breast, cervical, colon, testicular)<br>• Reproductive care and gender affirming care<br>• Appropriate education and counseling about healthy lifestyle choices<br>• COVID-19 testing<br>Full requested amount funds partial salaries for a Patient Navigator, a Primary Care Coordinator, Nurse Practitioner, health Services Specialist, Staff Physician and other clinicians and staff as well as some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $225,000 | FY23 Recommended: $225,000 |

***[Continued on next page]***

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Planned Parenthood Mar Monte - Mountain View Health Center

*[Continued from previous page]*

| | | | | |
|---|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 | |
| | FY22 Requested: $225,000<br>FY22 Approved: $225,000<br>FY22 6-month metrics met: 40% | FY21 Approved: $225,000<br>FY21 Spent: $225,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 80% | FY20 Approved: $225,000<br>FY20 Spent: $131,446<br>FY20 6-month metrics met: 80%<br>FY20 Annual metrics met: 40% | |
| ***FY23 Proposed Metrics*** | ***Metrics*** | | ***6-month Target*** | ***Annual Target*** |
| | Individuals served | | 130 | 260 |
| | Total Visits | | 240 | 490 |
| | Third Next Available appointment (TNA) within 5 days | | 45% | 75% |
| | Hemoglobin A1c of less than 9 for diabetes patients | | 55% | 65% |
| | Colon cancer screening completed as appropriate for target age group | | 50% | 70% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Ravenswood Family Health Network

| | | |
|---|---|---|
| ***Program Title*** | Primary Healthcare, Dental, and Lab Services at Mountain View and Sunnyvale Clinics | ***Recommended Amount:*** $1,250,000 |
| ***Program Abstract & Goal*** | Ravenswood Family Health Network (RFHN) aims to provide multilingual high quality, culturally competent medical, dental, and lab services to low income residents of the El Camino Hospital District. In addition to primary care, patients have access to pediatrics, women's health, integrated behavioral health, pharmacy, mammography, ultrasound, x-ray, lab, health education, and medically assisted treatment for substance use. Dental services will be provided twice a week through Ravenswood's mobile dental clinic, which will be parked at the Mountain View and Sunnyvale clinics. Ravenswood will continue to provide COVID-19 testing and vaccination services across all sites, with vaccine clinics at Mountain View twice a week and free antigen tests available for pickup. RFHN services are essential to the wellbeing of the community, helping keep residents out of the emergency room. Furthermore, RFHN serves the patient population with the highest uninsured rate locally (Latinx at 15%). Adding dental services with help to address the nearly 1/3 of children in Santa Clara County who have not had a recent dental exam. Ravenswood Family Health Network uses evidence-based best practice and is recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home Level Three. | |
| ***Agency Description & Address*** | 1885 Bay Road, East Palo Alto<br>http://https://ravenswoodfhc.org/<br>Ravenswood Family Health Network is a federally qualified health center. We operate five clinical sites—Ravenswood Family Health Center and Ravenswood Family Dentistry in East Palo Alto and our MayView Community Health Center clinics in Sunnyvale, Mountain View, and Palo Alto (Palo Alto site reopened for services in June 2021). We provide a full scope of health care services—pediatrics, family practice, women's health, integrated behavioral health, dentistry, optometry, pharmacy, mammography, ultrasound, x-ray, lab, health education, referrals, and enrollment—to low-income communities in Silicon Valley. Our mission is to improve the health of the community by providing culturally sensitive, integrated primary and preventative health care to all, regardless of ability to pay or immigration status, and collaborating with community partners to address the social determinants of health. | |
| ***Program Delivery Site(s)*** | Services provided at:<br>• 900 Miramonte Ave., Mountain View<br>• 785 Morse Ave., Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Routine Primary Care services and screenings<br>• Child Well Checks<br>• Immunizations<br>• Chronic Disease Management for patients with diabetes and/or hypertension<br>• Prenatal and Postpartum Care<br>• Telehealth medical services (when clinically appropriate)<br>• Lab services<br>• Oral health care visits at mobile clinic<br>• COVID-19 testing and vaccination<br>Full requested amount funds Medical: 2 Physicians, 1 Nurse Practitioner, 3 Medical Assistants, 2 Medical Scribes, Dental: partial salaries of Dentist, Dental Assistant and Dental Clinic Driver. Primary Care $1.18M; Dental $116,200. | |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

## Ravenswood Family Health Network

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $1,300,000 | FY23 Recommended: $1,250,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $ 1,300,000<br>FY22 Approved: $1,300,000<br>FY22 6-month metrics met: 57% | FY21 Approved: $1,200,000<br>FY21 Spent: $1,200,000<br>FY21 6-month metrics met: 43%<br>FY21 Annual metrics met: 71% | FY20 Approved: $1,700,000<br>FY20 Spent: $1,700,000<br>FY20 6-month metrics met: 86%<br>FY20 Annual metrics met: 100% |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 1,000 | 2,000 |
| | All Visits (Medical, Insurance Enrollment, and Mobile Dental combined) | 2,425 | 4,850 |
| | Breast Cancer Screening (HEDIS): Patients age 50-75 with appropriate Breast Cancer Screening | 45% | 50% |
| | Diabetic Patients with HbA1c <8% (HEDIS) | 68% | 70% |
| | Colon Cancer Screening (HEDIS) | 50% | 55% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Sunnyvale School District

| | | |
|---|---|---|
| ***Program Title*** | School Nurse and Health Services | ***Recommended Amount:*** $287,000 |
| ***Program Abstract & Goal*** | Sunnyvale School District is requesting support for two school nurses and one health assistant to provide comprehensive health services. With the hopes that schools will be able to operate more "normally" recovering from the pandemic, all services will be provided year-round, including case management, assessments, implementation of care plans and staff training. Depending on the status of the pandemic, nurses may be coordinating district wide COVID testing on a regular basis at all schools which would include continued training and support for health and administrative staff to ensure isolation protocols are adhered to when students show potential COVID symptoms and follow up for those in quarantine to ensure they have the necessary resources to get them back to school as soon as possible. | |
| ***Agency Description & Address*** | 819 W. Iowa Avenue, Sunnyvale<br>http://www.sesd.org<br>Sunnyvale School District's mission is to provide every student with a strong foundation of academic, behavioral, and social-emotional skills to prepare them for success in a diverse, challenging, and changing world. The district is comprised of a comprehensive preschool program, eight elementary schools serving students in kindergarten through fifth grade, and two middle schools serving students in sixth through eighth grade. | |
| ***Program Delivery Site(s)*** | Services provided at all 10 sites of Sunnyvale Elementary School District | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Collaborate with healthcare providers and parents to create and implement individualized healthcare plans for students with chronic medical conditions, such as allergies, asthma, diabetes and seizures.<br>• Inform school staff of students' medical conditions and provide appropriate training based on individualized need of students, such as EpiPen administration training, diabetes, asthma and seizure management.<br>• Provide vision screening for all students in the grades: TK, K, 2, 5, and 8.<br>• Provide individual vision and hearing screenings and/or health assessments for students in special education and contribute nursing assessment information to the assessment team.<br>• Follow up on students who do not have a Children's Health and Disability Prevention Program physical exam on file.<br>• Refer students who are uninsured or underinsured to programs where they can receive free eye exams and eye glasses.<br>• Provide case management for students with attendance issues where the barrier for attending school is health related.<br>• Follow up with parents of TK, K and new students who have a health problem listed in student data base in order to identify and address a potential health need at school.<br>• Participate in IEP (individual education program) meetings, MTSS (Multi Tiered Systems of Support) meetings, 504 plan (accommodation plan) meetings and SARB (student attendance review board) meetings as needed.<br>• Follow up with parents of TK, K and new students who have a health problem in order to identify and address a potential health need at school.<br>• Implement COVID-19 guidelines per updates as needed, provide training to staff, coordinate COVID-19 testing if needed.<br>Full requested amount funds a School Nurse, 1.5 FTE Health Assistants and some program support costs. | |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Sunnyvale School District

*[Continued from previous page]*

| | | | | |
|---|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $287,000 | | FY23 Recommended: $287,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 | |
| | FY22 Requested: $287,000<br>FY22 Approved: $287,000<br>FY22 6-month metrics met: 60% | FY21 Approved: $285,000<br>FY21 Spent: $285,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $282,000<br>FY20 Spent: $282,000<br>FY20 6-month metrics met: 80%<br>FY20 Annual metrics met: 40% | |
| ***FY23 Proposed Metrics*** | ***Metrics*** | | ***6-month Target*** | ***Annual Target*** |
| | Individuals served | | 1,975 | 3,951 |
| | Students who failed vision or hearing screening and saw their healthcare provider | | 22% | 52% |
| | Students out of compliance with required immunizations become compliant | | 85% | 95% |
| | TK & K students who received a Well Child exam as measured by the receipt of a complete CHDP (Child Health and Disability Prevention Program) "Health Exam for School Entry" form | | 30% | 60% |
| | Students who were assessed for potential health needs based upon parent reporting health problem at point of registration | | 30% | 95% |

# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Vista Center for the Blind and Visually Impaired

| | | |
|---|---|---|
| ***Program Title*** | Vision Loss Rehabilitation | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | This program will support the Vision Loss Rehabilitation Program for blind and visually impaired adults. A blind/visually impaired individual may have any combination of the following services based on their needs: Intake Assessment/Case Management, Individual Counseling/Support Group, Information and Referral, Orientation & Mobility training, Daily Living Skills training, Low Vision Exam and Assistive Technology. With the exception of the Low Vision Exam, all other services may be provided in the individual's home or community at a time that is agreed to by staff and the client. Vista's program is effective in helping adults care for themselves safely and effectively in their home environment, travel confidently in the community, access community resources, and maintain a level of adjustment to disability which will prevent isolation and depression. These skills are taught in a supportive environment and are necessary to remain independent. | |
| ***Agency Description & Address*** | 2500 El Camino Real, Suite 100, Palo Alto<br>http://www.vistacenter.org<br>Vista Center for the Blind and Visually Impaired mission is to empower individuals who are blind or visually impaired to embrace life to the fullest through evaluation, counseling, education, and training. We know that individuals who have significant vision loss can utilize resources and learn new ways of doing the tasks of daily living, thereby regaining their independence. We provide comprehensive vision loss rehabilitation services and resources to individuals who are blind or visually impaired in Santa Clara, San Mateo, Santa Cruz, and San Benito Counties regardless of ability to pay. In FY21, we served 3700 families and individuals by providing one or a combination of our programs: Safe & Healthy Living, Low Vision Services, Assistive Technology, Child & Family Services and Community Outreach. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Initial Assessments<br>• Individual or Group Counseling<br>• Weekly Rehabilitation Classes<br>• Low Vision Exams<br>Full requested amount funds partial expenses for the COO, a social worker, a rehabilitation specialist, an optometrist, a community relations director, a senior accountant, mileage, and facilities. | |
| ***FY23 Funding*** | FY23 Requested: $48,057 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $42,080<br>FY22 Approved: $30,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $30,000<br>FY21 Spent: $30,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $30,000<br>FY20 Spent: $30,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Dual Funding*** | FY23 Requested: $83,138 | FY23 Recommended: $40,000 |
|---|---|---|

| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $75.965<br>FY22 Approved: $40,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $40,000<br>FY21 Spent: $40,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $40,000<br>FY20 Spent: $40,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

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# FY23 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

## Vista Center for the Blind and Visually Impaired

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 24 | 48 |
| | Services provided | 162 | 328 |
| | Clients were informed about resources | 90% | 90% |
| | Clients are able to prepare simple meal and move within their home | 85% | 85% |
| | Clients are able to read printed material | 70% | 70% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Acknowledge Alliance

| | | |
|---|---|---|
| ***Program Title*** | Resilience Consultation Program at Sunnyvale School District | ***Recommended Amount:*** $50,000 |
| ***Program Abstract & Goal*** | Social Emotional Learning (SEL) services for students, teachers and administrators at schools in the Sunnyvale School District. This program promotes lifelong resilience and sound mental health in youth by strengthening the social and emotional skills of children/youth and the caring capacity of the adults who influence their lives. When teachers and other educators lack SEL knowledge and concrete strategies, teachers feel ineffective, and struggling students are left behind. Research has linked SEL to increased protective factors and decreased risk factors in students, including decreased depression and increased self-esteem and test scores. SEL helps create a positive school environment and safe, supportive classrooms in which students are respected, cared for, and connected. These are all factors needed to mitigate the emotional distress that can lead to a crisis. | |
| ***Agency Description & Address*** | 2483 Old Middlefield Way, Suite 201, Mountain View<br>http://www.acknowledgealliance.org<br>Founded in 1994, the Acknowledge Alliance mission is to promote lifelong resilience in children and youth and strengthen the caring capacity of the adults who influence their lives. Today, the agency provides innovative programs consisting of a three-tier Continuum of Support: lifelong resilience, social-emotional wellness, and academic success for teachers, students, and administrators. Acknowledge Alliance serves K-12 public and private schools in San Mateo and Santa Clara Counties, impacting over 300 educators and nearly 4,500 students annually. | |
| ***Program Delivery Site(s)*** | Services provided at all schools in the Sunnyvale School District: eight elementary and two middle schools, and virtually as needed:<br>• Bishop Elementary<br>• Cherry Chase Elementary<br>• Cumberland Elementary<br>• Ellis Elementary<br>• Fairwood Elementary<br>• Lakewood Elementary<br>• San Miguel Elementary<br>• Vargas Elementary<br>• Columbia Middle School<br>• Sunnyvale Middle School | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Students served through SEL practice (indirect through school staff trained in SEL)<br>• Weekly 1:1 consulting and support to teachers and school staff<br>• Monthly Teacher and Principal Resilience Group sessions<br>• Professional development training for educators and support<br>Full requested amount funds partial salaries for a clinical social worker, marriage and family counselor, counseling consultants and other program costs. | |
| ***FY23 Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $50,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $50,000<br>FY22 Approved: $50,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $50,000<br>FY21 Spent: $50,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 75% | FY20 Approved: $50,000<br>FY20 Spent: $50,000<br>FY20 6-month metrics met: 50%<br>FY20 Annual metrics met: 75% |

***[Continued on next page]***


## Acknowledge Alliance

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 150 | 300 |
| | Resilience Group and Individual Sessions, Classroom observations, and professional development. | 350 | 700 |
| | Teachers will report an increase in positive educator/ student relationships | N/A | 80% |
| | Teachers and administrators will increase their use of strategies to promote personal and professional resilience | N/A | 75% |
| | Teachers and administrators will report that the Acknowledge Alliance Resilience Staff worked to promote a positive school climate | N/A | 75% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Avenidas

| | | |
|---|---|---|
| ***Program Title*** | Avenidas Rose Kleiner Adult Day Health Program | ***Recommended Amount:*** $60,000 |
| ***Program Abstract & Goal*** | To provide full-time Social Worker positions to help provide integrated daily support services at this adult day health program. As an integral part of the Care Team, the licensed social worker coordinates support for older adults with chronic medical conditions and/or mental impairments; including Alzheimer's Disease, dementia and other cognitive conditions who need a much higher level of coordinated care. This program provides person-centered care in tandem with intensive care coordination, which supports the older adult's desire to age at home and avoid re-hospitalizations and emergency room visits. In addition, the social work team also provides support and access to needed services for family caregivers. | |
| ***Agency Description & Address*** | 450 Bryant Street, Palo Alto<br>http://www.avenidas.org<br>Avenidas is a non-profit organization that provides a range of services to adults 65+ focused on helping them to maintain their dignity, independence, health and life's purpose as they face transitions due to advancing age, illness and cognitive decline. Annually, we serve over 7,500 older adults and their families in Santa Clara County. | |
| ***Program Delivery Site(s)*** | Services are provided through agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>•Individual case management units comprised of:<br>• Daily check-in with each participant to determine general well-being (in-person or virtual)<br>• Daily review of progress in the Care Plan regarding psychosocial aspects<br>• Coordination of internal support services for participants as part of ARKC Interdisciplinary Team as needed<br>• Coordination of external support services with community-based service providers as needed<br>• Updating of Care Plan resulting from consultations with team, participant, and family.<br>• Monthly Participant Assessments/Psychosocial Evaluations by the Interdisciplinary Team<br>• Units of Family Support: Unit consists of average one-hour meeting with family caregiver to provide information and topic specific support group sessions<br>Full requested amount funds 1.5 FTE social workers. | |
| ***FY23 Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $60,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $60,000<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $55,000<br>FY21 Spent: $55,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $52,000<br>FY20 Spent: $52,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 70 | 100 |
| | Services provided | 1,070 | 1,950 |
| | Older adults with a history of ER visits do not experience any emergency room visits. | 85% | 85% |
| | Older adults who maintain at least 3 activities of daily living | 85% | 85% |
| | Family Caregivers agree or strongly agree that they experience an increase in their knowledge of effective caregiving techniques. | 95% | 95% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Caminar – Domestic Violence Support Services

| | | |
|---|---|---|
| ***Program Title*** | Domestic Violence Survivor Services Program | ***Recommended Amount:*** $80,000 |
| ***Program Abstract & Goal*** | To continue to deliver bilingual (English/Spanish), culturally competent and trauma-informed services for local survivors of domestic violence. These person-centered services increase personal and community safety, break cycles of violence and abuse, promote healing from the effects of trauma, and empower survivors to access local resources that promote health, stability, and self-sufficiency. Survivors will have access to various services, which are tailored to each survivor's present needs, strengths, and goals and adjusted in intensity as a survivor's circumstances change. These bicultural and trauma-informed services for domestic violence meet the needs of survivors and their children. Applying person-centered strategies, the program increase personal and community safety, break cycles of violence and abuse, and reduce the threat of harm for survivors and their children. Our Domestic Violence (DV) program relies on evidence-based programs and strategies that are trauma-informed, culturally competent and bilingual/bicultural. | |
| ***Agency Description & Address*** | 2600 S. El Camino Real, Suite 200, San Mateo<br>http://www.caminar.org<br>Caminar is a multi-county behavioral health care provider that applies science-based strategies to treating complex mental health, substance abuse, and co-occurring needs. Caminar focuses on the whole person and is known in the region for creating lasting improvements, and positive impacts for clients, families and communities. The Caminar teams combines validated behavioral health interventions and customized supports for clients with severe mental illness and behavioral health needs. | |
| ***Program Delivery Site(s)*** | Services are provided through agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Information/referral assistance and safety planning<br>• Individual/family advocacy and counseling services, including new client intakes, case management, clinical case management, therapy, and crisis support, and coordination with other providers<br>• Accompanying client to seek legal assistance for clinical care and visiting family resource centers<br>• Support groups, including virtual sessions<br>• Community outreach and education<br>• Internal outreach across all Caminar programs to facilitate internal referrals<br>• Building relationships with referrers and strategic program partners who serve similar populations and/or offer complementary services<br>Full requested amount funds a bilingual Clinician and partial salary for a Clinical Program Manager. | |
| ***FY23 Funding*** | FY23 Requested: $100,000 | FY23 Recommended: $80,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $60,000<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $50,000<br>FY21 Spent: $50,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $50,000<br>FY20 Spent: $50,000<br>FY20 6-month metrics met: 80%<br>FY20 Annual metrics met: 80% |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Caminar

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 30 | 60 |
| | Services Provided | 350 | 700 |
| | Participants in supportive services who report feeling more hopeful about their futures. | 85% | 85% |
| | Participants will maintain or improve their economic security | 60% | 60% |
| | Participants in supportive services who report that services are helpful to their healing process. | 85% | 85% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Caminar – LGBTQ+ Youth Space Awareness and Outreach Program

| | | |
|---|---|---|
| ***Program Title*** | LGBTQ+ Youth Space Awareness and Outreach Program | ***Recommended Amount:*** $75,000 |
| ***Program Abstract & Goal*** | Each year, Caminar's LGBTQ programs hear from an increasing number of community organizations, service providers, and schools requesting LGBTQ+ cultural awareness presentations. The LGBTQ Youth Space Speakers Bureau has been in operation since 2008, supporting these requests by providing around 90 panel requests per calendar year. Caminar proposes to build on and enhance the effective awareness-raising program by hiring a Coordinator to manage the Speakers Bureau calendar (90 panels, average of 2.5 speakers per panel), expand training, coach speakers, document services, oversee evaluation, and engage more adults, especially transgender individuals of color. The program trains multigenerational LGBTQ+ community members in the District to share their stories with our community, students, and professionals, increasing the public's understanding and support for LGBTQ+ identities and experiences in workplace and community settings. | |
| Agency ***Description & Address*** | 2600 S. El Camino Real, Suite 200, San Mateo<br>http://www.caminar.org<br>Caminar is a multi-county behavioral health care provider that applies science-based strategies to treating complex mental health, substance abuse, and co-occurring needs. Caminar focuses on the whole person and is known in the region for creating lasting improvements, and positive impacts for clients, families and communities. The Caminar teams combines validated behavioral health interventions and customized supports for clients with severe mental illness and behavioral health needs. | |
| ***Program Delivery Site(s)*** | Services are provided through agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Train multigenerational LGBTQ youth and adults in Santa Clara County to share their stories with community members, students, and professionals.<br>• Panel presentations at the request of hosts/sites.<br>Full requested amount funds the Youth Space Supervisor and partial salary for the Center Coordinator. | |
| ***FY23 Funding*** | FY23 Requested: $100,000 | FY23 Recommended: $75,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New Program in FY23 | New Program in FY23 | New Program in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 450 | 900 |
| | Encounters (trainings amd presentations) | 5 | 10 |
| | Hosts would recommend the panel to a friend | 80% | 80% |
| | Speakers report feeling they have contributed positively to their community | 85% | 85% |
| | Panel hosts would invite a panel discussion to return | 80% | 80% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## CHAC at Sunnyvale School District

| | | |
|---|---|---|
| ***Program Title*** | School Menal Health Intervention/Prevention Program | ***Recommended Amount:*** $280,000 |
| ***Program Abstract & Goal*** | To continue CHAC's school-based Intervention/Prevention program, a comprehensive, school-based mental health service program at ten schools within the Sunnyvale Elementary School District (SESD). Services include individual, small group, and parent and teacher collateral coaching as well as social emotional learning (SEL) groups offered to 3rd and 5th grades and middle school students who attend any of the ten schools in SESD. Mental health challenges are common in youth under the age of 18. Examples, especially during the pandemic, include housing and food insecurity, effects of systemic racism, immigration, trauma, anxiety, depression, suicidal ideation, grief and loss, lack of self-efficacy, substance use, and witnessing domestic and other violence. Unaddressed, any of these issues can impact overall physical and mental health and well-being. Research shows that prevention and early intervention are key to reducing risk for long-term adverse effects. Providing mental health services in the school setting provides children and their families with direct access to interventions, especially to those who otherwise lack access. | |
| ***Agency Description & Address*** | 590 W. El Camino Real, Mountain View<br>http://www.chacmv.org<br>CHAC serves the elementary and high school districts of Mountain View, Los Altos, Los Altos Hills, and Sunnyvale, plus individual/family counseling clinic clients from around Santa Clara County. CHAC provides services to clients regardless of their ability to pay using an income-based sliding fee schedule. | |
| ***Program Delivery Site(s)*** | • All ten schools in the Sunnyvale Elementary School District and virtually, as needed:<br>• Bishop Elementary<br>• Cherry Chase Elementary<br>• Cumberland Elementary<br>• Ellis Elementary<br>• Fairwood Elementary | • Lakewood Elementary<br>• San Miguel Elementary<br>• Vargas Elementary<br>• Columbia Middle<br>• Sunnyvale Middle |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Individual counseling, with child-specific treatment goals in multiple languages including Spanish, Mandarin, and Farsi.<br>• Dyads, Triads, and Small Groups, as well as specialized groups (e.g. Newcomers and LGBTQ+) to address common presenting issues in a therapeutic manner as well as peer support.<br>• IEP/ERMHS year-long support for those students identified as benefiting from mental health support in their education plans.<br>• Parent Liaison for collaborative, support, and bridging services for monolingual Spanish families.<br>• Collateral counseling hours, which engage parents and teachers in behavior change strategies.<br>• Social-Emotional Learning Programs (Just For Kids and Tween Talk)<br>• Co-teacher Support that provides direct support of teachers and classrooms to implement district SEL programs and cultural learning programs<br>• Referral of appropriate cases to CHAC's in-house clinic, as needed<br>Full requested amount funds partial salaries for Clinical Supervisors, a therapist, program coordinator, school district liaison, intern stipends and other program support costs. | |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## CHAC

*[Continued from previous page]*

| | | | | |
|---|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $405,107 | | FY23 Recommended: $280,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 | |
| | FY22 Requested: $280,000<br>FY22 Approved: $280,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $280,000<br>FY21 Spent: $280,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 50% | FY20 Approved: $280,000<br>FY20 Spent: $280,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 50% | |
| ***FY23 Proposed Metrics*** | ***Metrics*** | | ***6-month Target*** | ***Annual Target*** |
| | Individuals served | | 850 | 1,660 |
| | Service Hours (Direct client contact and collateral/case management) | | 4,000 | 8,000 |
| | Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire based on teacher, parent/guardian, self and/or other report (for students 11-17). | | N/A | 40% |
| | Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire based on teacher, parent/guardian and/or other report (for students 10 and under). | | N/A | 40% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## City of Sunnyvale/Sunnyvale Senior Center

| | | |
|---|---|---|
| ***Program Title*** | Care and Connect Program | ***Recommended Amount:*** $25,000 |
| ***Program Abstract & Goal*** | Reduce social isolation of low-income, older adults residing in a mobile home park in north Sunnyvale and connect them to services/programs/resources as needed to support their efforts to continue to live independently in their homes. The program will bring care management services to the residents where they are in order to reach those that may be experiencing significant isolation as the COVID 19 pandemic and its impact reaches the two-year mark. The program will be staffed by a qualified care manager with experience in working with older adults, case management, client engagement and resource development. Care management services will be provided on-site at a pre-identified mobile home park with residents that can benefit from this program. The Senior Center and the mobile home park will form a partnership to serve its residents. Care management model is an industry practice to support older adults and their families with identifying care and service needs. One of the primary goals of this service is to link individuals with services that will allow them to maintain their independence and continue to live in their homes. | |
| ***Agency Description & Address*** | P.O. Box 3707, Sunnyvale<br>https://sunnyvale.ca.gov/community/centers/senior/default.htm<br>The City of Sunnyvale Senior Center is a valuable community resource designed to foster human development and stimulate lifelong learning. The mission of the Senior Center is to encourage physical, mental, and emotional health, with the goal of maintaining and promoting independence and socialization among adults ages 50 and older. The City of Sunnyvale is designated as an Age-Friendly City and is committed to providing services and programs that are accessible and inclusive of our older adult community. | |
| ***Program Delivery Site(s)*** | Plaza Del Rey, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Weekly care management office hours at 3 mobile home parks in north Sunnyvale from September 2022 to June 2023.<br>• Monthly group activities/meetings at each location<br>• Care management services include but are not limited to assessment, care planning, service arrangements, regular check-ins with client, one-time emergency, immediate needs of supplies, medication, etc.<br>Full requested amount funds full salaries for Casual Care Manager and Casual Program Specialist as well as some program supplies. | |
| ***FY23 Funding*** | FY23 Requested: $42,014 | FY23 Recommended: $25,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 | |
|---|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 | |
| | Individuals served | | 30 | 90 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Cupertino Union School District – Mental Health Program

| | | |
|---|---|---|
| ***Program Title*** | Mental Health Counseling Program | ***Recommended Amount:*** $93,000 |
| ***Program Abstract & Goal*** | To continue and expand the mental health counseling program to meet the rising mental health challenges of students at the four Cupertino Union School District (CUSD) schools located within the ECHD boundaries. Through these services, students develop skills in emotional identification, emotional regulation, social interaction, healthy communication, effective coping strategies, self-advocacy and mindfulness. Over the past several years, CUSD has seen an exponential increase in students' need for mental health services and supports. Mental health services and wellness supports are an integral and imperative component of supporting students' ability to engage in all aspects of age-appropriate development and functioning, including engagement with education, relationships with peers and family, community involvement, and preparation for lifelong resilience, problem-solving, productivity, and giving back. CUSD counselors implement evidence-based practices, drawing on modalities such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution-Focused Therapy, mindfulness and interpersonal psychotherapy. | |
| ***Agency Description & Address*** | 1309 S. Mary Avenue, Sunnyvale<br>http://www.cusdk8.org<br>The Cupertino Union School District (CUSD) is a Local Education Agency that provides public education to students in preschool through eighth grade. The largest elementary school district in northern California, CUSD is comprised of approximately 1,500 employees serving approximately 15,000 students in 17 elementary schools, one K-8 school, and five middle schools located throughout Cupertino and parts of Sunnyvale, San Jose, Saratoga, Los Altos, and Santa Clara. | |
| ***Program Delivery Site(s)*** | At four Cupertino Union School District sites inside ECHD:<br>• Montclair Elementary School, Los Altos<br>• Chester W. Nimitz Elementary School, Sunnyvale<br>• West Valley Elementary School, Sunnyvale<br>• Cupertino Middle School, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Weekly counseling sessions (individual, group, and family).<br>• Social-emotional skill building groups for elementary and middle school students (topics such as social skills, executive functioning, emotional regulation, mindfulness, and self-esteem/empowerment).<br>• Risk assessment for suicidality, self-harm, aggressive externalizing behaviors, and other high risk/impulsive behaviors, as needed.<br>• Crisis intervention, as needed.<br>• Case management, weekly.<br>• Collaboration and consultation with school staff, including integration into interdisciplinary support teams, weekly.<br>• Social and Emotional Learning lessons, weekly, as caseload allows.<br>Full requested amount funds 2.0 FTE Mental Health Counseling Associates and program administration costs. | |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Cupertino Union School District

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $93,000 | FY23 Recommended: $93,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $92,500<br>FY22 Approved: $90,000<br>FY22 6-month metrics met: 33% | FY21 Approved: $90,000<br>FY21 Spent: $90,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | New in FY21 |
| ***FY23 Dual Funding*** | FY23 Requested: $137,000 | FY23 Recommended: $120,000 | |
| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $135,000<br>FY22 Approved: $120,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $120,000<br>FY21 Spent: $120,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $140,000<br>FY20 Spent: $140,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 40% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 60 | 130 |
| | Service hours provided | 645 | 1,425 |
| | Students who improve on treatment plan goals | 60% | 80% |
| | 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 self-report (for students age 11-17) | N/A | 50% |
| | 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 report (for students age 10 and under) | N/A | 50% |

# FY23 Behavioral Health Application Summary


## Eating Disorders Resource Center

| | | |
|---|---|---|
| ***Program Title*** | Support Towards Recovery and Getting Connected | ***Recommended Amount:*** $22,500 |
| ***Program Abstract & Goal*** | To raise awareness, promote recovery, and advocate on behalf of individuals struggling with eating disorders. Trained volunteers lead weekly support groups for those struggling and their families, while staff answer calls and emails from clients who are seeking information and treatment for eating disorders. Our website has a comprehensive treatment directory of providers in the Bay Area, all of which we have screened and approved. Those seeking to learn more about how eating disorders develop or how to spot symptoms can find resources on our website. As the only nonprofit in Silicon Valley that is focused on eating disorders, EDRC is an essential resource to our community members. Mental health issues have been exacerbated due to the ongoing pandemic, and we will use El Camino's grant money to fund our direct program staff, who's work addresses the critical need for support during this time. | |
| ***Agency Description & Address*** | 3131 S. Bascom Avenue, Suite 140, Campbell<br>http://www.edrcsv.org<br>EDRC is the only nonprofit in Santa Clara County addressing the need for education and awareness about eating disorders. The agency provides assistance to clients through monthly support groups and phone/e-mail resource assistance. | |
| ***Program Delivery Site(s)*** | Services will be provided primarily virtually and by phone. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Weekly support groups for those struggling as well as for family and friends<br>• Our Ask the Experts series, a monthly event hosted by our support groups<br>• Ongoing support for clients seeking treatment through the phone and email<br>• Ongoing case management<br>• Educational outreach programs for schools, hospitals, and community members<br>• Guiding clients through insurance difficulties and coverage<br>Full requested amount funds partial program manager salary. | |
| ***FY23 Funding*** | FY23 Requested: $22,500 | FY23 Recommended: $22,500 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $25,000<br>FY22 Approved: $25,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $22,500<br>FY21 Spent: $22,500<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $20,000<br>FY20 Spent: $20,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| | | |
|---|---|---|
| ***FY23 Dual Funding*** | FY23 Requested: $22,500 | FY23 Recommended: DNF |

| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | DNF in FY22 | New in FY22 | New in FY22 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 85 | 170 |

# FY23 Behavioral Health Application Summary


## El Camino Health

| | | |
|---|---|---|
| ***Program Title*** | Behavioral Health Navigator Program | ***Recommended Amount:*** $150,000 |
| ***Program Abstract & Goal*** | To support patients with behavioral health needs after an emergency department (ED) visit at El Camino Hospital Mountain View through the creation of a behavioral health navigator program. Complying with treatment plans and the ED team's recommendations can be difficult. The Behavioral Health Navigator will reinforce the plan of care, reduce barriers to treatment, and provide connections to local resources. Navigation is especially critical for patients with substance use disorders because these patients often have more difficulty accessing services and are more likely to have repeat ED visits until their condition is treated. Patients will be prioritized based on the criteria for substance abuse, with special focus on vulnerable populations such as Medi-Cal beneficiaries, the uninsured, and the unhoused. The navigator program expects to reduce repeat ED visits and to increase patient engagement with mental health providers and community health organizations. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>http://www.elcaminohealth.org<br>El Camino Health provides a safe and comfortable healing environment where patients are treated with respect and compassion by their professional staff. They offer separate treatment environments and programs based on patients' conditions, which helps each person feel secure in knowing that their needs are being attended to. | |
| ***Program Delivery Site(s)*** | El Camino Health - Mountain View Campus | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Identification of substance abuse patients through Epic reports and through referral by ED team<br>• Minimum 2 phone calls with patient within 30 days of ED discharge; first call within 7 days post ED discharge<br>• After Visit Summary (AVS) support and education- ensure patient understands the AVS and can access resources necessary to complete any follow-up recommended by the ED team<br>• Care Coordination- ensure patient is able to schedule and attend follow-up appointments with their care team, connect to support services offered through their health plan, and connect to community resources as needed<br>Full requested amount funds 1.0 FTE navigator. | |
| ***FY23 Funding*** | FY23 Requested: $150,000 | FY23 Recommended: $150,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 150 | 400 |
| | Patients served that were referred to community partners | 70% | 80% |
| | Patients identified that were served | 20% | 25% |
| | Decreased readmission rates of those who met with the BH navigator | 10% | 10% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Emotions in Harmony

| | | |
|---|---|---|
| ***Program Title*** | Historias que sanan (Stories that heal) | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To provide psychoeducation/facilitation for a project called "Historias que sanan" (Stories that heal) to Mountain View Spanish Speaking adults who are willing to share their stories and create a healing community. Storytelling is a well known tool to alleviate stress among Latinx populations who experience high levels of stress when compared to the overall county population. This program aims to empower mainly women in the Mountain View Latinx community. In partnership with the Fondo de Solidaridad de Mountain View, we will help the participants to identify and use their strengths to advocate for themselves, their families and their community. The proposed groups are a therapeutic first step to eliminate the stigma about seeking Mental health services. Program services are based in Transpersonal Psychology (TP), Gestalt Therapy (GT) and evidence-based practices such as Cognitive Behavior Therapy (CBT), Acceptance and Commitment (ACT) Therapy, and Mindfulness-Based Cognitive Therapy (MBCT). We are also based on Popular Education as suggested by Paulo Freire, Human Development and Non Violent communication. Program facilitators are native Spanish Speaking and paid professionals. | |
| ***Agency Description & Address*** | 501 Stockton Ave, San Jose<br>http://emotionsinharmony.org<br>Emotions in Harmony, Inc is a mental health non-profit that aims to eliminate mental health disparities experienced by bilingual and Hispanic immigrants by providing psychological tools and services in Spanish. With experts in trauma and domestic violence, anxiety, and grief, they offer individual psychotherapy, couples and family therapy, support groups, classes, and psycho-educational services to adults and families. We have expertise with the LGBTQ community as well as the elderly. | |
| ***Program Delivery Site(s)*** | This project is in partnership with Los Altos Mountain View Community Foundation and the groups will be offered online only. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Group and individual psychotherapy sessions in Spanish<br>Full requested amount funds partial staff salaries and some program expenses. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | DNF in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 12 | 24 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Family Alliance for Counseling Tools & Resolution

| | | |
|---|---|---|
| ***Program Title*** | Community Collaboration Model (CCM) | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To connect children and families to mental health services through partnerships with underserved schools, social service organizations, and community-based organizations. Using a trauma-informed perspective and linguistically and culturally appropriate activities, clients will be provided individual, family, and group counseling, at identified community partners' offices or via tele-health, based on the access needs of the clients served. Program creates a holistic service model by working with community partners to serve families experiencing trauma to develop tools to manage stress, anxiety, and depression, and support long-term self-sufficiency. | |
| ***Agency Description & Address*** | 453 W. San Carlos Street, San Jose<br>http://www.factr.org<br>Established in 2009, Family Alliance for Counseling Tools & Resolution (FACTR) is a nonprofit organization dedicated to promoting the resilience and well-being of refugees and immigrants through counseling, forensic services, educational workshops, and opportunities for cultural exchange throughout the broader Bay Area community. Recognizing that the problems immigrants face in this country are nuanced and multifaceted, FACTR provides holistic support to our clients to empower them to care for themselves, their family, and their community. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Both in-person and tele-health individual, family, and group counseling based on the access needs of the clients served<br>• Referrals to other programs on an as needed basis<br>• Outreach and education<br>Full requested amount funds 0.25 FTE Outreach Coordinator and an MSW intern stipend as well so some program costs. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 5 | 10 |

# FY23 Behavioral Health Application Summary


## Friends for Youth

| | | |
|---|---|---|
| ***Program Title*** | 1-to-1 and Group Mentoring | ***Recommended Amount:*** $30,000 |
| ***Program Abstract & Goal*** | To recruit, screen, train, and manage volunteer mentors and match them with disenfranchised youth in weekly 1-to-1 and Group Mentoring Programs. Mentorship improves the emotional and behavioral health of mentees by providing them with a non-judgmental friendship, and exposes them to new experiences, learning, and opportunities. Interactive and iterative social emotional learning curriculum helps mentees develop positive relationships with adults and school staff and learn social emotional skills. Mentees will also benefit from case management and wraparound services, including referrals to community resources where needed. | |
| ***Agency Description & Address*** | 1741 Broadway, Redwood City<br>http://www.friendsforyouth.org<br>Friends for Youth provides quality mentoring relationships for underserved youth who need support most, with the goal of empowering them to be mentally and behaviorally healthy, emotionally secure, and equipped with resiliency-building skills. | |
| ***Program Delivery Site(s)*** | Services will be provided to the City of Sunnyvale, Sunnyvale School District and Fremont Union High School District | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>For 1-to-1 mentorship:<br>• Recruitment, intensive screening, training, and matching of volunteer mentors<br>• 1-to-1 mentoring sessions weekly<br>• Holistic case management for each mentorship, providing referrals and resources as needed<br>• Mentorship group activities<br>• Mentor mixers and continuing education on youth mental health and development<br>• Monthly staff and practitioner trainings<br>For school-based group mentoring program:<br>• Recruitment, intensive screening, training, and matching of volunteer mentors<br>• Case management, mentor trainings and agency support<br>• Group mentoring sessions weekly<br>• Field trips and events outside of mentoring sessions<br>• Holistic case management for families, making referrals and recommendations as needed<br>• Support for school staff<br>Full requested amount funds partial salaries for 6 program staff and some small program costs. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: $30,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 250 | 300 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Kara

| | | |
|---|---|---|
| ***Program Title*** | Bereavement Services | ***Recommended Amount:*** $20,000 |
| ***Program Abstract & Goal*** | To provide bilingual (English/Spanish) comprehensive grief support, crisis response and education to individuals and communities facing death and dying, including vulnerable populations such as at-risk youth, low-income families, and monolingual or limited English speaking Latinos, utilizing a peer support model. Services are provided by trained and supervised volunteers with personal experience with loss. Individuals receive loss-specific, age appropriate, tailored and comprehensive grief support. Healthy community environments are restored after a loss through crisis response and grief training to increase the understanding about grief and the grieving process, allowing for compassionate responses to death within the community. | |
| ***Agency Description & Address*** | 457 Kingsley Avenue, Palo Alto<br>http://www.kara-grief.org<br>Guided by the values of empathy and compassion, Kara's mission is to provide grief support for children, teens, families, and adults. Serving the community for over 45 years, Kara offers comprehensive bereavement support, death-related crisis response, grief education, and therapy to children, teens, and adults in the San Francisco Bay Area and beyond. | |
| ***Program Delivery Site(s)*** | Services currently provided via telehealth; normally provided at agency site and in various community locations. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Client intakes<br>• Bilingual individual peer support<br>• Bilingual group peer support for all ages in age-appropriate groups<br>• Specialized grief support workshops<br>• Individual and family consultations<br>• Crisis response onsite service event and phone consultation<br>• Grief training and education sessions<br>• Bilingual community outreach presentations<br>• Grief-related psychotherapy<br>Full requested amount funds would support partial salaries for staff. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: $20,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $30,000<br>FY22 Approved: $20,000<br>FY22 6-month metrics met: 0% | New in FY22 | New in FY22 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 50 | 100 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Los Altos School District – Mental Health Program

| | | |
|---|---|---|
| ***Program Title*** | Mental Health Counseling Program | ***Recommended Amount:*** $130,000 |
| ***Program Abstract & Goal*** | To continue mental health services at Los Altos School District (LASD) to middle school students. These therapists will partner with district Psychologists and Behaviorists to implement individual therapy, group therapy, family therapy, and crisis management interventions, which have been demonstrated to increase wellness and academic progress. Providing counseling services in schools has been related to student achieving better success and high engagement at school, reducing the rate of high risk and delinquent behaviors, and reducing the risk of future mental health disorders. This is a continuation of a program that has been proven to be successful at treating mental health at risk students, and increasing their success in school and beyond. This program has dramatically reduced the need for more intensive treatments by being responsive at the school site level to the student and family needs. Additional funding request this year is to add a psychiatrist fellow, to support the home/school connection for the most at-risk students. | |
| ***Agency Description & Address*** | 201 Covington Avenue, Los Altos<br>http://www.losaltos.k12.ca.us<br>Los Altos School District operates seven elementary and two junior high schools and is a top-rated school district in the State of California. LASD serves K-8 students from portions of Los Altos, Los Altos Hills, Mountain View and Palo Alto. All nine schools in the district have been California Distinguished Schools and/or National Blue Ribbon Schools. | |
| ***Program Delivery Site(s)*** | At Los Altos School District sites and virtually, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Individual therapy<br>• Group counseling<br>• Family therapy: meetings with parent/guardian focused needs of student<br>• Crisis intervention: suicide assessments, creating a circle of care for students, preventing contagion, de-escalation and problem solving<br>• Case management: checking in on students with teachers, parents, and school administration, referral to outside providers<br>• Classroom interventions:<br>o Outreach to student population on emotional regulation and resiliency<br>o Collaboration with general education electives on mental health wellness education<br>• Teacher/staff support: short-term counseling and referrals to longer term care<br>Full requested amount funds support 1.5 FTE for Marriage and Family Therapists (MFTs). | |
| ***FY23 Funding*** | FY23 Requested: $150,000 | FY23 Recommended: $130,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $100,000<br>FY22 Approved: $100,000<br>FY22 6-month metrics met: 50% | FY21 Approved: $100,000<br>FY21 Spent: $100,000<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 33% | FY20 Approved: $100,000<br>FY20 Spent: $100,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 50% |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Los Altos School District

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 40 | 100 |
| | Services provided (in hours) | 250 | 500 |
| | Students who improve by at least 3 points from pre-test to post-test on the 40 pt. scale (SDQ) based upon self report | N/A | 30% |
| | Parents who reported improvement in their student by at least 3 points from pre-test to post-test on the 40 pt. scale (SDQ) based upon parent report | N/A | 30% |

# FY23 Behavioral Health Application Summary

Behavioral Health (Including Domestic Violence Trauma)

## Maitri

| | | |
|---|---|---|
| ***Program Title*** | South Asian Domestic Violence Survivor Services | ***Recommended Amount:*** $50,000 |
| ***Program Abstract & Goal*** | To provide comprehensive, culturally appropriate services for South Asian and immigrant survivors of domestic violence, helping them overcome the effects of violence so that they may achieve self-sufficiency and improved wellness. Services include: transitional housing, case management, legal and immigration services, peer counseling, economic empowerment services and outreach services at community events. Maitri provides pathways to self-sufficiency that impact social determinants of health and address homelessness, economic security, and overall wellness, which in turn positively impacts the overall community. | |
| ***Agency Description & Address*** | P.O. Box 697, Santa Clara<br>http://www.maitri.org<br>Maitri's mission is to empower South Asian survivors of domestic violence (DV) to lead lives of dignity and self-sufficiency through holistic programs, and to enable healthy relationships and gender equity through community education, engagement, and advocacy. Maitri envisions a society where all relationships are built on dignity, equity, and compassion. Maitri's services include its Helpline, Peer Counseling, Transitional Housing (TH), Housing Stabilization, Legal Advocacy, Economic Empowerment (EEP), Mental Health support, Volunteer Engagement, Outreach, Prevention, and Policy Advocacy programs. With its suite of programs and services, Maitri provides pathways to self-sufficiency that impact social determinants of health and address homelessness, economic security, and overall wellness, which in turn positively impacts the overall community. | |
| ***Program Delivery Site(s)*** | At agency site and virtually or by phone, as needed. Agency location and other sites are used, but addresses are not published for the safety of clients and staff. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Legal advocacy sessions and support accessing legal representation<br>• Transitional housing, case management<br>• Peer counseling sessions<br>• Economic Empowerment (EEP) workshops and individual EEP sessions<br>• Immigration services<br>• Job skills training via community partnerships<br>Full requested amount funds partial salaries for staff, including a Client Services Manager, Legal Advocacy Coordinator, and Crisis Intervention Coordinator, and some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $50,000 | FY23 Recommended: $50,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $50,000<br>FY22 Approved: $50,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $50,000<br>FY21 Spent: $50,000<br>FY21 6-month metrics met: 80%<br>FY21 Annual metrics met: 100% | FY20 Approved: $50,000<br>FY20 Spent: $50,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary


## Maitri

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 22 | 45 |
| | Services provided | 45 | 100 |
| | Legal clients will report increased awareness of legal rights in their situations. | 65% | 75% |
| | Crisis clients will benefit from a safety plan to increase their safety and wellbeing. | 65% | 75% |
| | Clients will achieve a key economic security goal, which may include finding a job, taking educational courses, or becoming more financially literate. | 60% | 70% |

# FY23 Behavioral Health Application Summary


## Momentum for Health

| | | |
|---|---|---|
| ***Program Title*** | La Selva Community Clinic | ***Recommended Amount:*** $290,000 |
| ***Program Abstract & Goal*** | To provide quality behavioral health services for clients with financial and language barriers. Barriers such as lack of insurance or other financial resources and language will not prevent access to services for individuals in need of a full range of behavioral health services. Clients benefit from a range of bilingual, culturally competent, evidence-based therapies tailored to treat their specific issue(s) often provided by a coordinated multidisciplinary team. Additional psychiatry assessment, medication management, case management, short-term counseling, crisis counseling, and discharge planning is available as needed. Momentum's La Selva Community Clinic serves clients who are undocumented and have difficulties finding jobs with benefits to provide mental health services. A majority - 76% - of clients are monolingual Spanish speakers who are often seeking behavioral health services for the first time. | |
| ***Agency Description & Address*** | 438 N. White Road, San Jose<br>https://momentumforhealth.org/<br>Momentum for Health is a non-profit corporation providing comprehensive programs and services in Santa Clara County for youth and adults who have a mental illness. The staff and volunteers at Momentum believe that people with a mental illness can, and do, recover to lead productive lives and become contributing members of our community. Helping clients reach this goal informs planning and daily operations. Momentum's treatment approach focuses on building on clients' strengths to help them achieve and sustain mental health. The staff at Momentum delivers services in 12 different languages – reflecting the linguistic and cultural diversity of this region. | |
| ***Program Delivery Site(s)*** | At agency site and through telehealth, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Psychiatry assessment<br>• Treatment and medication management<br>• Case management<br>• Short-term (individual and family counseling) and crisis counseling<br>Full requested amount funds partial salaries for staff including psychiatrists, mental health clinicians, program manager and other program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $290,000 | FY23 Recommended: $290,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $286,640<br>FY22 Approved: $290,000<br>FY22 6-month metrics met: 80% | FY21 Approved: $270,000<br>FY21 Spent: $270,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 40% | FY20 Approved: $268,140<br>FY20 Spent: $268,140<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| | | |
|---|---|---|
| ***FY23 Dual Funding*** | FY23 Requested: $46,000 | FY23 Recommended: $40,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Dual Funding History & Metric Performance*** | FY22 Requested: $51,127<br>FY22 Approved: $46,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $51,000<br>FY21 Spent: $51,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $50,000<br>FY20 Spent: $50,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

***[Continued on next page]***

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Momentum for Mental Health

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 71 | 120 |
| | Services provided | 870 | 1,764 |
| | Patients who report a reduction of 2 points or more in PHQ-9 measure severity of depression (repeat for FY23) | 75% | 85% |
| | Patients who report a reduction of 2 points or more in GAD-7 measure severity of anxiety (repeat for FY23) | 70% | 80% |
| | Patients who avoid psychiatric hospitalization for 12 months after beginning services with Momentum's LSCC (repeat for FY23) | 97% | 97% |

# FY23 Behavioral Health Application Summary


## Mountain View-Los Altos Union High School District – Mental Health Program

| | | |
|---|---|---|
| ***Program Title*** | Mental Health Counseling Program | ***Recommended Amount:*** $210,000 |
| ***Program Abstract & Goal*** | To provide mental health services to high school students in the Mountain View - Los Altos High School District. The services include crisis intervention, individualized therapy, group therapy, collateral therapy, check-ins, and case management services. The services will be provided at Mountain View High School and Los Altos High School during the school day. School-based mental health services are needed because mental health issues have widespread consequences for students including impeding a student's ability to access and to engage in school work, increasing the chance of engaging in high-risk behaviors, and inhibiting healthy relationships with peers and adults. | |
| ***Agency Description & Address*** | 1299 Bryant Avenue, Mountain View<br>http://www.mvla.net<br>The Mountain View Los Altos Union High School District is a culturally diverse district composed of three high schools serving the communities of Mountain View, Los Altos and Los Altos Hills. The mission of the School-Based Mental Health and Support Team is to protect and cultivate a culture of wellness by supporting the health, emotional well-being, educational outcomes, and self-advocacy of all students and staff. | |
| ***Program Delivery Site(s)*** | At school district sites and virtually or by phone, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Bilingual services, available in English and Spanish, include:<br>• Individual therapy<br>• Group therapy<br>• Collateral therapy<br>• Check-ins<br>• Crisis intervention / Risk assessments<br>• Case management<br>Full requested amount funds two FTE licensed therapists. | |
| ***FY23 Funding*** | FY23 Requested: $381,187 | FY23 Recommended: $210,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $160,000<br>FY22 Approved: $160,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $160,000<br>FY21 Spent: $160,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $160,000<br>FY20 Spent: $160,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 40% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 45 | 60 |
| | Services provided (in hours) | 800 | 1,600 |
| | Decrease the interference of psychosis / impulsivity / depression / anxiety / opposition / conduct / anger / substance abuse / or trauma on functioning by more than or equal to 25% | N/A | 60% |
| | Decrease the interference of family functioning / living situation / social functioning / decision-making / school behavior / school attendance / or sleep on functioning by more than or equal to 25% | N/A | 60% |
| | Decrease the interference of substance abuse / suicide risk / non-suicidal self-injurious behavior / other self-harm (recklessness) / danger to others / sexual aggression / or delinquent behaviors on functioning by more than or equal to 25% | N/A | 60% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## My Digital TAT2

| | | | |
|---|---|---|---|
| ***Program Title*** | Digital Literacy & Social and Emotional Health Online | ***Recommended Amount:*** $30,000 | |
| ***Program Abstract & Goal*** | To provide digital media literacy and online safety education to students who will soon transition to middle school. This age group is prone to peer pressure and risk-taking, which often occurs online, Support to students will also include culturally authentic Spanish program for parent education and professional development for teachers and school administrators. Services will mitigate the effects of increased unsupervised time online, therefore reducing risky online behavior and cyberbullying. Program curriculum aligns with statewide and social emotional learning standards. Students will learn how to navigate the online world safely. | | |
| ***Agency Description & Address*** | 231 Churchill Ave, Palo Alto<br>http://https://www.mydigitaltat2.org<br>My Digital TAT2 is a Silicon Valley nonprofit organization addressing one of the most challenging issues facing families today: how to build the healthy habits, critical thinking, and thoughtful online behavior necessary to integrate technology into our lives in a constructive way. My Digital TAT2's focus is to help families stay connected through open communication. My Digital TAT2's curriculum for each grade is unique and developmentally appropriate and covers topics and issues specific to the experiences of that age group and emphasizing early education and prevention. | | |
| ***Program Delivery Site(s)*** | All our programs are provided virtually | | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Bilingual services include:<br>• Workshops per each 3rd, 4th, and 5th grade classroom<br>• Teacher/administrator professional development<br>• Parent/guardian education workshop in English<br>• Parent/guardian education workshop in Spanish<br>Full requested amount funds partial salaries for multiple staff as well as some program costs and supplies. | | |
| ***FY23 Funding*** | FY23 Requested: $40,000 | FY23 Recommended: $30,000 | |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 805 | 2,415 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## NAMI Santa Clara County

| | | |
|---|---|---|
| ***Program Title*** | Community Peer Program | ***Recommended Amount:*** $100,000 |
| ***Program Abstract & Goal*** | To connect individuals with severe mental illnesses to peers who engage in their recovery. This grant will continue peer support and mentoring to community members who suffer from severe and persistent mental illness. NAMI SCC will partner with inpatient psychiatric units, outpatient programs, locked facilities and intensive treatment programs to identify Participants for the Community Peer Mentor Program. This type of peer support complements and enhances treatment by mental health professionals and makes more efficient use of scarce mental health resources. | |
| ***Agency Description & Address*** | 1150 S. Bascom Avenue, Suite 24, San Jose<br>http://www.namisantaclara.org<br>Since 1975, NAMI-SCC's has a goal to support, educate, and provide direction for self-advocacy for those living with mental health conditions and their families. Having knowledge and finding resources provides the ability to do this. It also helps to eliminate the stigma and discrimination that still exists on many levels. | |
| ***Program Delivery Site(s)*** | Meeting locations set by patient and Peer Mentor as well as virtually and by phone, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Weekly face-to-face meeting peer mentor sessions for up to four months<br>• Twice weekly phone call check-ins<br>• Linkages to services: referrals from Mentors for a range of services that promote and maintain recovery, alleviate loneliness and isolation and enhance quality of life<br>• Identification and training of participation of Peer Mentors<br>Full requested amount funds partial salary of program staff, mentors as well as administrative costs. | |
| ***FY23 Funding*** | FY23 Requested: $120,000 | FY23 Recommended: $100,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $100,000<br>FY22 Approved: $100,000<br>FY22 6-month metrics met: 60% | FY21 Approved: $75,000<br>FY21 Spent: $73,165<br>FY21 6-month metrics met: 40%<br>FY21 Annual metrics met: 100% | FY20 Approved: $75,000<br>FY20 Spent: $65,376<br>FY20 6-month metrics met: 40%<br>FY20 Annual metrics met: 40% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 35 | 70 |
| | Services provided | 1,190 | 2,380 |
| | Participants feel less isolated | 80% | 80% |
| | Feeling more hopeful about the future and recovery | 75% | 75% |
| | Peers feel increased meaning/self-confidence | 90% | 90% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Parents Helping Parents

| | | | |
|---|---|---|---|
| ***Program Title*** | Saving our Sanity-Caregiver Support During the Pandemic | ***Recommended Amount:*** $35,000 | |
| ***Program Abstract & Goal*** | To provide a virtual support group in both English and Spanish for parents of children with special needs. Parenting is marked by numerous responsibilities and pressures and when adding the cares and concerns that come with having a child with special needs parents can feel overwhelming. Multiple studies have shown being the parent of a child with special needs is associated with high levels of stress and depression and these parents are two to three times more likely to be depressed than parents of neurotypical, healthy children. COVID-19 has added more layers of difficulty and stress for parents raising children with special needs. Facilitated by a licensed mental health therapist and using industry practices, parents connect with others while learning self-care strategies to better cope with the stresses of raising a child with special needs. The goal is to establish practical skills to lower parental stress. | | |
| ***Agency Description & Address*** | 1400 Parkmoor Avenue, Suite 100, San Jose<br>http://www.php.com<br>Parents Heling Parents (PHP) has been helping families of children with special needs since 1976. The agency's mission is to help children and adults with special needs receive support and services they need to reach their full potential by providing information, training, and resources to build strong families and improve systems of care. | | |
| ***Program Delivery Site(s)*** | Provided virtually | | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Five series of a 8 week long group mental health session in English<br>• Five series of a 8 week long group mental health session in Spanish<br>Full requested amount funds partial salaries for staff, including Program Manager, Coordinator and Director, as well as contract Licensed Marriage and Family Therapists and other program support costs. | | |
| ***FY23 Funding*** | FY23 Requested: $62,971 | FY23 Recommended: $35,000 | |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $44,036<br>FY22 Approved: $35,000<br>FY22 6-month metrics met: 100% | New in FY22 | New in FY22 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 100 | 200 |
| | Encounters provided | 200 | 400 |
| | Participants report therapist was knowledgeable and communicated effectively | 85% | 85% |
| | Participants who would recommend the workshop to a friend | 85% | 85% |
| | Participants who learn anything useful that help them as a parent of a child with special needs | 85% | 85% |

# FY23 Behavioral Health Application Summary


## Project Safety Net

| | | |
|---|---|---|
| ***Program Title*** | Teen Mental Health First Aid for Mountain View - Los Altos Union High School District Students | ***Recommended Amount:*** $35,000 |
| ***Program Abstract & Goal*** | To expand the current teen Mental Health First Aid (teenMHFA or tMHFA) County of Santa Clara North County pilot to serve more high school students in the Mountain View-Los Altos Union High School District (MVLAUHSD), particularly reaching underserved, marginalized youth. tMHFA educates young people to recognize the signs of mental health and substance use challenges and crisis (particularly suicide), and to seek a responsible, trusted adult for assistance. Adults (educators and parents/guardians) are also trained to recognize these signs and understand how to support teens. Additional mental health counseling services are also available as needed. Students benefit from a comprehensively supportive environment where trained peers and adults can help them navigate mental health distress and find help. | |
| ***Agency Description & Address*** | 4000 Middlefield Road, Building T2 - Cubberley Community Center, Palo Alto<br>http://www.psnpaloalto.org<br>Project Safety Net (PSN) mobilizes community support and resources for youth suicide prevention and mental wellness. It is a coalition working on community education, outreach, and training; access to quality youth mental health services; and policy advocacy. PSN's vision is that all young people are empowered, in partnership with the whole community, to advocate for themselves and their peers. | |
| ***Program Delivery Site(s)*** | The training sessions for both students and adults as well as the teenMHFA collaboration meetings will be virtual until schools are ready for in-person. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• teenMental Health First Aid training for teens<br>• teenMental Health First Aid training for educators and parents/guardians<br>• Collaboration development for quarterly meetings to plan and evaluate the initiative with MVLAUHSD<br>Full requested amount funds partial salaries for the Community Education Specialist, Program Manager and other staff positions as well as the Youth Mental Health First Aid Contract, professional development and other program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $174,023 | FY23 Recommended: $35,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $30,000<br>FY22 Approved: $20,000<br>FY22 6-month metrics met: N/A | New Program in FY22 | New Program in FY22 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 120 | 240 |
| | Services provided | 6 | 12 |
| | Comfortable asking a young person/friend if they are thinking of suicide. | 75% | 75% |
| | Feel confident to help a young person/friend in need | 90% | 90% |
| | Training participants self-identify as a BAIPOC or LGBTQIA+ | 51% | 51% |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## Sunnyvale Police & Fire Foundation

| | | |
|---|---|---|
| ***Program Title*** | Sunnyvale Police and Fire Foundation Mental Health Support | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To improve the quality of life of active and retired Public Safety employees and/or their families by providing a variety of supports as needed by each individual/family. Support may include financial assistance, mental health services, and/or minor home repairs for disabled individuals. Public safety professionals are at particular risk for suicide and other mental health concerns so the majority of services focus on mental health and wellbeing. The stigma associated with mental health results in under- and non-use of existing services. Program provides a resource that allows for anonymity in addition to confidentiality and is independent of any particular employer. | |
| ***Agency Description & Address*** | P.O. Box 71001, Sunnyvale, CA<br>http://www.sunnyvalepff.org<br>The Sunnyvale Police & Fire Foundation is a volunteer run, community-based organization with a two-part mission. First and foremost, our goal is to support public safety personnel and their families during times of need. Additionally, we strive to cultivate and foster a strong partnership with the residents, businesses, and institutions of Sunnyvale in order to enrich our community and to enhance public safety services. | |
| ***Program Delivery Site(s)*** | Sunnyvale Public Safety Officer's Association Union Hall, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• One on one and/or group peer support<br>• Financial support for minor home repairs and construction as needed<br>• Financial support to families of public safety professionals as needed<br>• Group training and education for active public safety professionals<br>Full requested amount funds support administrative costs for peer support group, home repair, trainings, office supplies, website maintenance and wellness incentive program. No personnel expenses as personnel is all volunteer. | |
| ***FY23 Funding*** | FY23 Requested: $25,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | Did Not Apply in FY22 | FY21 Approved: $25,000<br>FY21 Spent: $12,915<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 100% | New in FY21 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 25 | 50 |

# FY23 Behavioral Health Application Summary

Behavioral Health (Including Domestic Violence Trauma)

## WomenSV

| | | |
|---|---|---|
| ***Program Title*** | Survivor Support Program | ***Recommended Amount:*** $30,000 |
| ***Program Abstract & Goal*** | To support victims of intimate partner violence address abuse more safely and effectively to build healthier lives for themselves and their children. The COVID-19 pandemic has increased demand for services with women trapped with their abuser 24/7 during shelter-in-place and families experiencing an increase in stressors such as unemployment and financial instability. This program focuses on survivors involved with powerful and sophisticated abusers who engage in coercive control, including emotional, financial, legal and technological abuse and other more covert tactics. Program services are delivered by Domestic Abuse Advocates who help create a customized safety plan for each survivor, with specific strategies to address each form of abuse they have experienced. In addition to immediate assistance, program offers long-term individual support, establishing a lasting relationship with each survivor for as long as she chooses. | |
| ***Agency Description & Address*** | P.O. Box 3982, Los Altos<br>http://www.womensv.org<br>WomenSV's mission is to empower survivors, train providers and educate the community to break the cycle of intimate partner abuse so that every victim and child can exercise their fundamental human right to be free and safe in their own home. WomenSV supports an often-overlooked population: survivors involved with powerful and sophisticated abusers who engage in coercive control—more covert forms of abuse including emotional, financial, legal and technological. | |
| ***Program Delivery Site(s)*** | Services provided at agency site and virtually or by phone, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Domestic abuse helpline<br>• One-on-one intake session and danger assessment<br>• One-on-one follow-up sessions including development of Safety Plan<br>• Support group<br>• Referrals for vocational mentoring, financial planning, personal counseling, attorneys, private investigators, therapists, and cybersecurity experts<br>• Client accompaniment – Advocates (as well as volunteers) accompany clients to court, the police station and attorney appointments to provide emotional and physical support as CoVID-19 protocols allow<br>Full requested amount funds support the partial salary for a Domestic Abuse Advocate. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: $30,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $30,000<br>FY22 Approved: $30,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $30,000<br>FY21 Spent: $30,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | New in FY21 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 20 | 40 |

# FY23 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

## YWCA Golden Gate Silicon Valley

| | | |
|---|---|---|
| ***Program Title*** | ARISE Trauma-informed Counseling Services | ***Recommended Amount:*** $85,000 |
| ***Program Abstract & Goal*** | To deliver trauma-informed counseling services to affordable housing sites, domestic violence shelters, and centers and schools serving at-risk youth, including LGBTQIA+ youth via a telehealth platform. Clinical therapy and counseling services include a significant focus on trauma processing, symptom reduction and resiliency. The health and economic crises of the COVID-19 pandemic created barriers limiting access to mental health services. Using telehealth mitigates these barriers, benefiting survivors by greatly increasing accessibility to mental health services. Telehealth also increases the capacity of this program to deliver mental health services, helping many more survivors heal from complex trauma through therapy and counseling. This is one of the only therapy clinics in the region focused on serving victims of complex trauma from domestic violence and sexual assault. | |
| ***Agency Description & Address*** | 375 S. Third Street San Jose<br>http://www.ywca-sv.org<br>YWCA Golden Gate Silicon Valley powers its mission with programs focused on 1) empowering people and communities in healing from the trauma of racism, bigotry and violence, 2) achieving solutions to homelessness for people impacted by racism, gender inequality, and violence and 3) inspiring opportunity and economic security by closing the prosperity and education gap. | |
| ***Program Delivery Site(s)*** | Services are provided via a virtual, telehealth platform | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Individual counseling sessions in English, Spanish and Mandarin<br>• Clinical therapy focused on trauma processing, symptom reduction, and resiliency<br>Full requested amount funds partial salaries of the clinical staff, Marriage and Family Therapist (MFT) stipend, LGBTQIA+ Coordinator/Crisis Counselor and some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $85,000 | FY23 Recommended: $85,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $95,000<br>FY22 Approved: $75,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $75,000<br>FY21 Spent: $75,000<br>FY21 6-month metrics met: 40%<br>FY21 Annual metrics met: 20% | FY20 Approved: $65,000<br>FY20 Spent: $65,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 80% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 17 | 33 |
| | Services provided | 85 | 85 |
| | Individuals who receive 3 or more counseling sessions increase their knowledge of trauma and the effects of trauma on their lives. | 80% | 80% |
| | Individuals who receive 3 or more counseling sessions experience a reduction of trauma symptoms. | 70% | 70% |
| | Individuals who receive 3 or more counseling sessions report they would be willing to seek counseling in the future. | 70% | 70% |

# FY23 Diabetes & Obesity Application Summary


## AbilityPath

| | | |
|---|---|---|
| ***Program Title*** | Health Curriculum for Adults with Developmental Disabilities | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To enhance the overall well-being of adults and seniors with developmental disabilities through physical and mental health activities and education. Participants benefit by gaining independent living skills and access to community-based resources, impoving physical and mental health outcomes. Classes and hands-on experiential learning are provided virtually and in-person (as public health guidelines allow) through the Adult Day Program. An additional Clinical Psychology Program within the Adult Day Program will support participants who are experiencing mental health challenges. Program seeks to mitigate the physical, mental and social-emotion impacts of the COVID-19 pandemic. | |
| ***Agency Description & Address*** | 350 Twin Dolphin Drive, Suite 123, Redwood City<br>http://www.abilitypath.org<br>AbilityPath empowers people with special needs to achieve their full potential through innovative, inclusive programs, and community partnerships. Their vision is a world where people of all abilities are fully accepted, respected, and included. Founded in 1920, their services have expanded through the years to meet the evolving needs and interests of individuals with developmental disabilities and their families. With educational, therapeutic, vocational, and family support services, they are distinctive in providing support to individuals throughout their lifetime. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Weekly one-hour classes delivered virtually<br>• Online video resources for self-guided learning<br>• Home delivery of monthly activity packets for 70+ individuals<br>• 45-60 minutes of weekly counseling once a week as needed<br>• Classroom-based and community-based learning, five days a week<br>Full requested amount funds partial salaries for VP of Adult Programs, Program Development manager, Recreation Therapy Manager and program supplies. | |
| ***FY23 Funding*** | FY23 Requested: $45,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY22 | New in FY22 | New in FY22 |

***[Continued on next page]***


## AbilityPath

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 150 | 300 |
| | Encounters | 120 | 240 |
| | Participants will attend Adult Day Program classes where and adults with developmental disabilities will achieve at least 50% of their individualized goals. | 25% | 50% |
| | Participants will engage in recreation and physical fitness activities at least twice per week, improving their ability to be more active in all aspects of life, maintain or achieve a healthy weight, and reduce chronic disease risk | 37% | 75% |
| | Our fitness Education and Health and Wellness classes participants will rarely or never require support to make healthy food choices to avoid diet-related chronic health conditions and help maintain or achieve a healthy weight. | 33% | 65% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Bay Area Women's Sports Initiative – Girls Program

| | | |
|---|---|---|
| ***Program Title*** | BAWSI Girls in Sunnyvale | ***Recommended Amount:*** $26,000 |
| ***Program Abstract & Goal*** | To generate positive attitudes towards rigorous exercise and active play and improve social-emotional behavior and attitudes in elementary aged girls in under-served communities. Physical fitness shows immediate and long-term positive impacts on physical and mental health outcomes. | |
| ***Agency Description & Address*** | 1922 The Alameda, Suite 420, San Jose<br>http://www.bawsi.org<br>BAWSI mobilizes the women's sports community to engage, inspire and empower the children who need BAWSI most, working with populations who have the least access to physical activity and organized sports. BAWSI builds physical literacy, defined as the ability, confidence and desire to be physically active for life and resilience, in children served. | |
| ***Program Delivery Site(s)*** | Bishop Elementary School, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• One school assembly at the start of each semester<br>• One weekly afterschool session of fitness activities<br>• One weekly 15-minute leadership development session for 5th Grade junior coaches<br>• One Game Day event attending a women's sporting event on a college campus<br>Full requested amount funds partial time for two athlete leaders, an athlete coordinator, an athlete leadership manager, two executive management positions, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $26,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $24,500<br>FY22 Approved: $17,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $19,500<br>FY21 Spent: $19,500<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 0% | FY20 Approved: $19,500<br>FY20 Spent: $19,500<br>FY20 6-month metrics met: 0%<br>FY20 Annual metrics met: 0% |

| ***FY23 Dual Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $15,000 |
|---|---|---|

| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $24,500<br>FY22 Approved: $15,000<br>FY22 6-month metrics met: 67% | FY21 Approved: $15,000<br>FY21 Spent: $15,000<br>FY21 6-month metrics met: 33%<br>FY21 Annual metrics met: 33% | FY20 Approved: $16,500<br>FY20 Spent: $16,500<br>FY20 6-month metrics met: 67%<br>FY20 Annual metrics met: 67% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 50 | 100 |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Bay Area Women's Sports Initiative – Rollers Program

| | | |
|---|---|---|
| **Program Title** | BAWSI Rollers in Sunnyvale | **Recommended Amount:** $21,000 |
| **Program Abstract & Goal** | To provide adaptive physical activities for girls and boys with physical, cognitive, and hearing disabilities. Weekly sessions include activities focused on goal setting, teamwork and healthy competition, as well as self-respect, responsibility and leadership. Participants develop hand-eye coordination, balance, strength, confidence, and a sense of independence. | |
| **Agency Description & Address** | 1922 The Alameda, Suite 420, San Jose<br>http://www.bawsi.org<br>BAWSI mobilizes the women's sports community to engage, inspire and empower the children who need BAWSI most, working with populations who have the least access to physical activity and organized sports. BAWSI builds physical literacy, defined as the ability, confidence and desire to be physically active for life and resilience, in children served. | |
| **Program Delivery Site(s)** | Ellis Elementary School, Sunnyvale | |
| **Services Funded By Grant/How Funds Will Be Spent** | Services include:<br>• One weekly in-school session of fitness activities and coordination elements<br>Full requested amount funds partial time for two athlete leaders, an athlete coordinator, an athlete leadership manager, two executive management positions, and administrative expenses. | |
| **FY23 Funding** | FY23 Requested: $53,000 | FY23 Recommended: $21,000 |

| **Funding History & Metric Performance** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $22,500<br>FY22 Approved: $18,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $15,000<br>FY21 Spent: $15,000<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 0% | FY20 Approved: $15,000<br>FY20 Spent: $15,000<br>FY20 6-month metrics met: 0%<br>FY20 Annual metrics met: 100% |

| **FY23 Proposed Metrics** | **Metrics** | **6-month Target** | **Annual Target** |
|---|---|---|---|
| | Individuals served | 15 | 15 |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Chinese Health Initiative

| | | |
|---|---|---|
| ***Program Title*** | Chinese Health Initiative (CHI) | ***Recommended Amount:*** $267,000 |
| ***Program Abstract & Goal*** | CHI at El Camino Health addresses the unique health disparities in the growing Chinese population, and accommodates cultural preferences in education, screening, and the delivery of healthcare. CHI promotes awareness and prevention of health conditions that commonly affect the Chinese population by providing culturally and linguistically appropriate outreach and education. CHI provides education and prevention on diabetes, hypertension and hepatitis B in addition to resource and physician referral to promote access to care and services. CHI also delivers culturally tailored healthy lifestyle programs for the Chinese community. Health education workshops, available in both English and Chinese, are conducted by registered dietitians, certified diabetes educators, and physicians in primary care and specialties. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>http://https://www.elcaminohealth.org/<br>Chinese Health Initiative (CHI) promotes awareness of health disparities and prevention of health conditions that commonly affect the Chinese population by providing culturally and linguistically competent outreach and education. Offerings include workshops and free screenings for hepatitis B, hypertension, and diabetes. We also provide access to health information from physicians and other credible sources, and programs that address physical health and emotional well-being. Our curriculum is evidenced-based and culturally adapted to the unique health needs of the Chinese population. | |
| ***Program Delivery Site(s)*** | Services will be delivered virtually and at various community sites including senior centers and community centers. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Educational workshops and webinars on diabetes and hypertension adapted to reflect Chinese cultural and language preferences, with an emphasis on lifestyle changes<br>• Screenings and health consultations with a dietitian or physician and resource support through the call center or from event outreach<br>• Specific hypertension and diabetes prevention and management programs conducted in Mandarin<br>• Maintain other media outreach, including bilingual website, quarterly bilingual eNewsletters, and COVID-19 updates<br>• Monthly Qigong exercise classes presented in Chinese and English<br>• Manage and distribute resources such as network of Chinese-speaking physicians, bilingual Health Resource Guide for Chinese Seniors, and list of free/low cost health clinics<br>• Annual Health Fair, including health screenings, workshops, dietitian and physician consultation<br>Full requested amount funds partial time for a manager, administrative coordinator, outreach contractors, interpreters, and administrative expenses. | |

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# FY23 Diabetes & Obesity Application Summary


## Chinese Health Initiative

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $280,000 | FY23 Recommended: $267,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $267,000<br>FY22 Approved: $267,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $269,030<br>FY21 Spent: $248,831<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $235,000<br>FY20 Spent: $178,402<br>FY20 6-month metrics met: 67%<br>FY20 Annual metrics met: 100% |
| ***FY23 Dual Funding*** | FY23 Requested: $45,000 | FY23 Recommended: $20,000 | |
| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $42,000<br>FY22 Approved: $42,000<br>FY22 6-month metrics met: 100% | Not Funded in FY21 | FY20 Approved: $35,000<br>FY20 Spent: $35,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 650 | 1,445 |
| | Services provided | 1,412 | 3,137 |
| | Healthy Lifestyle for Diabetes Prevention participants who report meeting at least two of the lifestyle recommendations upon program completion. | 75% | 75% |
| | Participants who strongly agree or agree that dietitian consultations help them improve their eating habits | 95% | 95% |
| | Participants who are very likely (9-10 rating) to recommend CHI to a friend or colleague on the NPS scale | 80% | 80% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## City of Sunnyvale - Columbia Neighborhood Center

| | | |
|---|---|---|
| ***Program Title*** | ShapeUp Sunnyvale | ***Recommended Amount:*** $45,000 |
| ***Program Abstract & Goal*** | To reverse health trends like obesity through healthy eating and active living activities for low income Sunnyvale youth and adults. Participants will be encouraged to engage in healthier behaviors and develop skills for long-term health impact. The program focuses on small changes in daily lives and routines so they can be maintained and supported after the program ends. Outreach will focus on families on government assistance and/or who qualify for free/reduced lunch program, older adults, and referrals from onsite health clinic. These programs complement the wide range of health and wellness programs at Columbia Neighborhood Center. | |
| ***Agency Description & Address*** | 785 Morse Avenue, Sunnyvale<br>http://https://sunnyvale.ca.gov/community/centers/neighborhood/default.htm<br>Columbia Neighborhood Center (CNC) supports and empowers youth and families so that the children of the community will develop the life skills necessary to be successful in school and beyond. CNC's priorities are to serve: a) at-risk, limited income Sunnyvale youth as defined by their ability to qualify for free and reduced-price school meals and/or the City's activities scholarship program, and b) families in Sunnyvale with limited access to basic services. CNC is a partnership between the Sunnyvale Elementary School District and the City of Sunnyvale. A priority area for CNC's program and service development is residents' physical health and wellness. In Fiscal Year 2020-21, CNC recorded a total of 35,711 participant-hours. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• 16 weekly fitness sessions each of yoga, Zumba, salsa dance, and U-Jam, led by an instructor<br>• 16 weeks of 9-hour fitness room sessions led by an instructor (open to public)<br>• 34 weeks of fitness room sessions open to Columbia Middle School youth before school starts on Wednesday late start mornings during the school year while school is in session<br>• 16 weekly youth drop-in gym sessions<br>• 16 weekly healthy meal kits with all necessary ingredients and instructions for up to 25 participating families<br>Full requested amount funds partial staff salaries and some program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $45,745 | FY23 Recommended: $45,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $45,508<br>FY22 Approved: $35,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $25,000<br>FY21 Spent: $25,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $24,500<br>FY20 Spent: $16,206<br>FY20 6-month metrics met: 67%<br>FY20 Annual metrics met: 100% |

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# FY23 Diabetes & Obesity Application Summary


## City of Sunnyvale - Columbia Neighborhood Center

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 40 | 70 |
| | Services provided | 500 | 925 |
| | Participants who report at least a 45-minute weekly increase in moderate to strenuous physical activity as assessed by pre/post survey. | 80% | 85% |
| | Participants who report learning at least two new recipes or tried at least two new healthy ingredients in their home cooked meals or snacks as assessed by pre/post survey. | 70% | 80% |
| | Participants who report increasing their home cooked meals/snacks by at least two per week for a month as assessed by pre/post survey. | 60% | 70% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## El Camino Hospital - Prenatal Diagnostic Center

| | | |
|---|---|---|
| ***Program Title*** | Sweet Success | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To manage gestational diabetes and reduce complications for pregnant women and their babies. Complications from gestational diabetes are varied and can be life-threatening for both the mother and her baby. Mothers in the program will have better health outcomes from stabilizing their blood sugar level and improving their cardiovascular health through diet, medication and treatment management and support services. This improves the health outcomes of the baby as well. Evidence-based program is modeled on the guidelines of the state-wide California Diabetes and Pregnancy Program. | |
| ***Agency Description & Address*** | 2500 Grant Road, Mountain View<br>http://https://www.elcaminohealth.org/<br>ECH maternal child health services have been consistently recognized both nationally and regionally for excellence in caring for women and newborns. We offer a high level of specialized, customized care including labor and delivery services, OBED triage, postpartum recovery space, as well as a level III NICU. We also offer high risk pregnancy support in our Prenatal Diagnostic Center (PDC). To improve our PDC offerings and support our high risk population, we are developing a Sweet Success gestational diabetes program. | |
| ***Program Delivery Site(s)*** | El Camino Health - Mountain View Campus | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Biweekly consultations with certified diabetes educator<br>• Biweekly consultations with registered dietician<br>• Consultations with maternal fetal medicine as needed after initial meeting<br>Full requested amount funds 1.0 FTE maternal fetal medicine physician, 1.0 FTE registered dietician, 1.0 FTE certified diabetes educator, 0.8 FTE administrative assistant, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $300,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 100 | 250 |
| | Appointments, sessions, classes (combined) | 400 | 1,125 |
| | Patients who attend first dietitian/diabetes educator sessions after initial MFM consultation | 60% | 70% |
| | Patients who complete the Sweet Success program as defined/prescribed by MFM (attended 90% of appointments/sessions) | 40% | 50% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Fresh Approach

| | | |
|---|---|---|
| ***Program Title*** | Prescribing Produce to Improve Nutrition Security and Community Health | ***Recommended Amount:*** $73,500 |
| ***Program Abstract & Goal*** | To improve health outcomes and alleviate food insecurity by providing easy access to healthy, affordable produce, nutrition education and resources. Participants benefit from program's long-standing successful combination of community-based nutrition education (VeggieRx program), "prescription" fruit and vegetable vouchers (to spend at local farmers' markets), nutrition incentives and the Mobile Farmers' Market. Nutrition interventions consider cultural preferences, economic constraints, digital and health literacy levels of the participants. This comprehensive program aligns with the Dietary Guidelines for Americans 2020-2025 and the Healthy People 2030 objectives for Nutrition and Healthy Eating. | |
| ***Agency Description & Address*** | 5060 Commercial Circle, Suite C, Concord<br>http://www.freshapproach.org<br>Fresh Approach's innovative programs empower families throughout the Bay Area to access nutritious, healthy, and affordable food via mobile and traditional farmers' markets that offer matching nutrition incentives expand families nutrition and cooking skills through VeggieRx nutrition classes that offer "prescription vouchers" to spend on fruits and vegetables. Fresh Approach offers programs that empower underserved neighborhoods and communities of color throughout the Bay Area to improve food access and reduce health disparities. | |
| ***Program Delivery Site(s)*** | Columbia Neighborhood Center in Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• VeggieRx, an eight-series nutrition education and cooking class, offered both in-person or via hybrid format (online), as needed<br>• VeggieRx Vouchers for class participants<br>• Training/hiring one Adult Community Ambassador to assist nutrition workshops and support community outreach and vouchers distribution.<br>Full requested amount funds partial staff salaries including a Nutrition Education Program Coordinator, Program Manager, and other program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $73,803 | FY23 Recommended: $73,500 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $93,000<br>FY22 Approved: $93,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $93,000<br>FY21 Spent: $93,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 50% | FY20 Approved: $93,000<br>FY20 Spent: $93,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 25% |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 41 | 182 |
| | Services provided | 41 | 232 |
| | VeggieRx participants who attend 6 or more classes will report an increase in the median frequency of daily intake of fruits and vegetables | N/A | 85% |
| | VeggieRx recipients who receive VeggieRx vouchers for 10 weeks will report an increase of 1 additional serving of fruits and vegetables | 60% | 60% |
| | Community Ambassador participants who complete their service will report gaining the needed technical skills, behavior experience, and mind-set skills | 100% | 100% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Living Classroom

| | | |
|---|---|---|
| ***Program Title*** | Garden-Based Education to Enhance Food Literacy in Youth at Mountain View Whisman School District | ***Recommended Amount:*** $60,000 |
| ***Program Abstract & Goal*** | To continue the Mountain View Whisman School District Transitional Kindergarten (TK) through 6th grade instructional and Farm to Lunch program promoting healthy eating and active living through gardening. Living Classroom's food-based lessons help ingrain and internalize the connection between fresh produce and healthy eating by direct exposure to and hands-on growing, harvesting, and preparation. | |
| ***Agency Description & Address*** | P.O. Box 4121, Mountain View<br>http://www.living-classroom.org<br>Living Classroom's mission is to make education come alive and empower the next generation of children to become environmental champions, inquisitive learners, and healthy eaters. Living Classroom collaborates with school districts to provide all the materials needed to create hands-on, outdoor learning experiences for children to learn science in a fun and engaging way, and have students participate in growing and tasting new foods.. | |
| ***Program Delivery Site(s)*** | The following schools in the Mountain View Whisman School District:<br>• Benjamin Bubb Elementary School<br>• Crittenden Middle School<br>• Edith Landels Elementary School<br>• Frank L. Huff Elementary School<br>• Gabriela Mistral Elementary School<br>• Graham Middle School<br>• Jose Antonio Vargas Elementary School<br>• Mariano Castro Elementary School<br>• Monta Loma Elementary School<br>• Stevenson Elementary School<br>• Theuerkauf Elementary School | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Teach Next Generation Science Standards-aligned school-day lessons for T/K-6th grade students<br>• Offer Farm to Lunch food tastings during lunchtime<br>• Maintain 22 edible and native habitat gardens for school lessons and to grow Farm to Lunch program produce<br>• Survey students after nutritionally focused lessons<br>Full requested amount funds partial staff salaries and program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $84,740 | FY23 Recommended: $60,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $95,245<br>FY22 Approved: $60,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $60,000<br>FY21 Spent: $60,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 25% | FY20 Approved: $76,000<br>FY20 Spent: $76,000<br>FY20 6-month metrics met: 50%<br>FY20 Annual metrics met: 50% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 2,350 | 2,800 |
| | Student encounters | 1,520 | 3,800 |
| | Teacher evaluations that average a 4 or higher | 90% | 95% |
| | Student comments about lessons that reflect new learning about healthy foods, healthy living, and experiences | 65% | 65% |
| | Student journals describing or illustrating learning about eating habits | N/A | 55% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Palo Alto Medical Foundation – 5-2-1-0 Program

| | | |
|---|---|---|
| ***Program Title*** | 5210 Program Numbers to Live By! | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | Offers nutrition lessons and wellness education to elementary school-aged children, parents, school staff and administration. The 5-2-1-0 Health Awareness Program is built on evidence-based recommendations from groups such as the American Academy of Pediatrics, US Department of Health and Human Services and the Nationals Association for Sport & Physical Education. The 5-2-1-0 health behaviors includes: 5 or more servings of fruits and vegetables, 2 or fewer hours of recreational screen time, 1 or more hours of physical activity and 0 sweetened beverages. The program offers nutrition lessons and wellness education provided by Health Educators. Elementary school-aged children, parents, school staff and administrators will benefit from the services provided to promote ongoing health and wellness messages. Program offerings include 5th and 3rd grade nutrition lessons, physical activity contests, and after school programming. In addition, the program partners with community organizations to provide additional education and informative presentations to staff and administrators throughout the school year. | |
| ***Agency Description & Address*** | 2300 River Plaza Dr., Sacramento<br>http://www.pamf.org<br>The purpose of the 5-2-1-0 Health Awareness Program is to increase nutritional awareness and competency among youth within the service area and to create environments that make healthy choices easier choices for families and children. This program is a partnership between El Camino Health and the Palo Alto Medical Foundation for Health Care, Research and Education (PAMF), a not-for-profit health care organization dedicated to enhancing health. | |
| ***Program Delivery Site(s)*** | Services will be provided at 11 schools in Sunnyvale:<br>• Bishop Elementary<br>• Cherry Chase Elementary<br>• Columbia Middle School<br>• Cumberland Elementary<br>• Ellis Elementary<br>• Fairwood Elementary<br>• Lakewood Elementary<br>• Sunnyvale Middle School<br>• San Miguel Elementary<br>• Vargas Elementary<br>• Nimitz Elementary | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Classroom nutrition and health lessons<br>• After-school nutrition and activity lessons<br>• Nutrition and cooking lessons for parents<br>Full requested amount funds two 0.5 FTE health education coordinators and supplies. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $ 30,000<br>FY22 Approved: $ 25,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $ 30,000<br>FY21 Spent: $ 14,885<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 0% | FY20 Approved: $ 25,000<br>FY20 Spent: $ 22,942<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 0% |

| ***FY23 Dual Funding*** | FY23 Requested: $25,000 | FY23 Recommended: DNF |
|---|---|---|

| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $25,000<br>FY22 Approved: $20,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $25,000<br>FY21 Spent: $12,100<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 0% | FY20 Approved: $20,000<br>FY20 Spent: $20,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 67% |

***[Continued on next page]***

# FY23 Diabetes & Obesity Application Summary


## Palo Alto Medical Foundation

*[Continued from previous page]*

| FY23 Proposed Metrics | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| | Individuals served | 1,120 | 2,240 |

# FY23 Diabetes & Obesity Application Summary


## Playworks

| | | |
|---|---|---|
| ***Program Title*** | Playworks at Sunnyvale School District | ***Recommended Amount:*** $200,000 |
| ***Program Abstract & Goal*** | To increase physical activity, promote healthy behaviors, foster social/emotional learning and improve school climate using play-based strategies. Participating in regular physical activity is associated with many positive outcomes including short- and long- term health benefits, improved academic performance, and a lower likelihood of engaging in risky behaviors. A comprehensive variety of onsite programming is offered at each school site to create a healthy emotional environment while increasing physical activity for every student and offering professional development for educators. Instructions on providing remote activities are also offered, in addition to online video courses to further support educators. | |
| ***Agency Description & Address*** | 2155 South Bascom Ave #201, Campbell<br>http://www.playworks.org<br>Playworks is the leading organization to use play as an organic way to give children foundational skills for success -- on the playground, in the classroom, and in the community. Our high-quality early intervention programs are proven to increase physical activity among children attending elementary schools, while improving overall school climate. Playworks creates a place for every child on the playground- where every child belongs, has fun and is part of the game. Since our founding in 1996 at two schools in Northern California, Playworks has helped more than a million children at thousands of elementary schools across the country experience safe, healthy play. | |
| ***Program Delivery Site(s)*** | Proposed grant activities will be delivered at the following Sunnyvale School District sites:<br>• Bishop Elementary, Sunnyvale<br>• Cherry Chase Elementary School, Sunnyvale<br>• Cumberland Elementary School, Sunnyvale<br>• Ellis Elementary School, Sunnyvale<br>• Fairwood Elementary School, Sunnyvale<br>• Lakewood Elementary School, Sunnyvale<br>• San Miguel Elementary School, Sunnyvale<br>• Vargas Elementary School, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Daily implementation of play-based strategies onsite by Playworks professional<br>• Biweekly class for individualized support on conflict resolution strategies and rules of games during regularly scheduled periods<br>• After school noncompetitive teams designed to develop skills, provide a positive team experience, and teach positive sporting behavior to students who may not otherwise have an opportunity to participate in sports<br>• Training of upper grade students to serve as Junior Coaches during recess to lead games and activities, and manage conflict<br>• Professional development workshops and consultations for educators<br>• Training school staff on specific Playworks strategies<br>• Digital services for educators that include courses on demand, weekly game instruction, and online tools<br>Full requested amount funds partial salaries for a Site Coordinator and Program Coordinator as well as a Digital Support Package | |

***[Continued on next page]***

# FY23 Diabetes & Obesity Application Summary


## Playworks

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $231,000 | FY23 Recommended: $200,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $218,000<br>FY22 Approved: $200,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $218,000<br>FY21 Spent: $191,841<br>FY21 6-month metrics met: 0%<br>FY21 Annual metrics met: 80% | FY20 Approved: $216,034<br>FY20 Spent: $216,034<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |
| ***FY23 Dual Funding*** | FY23 Requested: $86,000 | FY23 Recommended: $40,000 | |
| ***Dual Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $86,000<br>FY22 Approved: $86,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $86,000<br>FY21 Spent: $12,900<br>FY21 6-month metrics met: N/A<br>FY21 Annual metrics met: 0% | FY20 Approved: $91,627<br>FY20 Spent: $91,627<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 80% |

| | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| ***FY23 Proposed Metrics*** | Individuals served | 4,450 | 4,450 |
| | Number of days Playworks Coach is on campus during the school year | 85 | 175 |
| | Teacher/administrators reporting that Playworks positively impacts classroom climate | N/A | 95% |
| | Teachers reporting that overall engagement increased attentiveness and participation in class | N/A | 91% |
| | Teacher/administrators who agree or strongly agree that Playworks helps increase physical movement | N/A | 96% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## Silicon Valley Bicycle Coalition

| | | | |
|---|---|---|---|
| **Program Title** | Bike to Health | **Recommended Amount:** | $30,000 |
| **Program Abstract & Goal** | To prevent diabetes and obesity by promoting an active lifestyle that includes bicycling for underprivileged youth and adults, particularly women. Through fun, accessible bike rides, participants will be more excited to incorporate bicycling intentionally into their every day transportation habits. Instructor-led fun and educational adult and family bike rides will be targeted toward populations with greater health disparities. Volunteer Bike Champions will help other riders develop positive attitudes about bicycling by offering guidance, answering any questions, and generally encouraging participants, epecially women. Adopting bicycling into everyday activities will lead to improved physical and mental health. | | |
| **Agency Description & Address** | 96 N. 3rd Street Suite 375, San Jose<br>http://www.bikesiliconvalley.org<br>Silicon Valley Bicycle Coalition (SVBC) was incorporated as a 501(c)(3) in 1993 to create a community that values, includes, and encourages bicycling for all purposes for all people in Santa Clara and San Mateo Counties. SVBC works with public agencies, non-profit organizations, business partners, and community members to reach the overarching goal to have 10% of all trips taken by bike in 2025. The intention behind this is to address many of our society's most pressing problems, particularly human health. | | |
| **Program Delivery Site(s)** | Services provided at safe biking routes in Mountain View and Sunnyvale, in partnership with community-based organizations | | |
| **Services Funded By Grant/How Funds Will Be Spent** | Services include:<br>• Rides for adults and families in partnership with nonprofit partners serving target constituencies.<br>• Training and deployment of Bike Champions who offer guidance and encouragement<br>Full requested amount funds partial salaries for Program Director, Program Coordinator and Bike Champions/Partners | | |
| **FY23 Funding** | FY23 Requested: $30,000 | FY23 Recommended: | $30,000 |

| **Funding History & Metric Performance** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $30,000<br>FY22 Approved: $25,000<br>FY22 6-month metrics met: 0% | Did not Apply in FY21 | FY20 Approved: $25,000<br>FY20 Spent: $25,000<br>FY20 6-month metrics met: 0%<br>FY20 Annual metrics met: 0% |

| **FY23 Proposed Metrics** | **Metrics** | **6-month Target** | **Annual Target** |
|---|---|---|---|
| | Individuals served | 95 | 190 |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## South Asian Heart Center

| | | |
|---|---|---|
| ***Program Title*** | AIM to Prevent | ***Recommended Amount:*** $300,000 |
| ***Program Abstract & Goal*** | This program will enroll, screen and coach participants in its Assess, Intervene and Manage (AIM) to Prevent program, a specialized, evidence-based, three phase prevention program: 1) Assess with advanced and comprehensive screening to uncover hidden risks, 2) Intervene with culturally-appropriate Lifestyle MEDS™ (Meditation, Exercise, Diet, and Sleep) counseling and 3) Manage with personalized, heart health coaching. Additionally, SlimFIT and STOP-D programs target those who need more intense intervention to address obesity and their steady progression towards diabetes. | |
| ***Agency Description & Address*** | 2480 Grant Road, Suite 206, Mountain View<br>https://www.southasianheartcenter.org<br>The South Asian Heart Center is a non-profit since 2006 with the mission to reduce the high incidence of diabetes and heart attacks in Indians and South Asians through culturally tailored, science-based, and lifestyle-focused services. People who trace their ancestry to countries in the Indian subcontinent have a higher incidence, more severe presentation and earlier onset of disease compared to the general population, despite being mostly vegetarian, non-smoking, and non-obese. | |
| ***Program Delivery Site(s)*** | Services will be provided virtually, by phone and at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Conducting health assessments and engaging participants in the AIM to Prevent, STOP-D and SlimFIT programs<br>• Personalized assessment and counseling on nutrition and exercise<br>• Providing outreach, workshops, and seminars on lifestyle topics<br>• Delivering trainings that provide Continued Medical Education (CME) units to train physicians on evidence-based practice methods and research data to encourage patient referrals and collaborate on a health plan<br>Full requested amount funds partial time for the executive director, case manager, health educator, medical director, lab fees, supplies, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $330,000 | FY23 Recommended: $300,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $300,000<br>FY22 Approved: $300,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $210,000<br>FY21 Spent: $210,001<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 67% | FY20 Approved: $140,000<br>FY20 Spent: $116,669<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |
| ***FY23 Dual Funding*** | FY23 Requested: $110,000 | FY23 Recommended: $50,000 | |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Dual Funding History & Metric Performance*** | FY22 Requested: $100,000<br>FY22 Approved: $100,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $75,000<br>FY21 Spent: $75,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 67% | FY20 Approved: $110,000<br>FY20 Spent: $110,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

***[Continued on next page]***

# FY23 Diabetes & Obesity Application Summary


## South Asian Heart Center, El Camino Health

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 210 | 495 |
| | Service encounters | 1,095 | 2,280 |
| | Improvement in average level of weekly physical activity from baseline | 21% | 21% |
| | Improvement in average levels of daily servings of vegetables from baseline | 20% | 20% |
| | Improvement in cholesterol ratio as measured by follow-up lab test | 6% | 6% |

# FY23 Diabetes & Obesity Application Summary

Diabetes & Obesity

## YMCA of Silicon Valley

| | | |
|---|---|---|
| ***Program Title*** | YMCA Summer Camp | ***Recommended Amount:*** $67,000 |
| ***Program Abstract & Goal*** | This program aims to promote physical activity and healthier food choices amongst youth and is committed to fostering health and well-being practices in out-of-school time programs, using science-based standards for healthy eating, physical activity, screen time, and social supports for these behaviors including staff, family and youth engagement. | |
| ***Agency Description & Address*** | 80 Saratoga Avenue, Santa Clara<br>http://www.ymcasv.org<br>The YMCA's mission is to strengthen the community by improving the quality of life and inspiring individuals and families to develop their fullest potential in spirit, mind and body by focusing on three core areas: youth development, healthy living, and social responsibility. | |
| ***Program Delivery Site(s)*** | Services Provided at the YMCA Mountain View and at the following locations:<br>• Jose Antonio Vargas Elementary School, Mountain View<br>• Almond Elementary School, Los Altos<br>• West Valley Elementary, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Providing summer camps to low-income youth that focus on physical activity and fitness, healthy meals, healthy lifestyles, water safety, caring adult role models, leadership, social-emotional learning, and academic enrichment focused on literacy skills/reading for pleasure and STEM<br>Full requested amount funds staffing for camp leaders and program supplies. | |
| ***FY23 Funding*** | FY23 Requested: $67,562 | FY23 Recommended: $67,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $65,000<br>FY22 Approved: $65,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $65,000<br>FY21 Spent: $65,000<br>FY21 6-month metrics met: 67%<br>FY21 Annual metrics met: 100% | FY20 Approved: $65,000<br>FY20 Spent: $65,000<br>FY20 6-month metrics met: 33%<br>FY20 Annual metrics met: 33% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 275 | 405 |
| | Attendance encounters | 51,624 | 83,889 |
| | Families who agree that their children were moderately, or significantly more physically active, after attending camp | 88% | 88% |
| | Families who agree or strongly agree that their child eats at least an additional serving of fruits or vegetables, after attending camp | 88% | 88% |
| | Families who state that the healthy meals/snacks served in camp were good or excellent | 70% | 70% |

# FY23 Chronic Conditions Application Summary


## American Heart Association

| | | |
|---|---|---|
| ***Program Title*** | Healthy Hearts Initiative | ***Recommended Amount:*** $100,000 |
| ***Program Abstract & Goal*** | To continue the Healthy Hearts Initiative focused on reducing hypertension and pre-diabetes through the promotion of healthy lifestyles. This program aims to improve rates of hypertension among hypertensive and prediabetic adults in underserved communities through screenings, referrals and the promotion of healthy lifestyles. High blood pressure is a risk factor for diabetes and other chronic conditions, but the combination of high blood pressure and prediabetes is particularly harmful. Patients will benefit from a comprehensive community to clinic initiative with a long-term focus on reducing rates of cardiovascular disease, prediabetes, and associated chronic conditions. Program will continue to work with other partners to increase awareness, screenings, referrals, and education. Program also utilizes an evidence-based chronic disease management program which targets key lifestyle areas that can lower risks for heart disease and prediabetes and improve quality of life. | |
| ***Agency Description & Address*** | 1111 Broadway, Suite 1360, Oakland<br>http://www.heart.org https://www.heart.org/en/affiliates/california/greater-bay-area/<br>The American Heart Association (AHA) is one of the largest and most trusted voluntary health organizations in the world. To fulfill their mission to be a relentless force for a world of longer, healthier lives, the AHA seeks to be a catalyst to achieving maximum impact in equitable health and well-being. The AHA established and now champions 10 commitments designed to break down barriers to health equity. AHA Greater Bay Area runs this program in Santa Clara County. | |
| ***Program Delivery Site(s)*** | Services provided at Mountain View Community Center, Mountain View and Columbia Neighborhood Center, Sunnyvale | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Community health screenings, health education, and clinic referrals<br>• Recruitment of hypertensive and prediabetic individuals<br>• Four-month intervention program consisting of classes and coaching for enrolled hypertensive and prediabetic participants<br>• Trainings for Community Health Workers<br>Full requested amount funds partial salaries of staff, contract RNs and program support costs. | |
| ***FY23 Funding*** | FY23 Requested: $110,000 | FY23 Recommended: $100,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $116,500<br>FY22 Approved: $110,000<br>FY22 6-month metrics met: 80% | FY21 Approved: $110,000<br>FY21 Spent: $101,113<br>FY21 6-month metrics met: 40%<br>FY21 Annual metrics met: 50% | FY20 Approved: $110,000<br>FY20 Spent: $94,825<br>FY20 6-month metrics met: 67%<br>FY20 Annual metrics met: 50% |

| | | |
|---|---|---|
| ***FY23 Dual Funding*** | FY23 Requested: $60,000 | FY23 Recommended: $60,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Dual Funding History & Metric Performance*** | FY22 Requested: $80,000<br>FY22 Approved: $50,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $50,000<br>FY21 Spent: $49,210<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | New Program in FY21 |

***[Continued on next page]***

# FY23 Chronic Conditions Application Summary


## American Heart Association

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 400 | 1,100 |
| | Check.Change.Control. Intervention Workshop Participants | 120 | 210 |
| | CCC Participants will improve BP by 10mm | 40% | 40% |
| | CCC Participants will measure 8 BP readings in 4 months | 60% | 60% |
| | Prediabetes participants (A1c above 5.7) of the CCC program will improve an average A1c by 0.5% over 4 months | 30% | 30% |

# FY23 Chronic Conditions Application Summary


## Breathe California

| | | | |
|---|---|---|---|
| ***Program Title*** | Seniors Breathe Easy | ***Recommended Amount:*** $25,000 | |
| ***Program Abstract & Goal*** | To provide senior-focused health education to older adults age 65 years+ and their caregivers. Comprehensive and holistic approach offers a variety of evidence-based, culturally and linguistically appropriate, health and wellness programs, screenings and caregiver trainings, targeting populations with health inequities. Older adults benefit from increased access to prevention programs and information, while caregivers increase their competence and confidence. | | |
| ***Agency Description & Address*** | 1469 Park Avenue, San Jose<br>http://www.breathebayarea.org<br>Breathe California of the Bay Area (BCBA) is a 110-year-old grassroots, community-based, voluntary non- profit that is committed to achieving clean air and healthy lungs. As the local Clean Air and Healthy Lungs Leader, BCBA fights lung disease in all its forms and works with its communities to promote lung health. The agency's goals are tobacco-free communities, healthy air quality and reduced lung diseases. | | |
| ***Program Delivery Site(s)*** | Services provided at community centers and senior centers across ECHD service area, and virtually as needed, such as Mountain View Senior Center and Charities Adult Day Program, Sunnyvale | | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Health education presentations on a variety of health and wellness topics<br>• Health screenings<br>• Breathing exercise instruction<br>• In-home assessments for respiratory and falling hazards<br>• Tobacco cessation assistance<br>• Educational materials<br>• Public Information Media Campaign to encourage COVID and influenza vaccinations in this high-risk population<br>Full requested amount funds support partial salaries for staff and some program support costs. | | |
| ***FY23 Funding*** | FY23 Requested: $25,000 | FY23 Recommended: $25,000 | |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $25,000<br>FY22 Approved: $25,000<br>FY22 6-month metrics met: 0% | FY21 Approved: $25,000<br>FY21 Spent: $23,077<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $20,000<br>FY20 Spent: $20,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 0% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 400 | 1,000 |

# FY23 Chronic Conditions Application Summary


## Community Services Agency of Mountain View and Los Altos

| | | |
|---|---|---|
| ***Program Title*** | Senior Intensive Case Management | ***Recommended Amount:*** $228,000 |
| ***Program Abstract & Goal*** | To provide senior intensive case management (ICM) for seniors with chronic conditions for twelve months after they are discharged from the hospital. Older adults with chronic health conditions are more likely to be rehospitalized. Others have limitations that make compliance with post-discharge instructions difficult. Case management would help vulnerable seniors manage their health conditions and reduce the likelihood of hospital readmission, allowing them to age in place in their own homes. Case management services will be provided in the client's home, at medical facilities, and at other community service providers. | |
| ***Agency Description & Address*** | 204 Stierlin Rd, Mountain View<br>http://csacares.org<br>Community Services Agency (CSA) is the safety net organization for Mountain View, Los Altos and Los Altos Hills. CSA provides food, case management, emergency financial assistance, housing case management and referrals to benefits for anyone who is low-income, homeless and/or aging in our community. | |
| ***Program Delivery Site(s)*** | Services will be delivered at agency site in Mountain View, clients' homes and medical offices and hospitals | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Health assessments (bio-psycho-social assessment, fall risk and home safety, nutrition)<br>• Blood pressure checks<br>• Assistance scheduling medical appointments as needed<br>• Medication reconciliation and evaluation<br>• Targeted interventions to mitigate fall risk concerns<br>• Advocacy at medical appointments as needed<br>• Financial assistance or cost lowering options for medication as needed<br>• Assistance signing up for local, county, state, and federal benefits/services<br>• Coordination with the client's medical team, family, and/or friends as needed<br>• Education and referrals, as needed<br>Full requested amount funds a Social Work Case Manager, a Registered Nurse Case Manager, and a Licensed Vocational Nurse Case Manager and other program costs. | |
| ***FY23 Funding*** | FY23 Requested: $258,811 | FY23 Recommended: $228,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $228,884<br>FY22 Approved: $228,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $210,000<br>FY21 Spent: $210,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $235,000<br>FY20 Spent: $218,623<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 56 | 88 |
| | Services provided | 2,550 | 5,100 |
| | Clients who were not re-hospitalized within 90 days for reasons related to a chronic health condition | 90% | 90% |
| | Clients who were able to maintain or improve their fall-risk score | 70% | 70% |
| | Patients with hypertension who attained or maintained a blood pressure of <140/90 | 70% | 70% |

# FY23 Healthcare Access & Delivery Application Summary

Chronic Conditions
(Other than
Diabetes & Obesity)

## Stanford Health Care

| | | |
|---|---|---|
| ***Program Title*** | Fall Prevention Programs - Farewell to Falls, A Matter of Balance and Bingocize | ***Recommended Amount:*** $20,000 |
| ***Program Abstract & Goal*** | To reduce the number of falls, fear of falling, and fall injuries sustained by older adults 65 years and older. Three different programs focus on preventing falls through improving strength and balance and sharing fall prevention strategies. Offering a variety of fall prevention programs, individually in the home, in groups at senior centers and virtually, helps meet the individual needs of each older adult. Farewell to Falls (FTF) offers home visits to assess home safety and medications, and provides a customized exercise plan. A Matter of Balance (MOB) offers fall prevention education in both in person group classes at senior centers and virtual classes. Bingocize is a virtual program that encourages older adults to exercise while learning fall prevention strategies. Programs are evidence-based and utilize best practices in preventing falls. | |
| ***Agency Description & Address*** | 300 Pasteur Drive, MC 5898, Stanford<br>http://www.stanfordhealthcare.org/trauma<br>Stanford Health Care's Trauma Service provides specialized care to over 3,000 patients/year. The mission of Stanford Health Care is to care, to educate and to discover. The Injury Prevention program is an important part of this level 1 trauma center. The program looks at local data on mechanism of injury and finds interventions to address those injury areas. Falls are the number one mechanism of injury for older adults. Stanford Health Care offers home-based and community-based programs to address this significant problem. | |
| ***Program Delivery Site(s)*** | The falls prevention program is delivered in the homes of the older adult participants, along with in-person classes at:<br>• Sunnyvale Senior Center<br>• Mountain View Senior Center | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Home visits and risk assessment by occupational therapist<br>• Reminders to exercise through phone calls and Amazon Echo Show)<br>• 1:1 Virtual visit (Farewell to Falls pilot program participants only)<br>• Bingocize exercise and falls prevention classes<br>• A Matter of Balance falls preventionclasses<br>Full requested amount funds partial salaries for 3 Occupational Therapists and 2 Administrative support personnel as well as some program costs. | |
| ***FY23 Funding*** | FY23 Requested: $52,000 | FY23 Recommended: $20,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $46,349<br>FY22 Approved: $46,100<br>FY22 6-month metrics met: 83%<br><br>*Farewell to Falls Program and Matter of Balance Program were combined into a single program, Falls Prevention, in FY22* | *Farewell to Falls Program*<br>FY21 Approved: $<br>FY21 Spent: $<br>FY21 6-month metrics met: %<br>FY21 Annual metrics met: %<br><br>*Matter of Balance Program*<br>FY21 Approved: $<br>FY21 Spent: $<br>FY21 6-month metrics met: %<br>FY21 Annual metrics met: % | *Farewell to Falls Program*<br>FY20 Approved: $<br>FY20 Spent: $<br>FY20 6-month metrics met: %<br>FY20 Annual metrics met: %<br><br>*Matter of Balance Program*<br>FY20 Approved: $<br>FY20 Spent: $<br>FY20 6-month metrics met: %<br>FY20 Annual metrics met: % |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 70 | 150 |

# FY23 Chronic Conditions Application Summary


## The Health Trust

| | | |
|---|---|---|
| ***Program Title*** | Nutritional Security for Older Adults with HIV and Chronic Diseases | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To increase food security and medication adherence in low income, HIV+ older adults with underlying chronic conditions. Individual health outcomes improve because interventions are specific to each client. Clients benefit by receiving medically tailored meals (MTM) and individualized medical nutrition therapy intervention (MNT) in alignment with their specific medication protocol, as well as free healthy groceries. Each client will receive a customized nutrition plan. Older adults will be able to successfully age in place, living longer, idependent lives with better health outcomes and less hospital utilization. | |
| ***Agency Description & Address*** | 3180 Newberry Drive, Suite 200, San Jose<br>http://www.healthtrust.org<br>Celebrating 26 years of service to the community, The Health Trust's mission is to build health equity in Silicon Valley. As a provider of programs and direct services, The Health Trust offers quality and culturally competent services that meet the health needs of populations most affected by health disparities. With a focus on seniors who are low-income, individuals living with complex chronic health conditions, and individuals and families who are homeless or recently housed, The Health Trust pursues three strategies to carry out its mission: Improving Health through Food, Making Chronic Conditions More Preventable & Manageable, and Prioritizing Health in Housing. Across all direct service programs, The Health Trust served 20,319 people across Santa Clara County in Fiscal Year 2021. | |
| ***Program Delivery Site(s)*** | Services will be provided at agency locations and in the homes of Mountain View and Sunnyvale clients | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• In-Take Assessments (Food Insecurity, Hospital ER Recall, LSNS-6, MTM)<br>• Nutritional assessment<br>• Nutritional consultation<br>• Customized nutrition plan<br>• Health screenings for blood sugar, blood pressure, weight gain or loss<br>• Home delivery of medically tailored meals for 12 weeks<br>• Medical nutrition therapy sessions<br>• Nutrition workshops (with education handouts)<br>• Bags of healthy groceries for 6 months<br>• Wellness checks and social visits<br>Full requested amount funds 1.0 FTE Registered Dietician, half the cost of meals, and administrative expenses. | |
| ***FY23 Funding*** | FY23 Requested: $101,760 | FY23 Recommended: DNF |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | Not funded in FY22<br>*Fun with Friends Program Proposed* | Meals on Wheels<br>FY20 Approved: $70,000<br>FY20 Spent: $53,386<br>FY20 6-month metrics met: 40%<br>FY20 Annual metrics met: 60% | *Meals on Wheels*<br>FY20 Approved: $60,000<br>FY20 Spent: $60,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 75% |

***[Continued on next page]***

# FY23 Chronic Conditions Application Summary


## The Health Trust

*[Continued from previous page]*

| | Metrics | 6-month Target | Annual Target |
|---|---|---|---|
| FY23 Proposed Metrics | Individuals served | 15 | 30 |
| | Medically Tailored Meals Delivered and Served | 2,520 | 5,040 |
| | Improved health status related to complications of chronic conditions, as indicated by Health Screening results over time | 50% | 60% |
| | Surveyed clients report at their health screenings improved adherence to their medications. | 50% | 60% |
| | Surveyed clients report that the AS Nutrition Services program contributed to their increased use/consumption of fresh produce, lean proteins and whole grains. | 70% | 80% |

# FY23 Chronic Conditions Application Summary


## Via Services

| | | | |
|---|---|---|---|
| ***Program Title*** | Healthy Living at Via West | ***Recommended Amount:*** $20,000 | |
| ***Program Abstract & Goal*** | To provide a comprehensive healthy living curriculum in a camp-like setting to both children and adults with special needs. These needs are generally developmental disabilities, but may also include other underlying chronic medical and/or behavioral challenges. Providing services in a 24/7 educational-living environment allows clients many more formal and informal learning opportunities. Healthy living educational components are offered in addition to traditional camp activities. Lessons will cover topics in nutrition and both physical and mental health, which encourage clients to take ownership of their health, and become more independent and self-sufficient. | | |
| ***Agency Description & Address*** | 2851 Park Avenue, Santa Clara<br>http://www.viaservices.org<br>Via Services has been serving the Bay Area since 1945. Our mission is to empower people with disabilities & their families to grow, develop & thrive by providing essential skill-building, therapeutic & recreational programs. The Via West Campus is the site of residential respite care with weekend & week-long special needs camping programs for children & adults. The Science/Environmental Education Camps for children with disabilities at Via West, are unique in Northern California. They actively promote a community of diversity, equity, & inclusion that embraces all people & celebrates their differences. | | |
| ***Program Delivery Site(s)*** | Services provided at agency site | | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Monthly thematic health education lessons and activities during client's respite weekend or week-long session<br>• Monthly follow-up virtual meetings<br>Full requested amount funds partial salaries of multiple employees, small portion of scholarships as well as some program and administrative costs. | | |
| ***FY23 Funding*** | FY23 Requested: $73,524 | FY23 Recommended: $20,000 | |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New in FY23 | New in FY23 | New in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 100 | 300 |

# FY23 Economic Stability Application Summary


## Day Worker Center of Mountain View

| | | |
|---|---|---|
| ***Program Title*** | Healthy Body, Healthy Mind, Healthy Community | ***Recommended Amount:*** $30,000 |
| ***Program Abstract & Goal*** | To alleviate food insecurity, reduce stress, and provide mental and emotional support to day workers and their families. Pandemic-related stress and other socioeconomic challenges have created a physical and mental health crisis in the day worker community. Day workers and their families will receive healthy, nutritious and culturally relevant meals as well as emotional support, skills training, nutrition education classes and workshops on important health related topics. The positive impact on the overall wellbeing of this community would help day workers and their families survive the current environment and enable them to thrive. | |
| ***Agency Description & Address*** | 113 Escuela Avenue, Mountain View<br>http://www.dayworkercentermv.org<br>The Day Worker Center of Mountain View was founded in 1996 by day workers, local business, church and community leaders. The Center provides job-matching services for residents and businesses in Mountain View, Los Altos, Los Altos Hills, Sunnyvale, Palo Alto and surrounding areas. Each year the Day Worker Center serves about 500 unduplicated day workers and their families. | |
| ***Program Delivery Site(s)*** | At agency site in Mountain View | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Daily distribution of healthy meals, including fresh fruit<br>• Relevant classes and workshops are provided virtually when possible<br>Full requested amount funds partial staffing, fresh produce as well as program supplies. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: $30,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $30,000<br>FY22 Approved: $30,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $30,000<br>FY21 Spent: $30,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $25,000<br>FY20 Spent: $25,000<br>FY20 6-month metrics met: 0%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 200 | 350 |

# FY23 Economic Stability Application Summary

**Economic Stability**
(Including Food Insecurity, Housing & Homelessness)

## Hope's Corner Inc.

| | | |
|---|---|---|
| ***Program Title*** | Healthy Food for Hope | ***Recommended Amount:*** $30,000 |
| ***Program Abstract & Goal*** | To reduce food insecurity and positively impact physical and mental health outcomes in local seniors, adults and children who are hungry and in need of nourishment. Nutritious meals offer a path to improved health that can sustain unhoused guests while they seek housing, employment, and basic services. Program benefits anyone who is hungry, and fills gaps in the availability of free meals provided by other community partners. Meals follows dietary standards that promote good health by providing high-quality sources of protein, boosting the amount of fresh vegetables and fruit, and avoiding sugary drinks and snacks. Twice per week, program offers hot breakfast with to-go lunch, provides meals for the Day Worker Center of Mountain View, and delivers meals to RV residents. Multilingual educational materials that promote healthy eating habits and an active lifestyle are disseminated. Clients are also connected to other resources in the community. | |
| ***Agency Description & Address*** | 748 Mercy Street, Mountain View<br>http://www.hopes-corner.org/<br>Hope's Corner provides healthy meals, hot showers, and linkages to resources to seniors, adults, and children in need in our community in a dignified and welcoming environment. They collaborate with Community Services Agency of Mountain View, Los Altos, and Los Altos Hills (CSA), other nonprofit organizations and local businesses to provide services that improve the lives and health of homeless, low-income, and vulnerable individuals in Mountain View and adjacent communities. Through their programs and services, we provide dignity to the underserved members of the community and offer hope for a better future. | |
| ***Program Delivery Site(s)*** | At agency site in Mountain View | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Nutritious weekly Saturday breakfast with to-go lunch<br>• Nutritious weekly Wednesday breakfast with to-go lunch<br>• Meals delivered to RV residents after every Wednesday and Saturday breakfast<br>• Meals provided to the Day Worker Center of Mountain View after every Saturday breakfast<br>• Multilingual educational materials that promote healthy eating habits and an active lifestyle<br>• Referrals to community resources including farmers' markets and COVID-19 testing sites<br>Full requested amount would support the purchase of nutritious foods and distribution of educational materials on healthy eating. | |
| ***FY23 Funding*** | FY23 Requested: $30,000 | FY23 Recommended: $30,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $30,000<br>FY22 Approved: $30,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $30,000<br>FY21 Spent: $30,000<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $25,000<br>FY20 Spent: $25,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 1,000 | 1,400 |

# FY23 Economic Stability Application Summary


## Mountain View Police Department's Youth Services Unit

| | | |
|---|---|---|
| ***Program Title*** | Dreams and Futures Summer Camp for At-risk Youth | ***Recommended Amount:*** $25,000 |
| ***Program Abstract & Goal*** | To offer summer enrichment for under-served 4th-8th grade students who are at high risk for violence and/or involvement with gangs, drugs and/or alcohol use. The main program components are academics, athletics, and enrichment. The targeted age group is a vulnerable age where risk factors for poor health (e.g., alcohol, smoking, poor diet, violence) are most likely to begin, and summer is a time when they fall behind in academic achievement and are exposed to the dangers of gangs and youth violence. Program's emphasis on teamwork, self-esteem, decision making, and communication skills encourages youth to believe in higher education and to take a strong stand against drugs, alcohol and gangs. Additional various educational course and field trips aim to prevent summer learning loss. | |
| ***Agency Description & Address*** | 1000 Villa Street, Mountain View<br>http://www.mvpal.org<br>The Mountain View Police Department's Youth Services Unit sponsors the Dreams and Futures Summer Program. The Dreams and Futures Program was created as a gang prevention program. The program services kids within the community and promotes healthy nutrition, physical activity, and healthy minds through various educational blocks of instruction. The Dreams and Futures program promotes education to prevent summer learning loss and promotes positive interactions between police and youth as well as other community partners. | |
| ***Program Delivery Site(s)*** | Services provided at agency site and various sites for students in the Mountain View Whisman School District. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Two 2-week sessions in one month during the summer- one for 4th-5th graders and one for 6th-8th graders<br>• Morning workshops on conflict resolution, participatory educational activities, and classes in writing and computer skills.<br>• Afternoons sessions include fitness and sports camps that are coached by police, community volunteers, and youth mentors.<br>• Two educational field trips per week<br>• Daily healthy breakfast and lunch<br>Full requested amount funds partial staffing for High School and Community College Leaders and program supplies such as nutritious meals and personal protective equipment. | |
| ***FY23 Funding*** | FY23 Requested: $25,000 | FY23 Recommended: $25,000 |

| | FY22 | FY21 | FY20 |
|---|---|---|---|
| ***Funding History & Metric Performance*** | FY22 Requested: $25,000<br>FY22 Approved: $25,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $25,000<br>FY21 Spent: $7,676<br>FY21 6-month metrics met: 100%<br>FY21 Annual metrics met: 100% | FY20 Approved: $25,000<br>FY20 Spent: $25,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 85 | 85 |

# FY23 Economic Stability Application Summary


## Second Harvest of Silicon Valley

| | | |
|---|---|---|
| ***Program Title*** | Access to Healthy Food | ***Recommended Amount:*** $40,000 |
| ***Program Abstract & Goal*** | To provide food insecure community members in the District with nutritious foods. The program will purchase and distribute nutrient dense foods (fresh fruits and vegetables, milk, eggs, dairy, meat, beans, lentils, whole grains, etc.) at no-cost to low-income community members. Nutrition education will also be provided to clients, including live workshops and virtual online sessions, cooking videos and recipes, distributing flyers with QR codes that link to our Nutrition Center website. Clients will also be referred to food programs through a multilingual toll-free hotline that will help connect callers to nearest free food programs in their neighborhood. Healthy food distribution and provision of other integrated resources provided by partner organizations will enable children, families, and seniors to maintain balanced nutrition, health, and well-being. | |
| ***Agency Description & Address*** | 4001 N. 1st St, San Jose<br>http://www.shfb.or.g<br>Second Harvest of Silicon Valley's mission is to lead our community to ensure that anyone who needs a healthy meal can get one. As one of largest food banks in USA, we work with 300+ partners to distribute food, FREE OF COST, to low-income clients in TWO counties of Santa Clara and San Mateo. Additional client services - Nutrition education (live workshops/virtual); multilingual toll-free hotline (1-800-984-3663) to connect callers to free food programs in their neighborhood; CalFresh (formerly food stamps) outreach/enrollment assistance. | |
| ***Program Delivery Site(s)*** | • Will partner with local community partners that will assist with food distributions at 41 program sites in Cupertino, Mountain View and Sunnyvale. | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Purchasing a variety of nutritious foods that will be distributed at no-cost to low-income food insecure clients in Mountain View and Sunnyvale<br>Full requested funding would support the purchase of nutritious food. | |
| ***FY23 Funding*** | FY23 Requested: $90,000 | FY23 Recommended: $40,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $150,000<br>FY22 Approved: $90,000<br>FY22 6-month metrics met: 100% | New Program in FY22 | New Program in FY22 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 720 | 1,440 |
| | Food Distribution to food insecure clients (in pounds) | 4,615 | 9,231 |
| | Food insecure clients who report preparing at least one new recipe using the nutritious foods from the distribution | 30% | 30% |
| | Food insecure clients who report trying at least one new produce item from the distribution | 30% | 30% |

# FY23 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

## Senior Inclusion and Participation Project

| | | |
|---|---|---|
| ***Program Title*** | Fondo de Solidaridad de Mountain View / MV Solidarity Fund | ***Recommended Amount:*** DNF |
| ***Program Abstract & Goal*** | To provide flexible financial assistance and financial support for housing security deposits and access to mental health services. Families facing challenges around financial stability, housing, and mental health will benefit from the financial assistance. Program will create more culturally sensitive, equitable access to resources- rent deposits for displaced families trying to stabilize housing, financial support for culturally appropriate therapy to address mental health challenges and support for under-resourced community organizations. Targeted population will be primarily Latino immigrant families, women, low-income or very low-income households, and monolingual Spanish speakers in Mountain View. | |
| ***Agency Description & Address*** | 183 Hillview Ave., Los Altos<br>http://www.losaltoscf.org<br>The MV Solidarity Fund is the latest effort in a 20+ year arc to support the community. The 7 Latina community leaders who guide MV Solidarity Fund are mostly undocumented women who have been organizing in the community for 20+ years and are all graduates of the City of Mountain View's Latino Civic Leadership Academy. Through groups like Community Action Team, MV Tenants Coalition, the ELAC (English Language Advisory Councils) of the MVLA and Mountain View Whisman School districts, they have fought for equitable access to education, affordable housing and tenants rights, and economic opportunity. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Flexible financial assistance, as needed<br>• Financial support for housing stability, as needed<br>• Financial support for access to mental health services, as needed<br>Full requested amount would fund direct financial assistance and some administration costs. | |
| ***FY23 Funding*** | FY23 Requested: $100,000 | FY23 Recommended: DNF |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | New Application in FY23 | New Application in FY23 | New Application in FY23 |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 25 | 50 |
| | Services provided | 75 | 150 |
| | Beneficiaries who have increased knowledge of local resources. | 50% | 80% |
| | Beneficiaries who feel more stable in their housing. | 35% | 50% |
| | Beneficiaries who report decrease stress. | 40% | 60% |

# FY23 Economic Stability Application Summary


## Sunnyvale Community Services – Comprehensive Safety-Net Services

| | | |
|---|---|---|
| ***Program Title*** | Comprehensive Safety-Net Services | ***Recommended Amount:*** $75,000 |
| ***Program Abstract & Goal*** | To help Sunnyvale Community Services (SCS) improve the health and housing stability of low-income Sunnyvale residents who have medical issues. SCS case workers will provide families and individuals with emergency financial aid when they are in danger of eviction because of the financial strain of a medical condition. The program provides financial aid for medically-related equipment such as wheelchairs, walkers and ramps to homebound clients. These financial interventions can keep people stably housed, preventing the time-consuming and costly process of getting re-housed after an eviction. They can also enable people with mobility challenges to keep living independently in their own homes instead of having to move to a care facility. Even before the pandemic, the financial pressures on low-income Sunnyvale households were increasing as the economic divide in Silicon Valley grew wider. As with other safety-net agencies, SCS saw a dramatic increase in requests for assistance after the pandemic began and, while the end of the pandemic is in sight, economic disruptions will continue. | |
| ***Agency Description & Address*** | 725 Kifer Road, Sunnyvale<br>http://www.svcommunityservices.org<br>Sunnyvale Community Services (SCS) keeps people housed and fed in Santa Clara County's second-largest city. Our mission is to prevent homelessness and hunger. Our vision is a community where everyone has a home with food on the table. We help over 10,000 people each year with financial aid, food, case management and/or other emergency support.<br>To better achieve our mission, SCS moved into a new building in November 2021. Our new home is triple the size of our previous site and is becoming a much-needed hub in north Santa Clara County for safety-net services. Low-income North County families and individuals will have access to food, financial aid, direct referrals for benefits, and wrap-around case management from SCS and other providers, all under one roof. | |
| ***Program Delivery Site(s)*** | Services provided at agency site | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Financial assistance for medically related bills.<br>• Financial assistance for medical equipment for homebound clients<br>Full requested amount funds financial aid for medically related bills and medical equipment. | |
| ***FY23 Funding*** | FY23 Requested: $75,000 | FY23 Recommended: $75,000 |

| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
|---|---|---|---|
| | FY22 Requested: $75,000<br>FY22 Approved: $75,000<br>FY22 6-month metrics met: 67% | FY21 Approved: $65,000<br>FY21 Spent: $65,000<br>FY21 6-month metrics met: 50%<br>FY21 Annual metrics met: 100% | FY20 Approved: $65,000<br>FY20 Spent: $65,000<br>FY20 6-month metrics met: 100%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 60 | 100 |
| | Individuals receiving financial assistance for medically related bills who are still housed 60 days after assistance - if they are not homeless when assisted | 80% | 80% |
| | Homebound recipients who are able to continue living independently | 85% | 85% |

# FY23 Economic Stability Application Summary

**Economic Stability**
(Including Food Insecurity, Housing & Homelessness)

## Sunnyvale Community Services – Social Work & Homebound Case Management

| | | |
|---|---|---|
| ***Program Title*** | Social Work & Homebound Client Case Management | ***Recommended Amount:*** $197,000 |
| ***Program Abstract & Goal*** | To continue the Social Work Case Management and Homebound Case Management programs, which are focused on improving the health and wellness of the most vulnerable community members by preventing or alleviating homelessness. Care management triage system allows intake case workers to quickly assess each client's risk and determine the level of care and support needed to address their immediate housing and health concerns. The specialized assessments administered at first contact allow a case worker to identify which clients are at greatest risk and should be referred to the Social Work Case Manager. For the Homebound Case Management program, case managers visits each client's home to perform a needs assessment, recommend services and referrals, as appropriate, monitor clients on an ongoing basis, and work with Santa Clara County's Food and Nutrition Department to strengthen and streamline the Home Food Delivery program. | |
| ***Agency Description & Address*** | 725 Kifer Road, Sunnyvale<br>http://www.svcommunityservices.org<br>Sunnyvale Community Services (SCS) keeps people housed and fed in Santa Clara County's second-largest city. Our mission is to prevent homelessness and hunger. Our vision is a community where everyone has a home with food on the table. We help over 10,000 people each year with financial aid, food, case management and/or other emergency support. To better achieve our mission, SCS moved into a new building in November 2021. Our new home is triple the size of our previous site and is becoming a much-needed hub in north Santa Clara County for safety-net services. Low-income North County families and individuals will have access to food, financial aid, direct referrals for benefits, and wrap-around case management from SCS and other providers, all under one roof. | |
| ***Program Delivery Site(s)*** | • At agency site and at client homes of Homebound Services, and virtually or by phone, as needed | |
| ***Services Funded By Grant/How Funds Will Be Spent*** | Services include:<br>• Initial intake assessment<br>• Care coordination and referrals to public benefits and safety net services<br>• Development of a needs assessment and case plan for each household<br>• Weekly follow-up meetings and quarterly assessments<br>• Accompaniment to medical or legal appointments, as needed<br>• Monthly monitoring checks by telephone or in person<br>• Assistance and advocacy with applications to support access to social benefits, e.g., health care, nutrition programs, affordable housing, child care<br>• Access to financial management and health and nutrition programs and services<br>• Healthy nutritious groceries and ready-to-eat meals<br>• Access to low-cost monthly bus passes and free Clipper cards<br>Full requested amount funds partial staff salaries including a Social Work Case Manager, Homebound Case Manager, Home Food Delivery Program Specialist, Self-Sufficiency Program Manager, food for delivery to homebound clients and other program support costs. | |

***[Continued on next page]***

# FY23 Economic Stability Application Summary

**Economic Stability**
(Including Food Insecurity, Housing & Homelessness)

## Sunnyvale Community Services

*[Continued from previous page]*

| | | | |
|---|---|---|---|
| ***FY23 Funding*** | FY23 Requested: $332,027 | FY23 Recommended: $197,000 | |
| ***Funding History & Metric Performance*** | FY22 | FY21 | FY20 |
| | FY22 Requested: $199,043<br>FY22 Approved: $187,000<br>FY22 6-month metrics met: 100% | FY21 Approved: $154,000<br>FY21 Spent: $154,000<br>FY21 6-month metrics met: 75%<br>FY21 Annual metrics met: 100% | FY20 Approved: $153,344<br>FY20 Spent: $153,344<br>FY20 6-month metrics met: 50%<br>FY20 Annual metrics met: 100% |

| ***FY23 Proposed Metrics*** | ***Metrics*** | ***6-month Target*** | ***Annual Target*** |
|---|---|---|---|
| | Individuals served | 328 | 450 |
| | Case management meetings for intensive case management; needs assessments and monitoring visits for homebound clients; deliveries of diabetes-friendly food to homebound households | 2,746 | 5,860 |
| | Case management clients whose scores on the Step Up Silicon Valley Self-Sufficiency Measure improve to an average of 3.0 or higher six months after entering program | 80% | 80% |
| | Sheltered clients who maintain housing for 60 days after receiving financial assistance and referrals | 90% | 90% |
| | Homebound clients who are connected to appropriate benefits programs, support programs and resources | 70% | 70% |

# 2022 Community Health Needs Assessment

June 2022



El Camino Health

## ACKNOWLEDGEMENTS

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  Barbara Avery, Director (retired), Community Benefit
  Sharan Johal, Senior Community Benefit Specialist

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### EL CAMINO HOSPITAL CEO AND BOARD OF DIRECTORS



[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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# TABLE OF CONTENTS

# 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

[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.

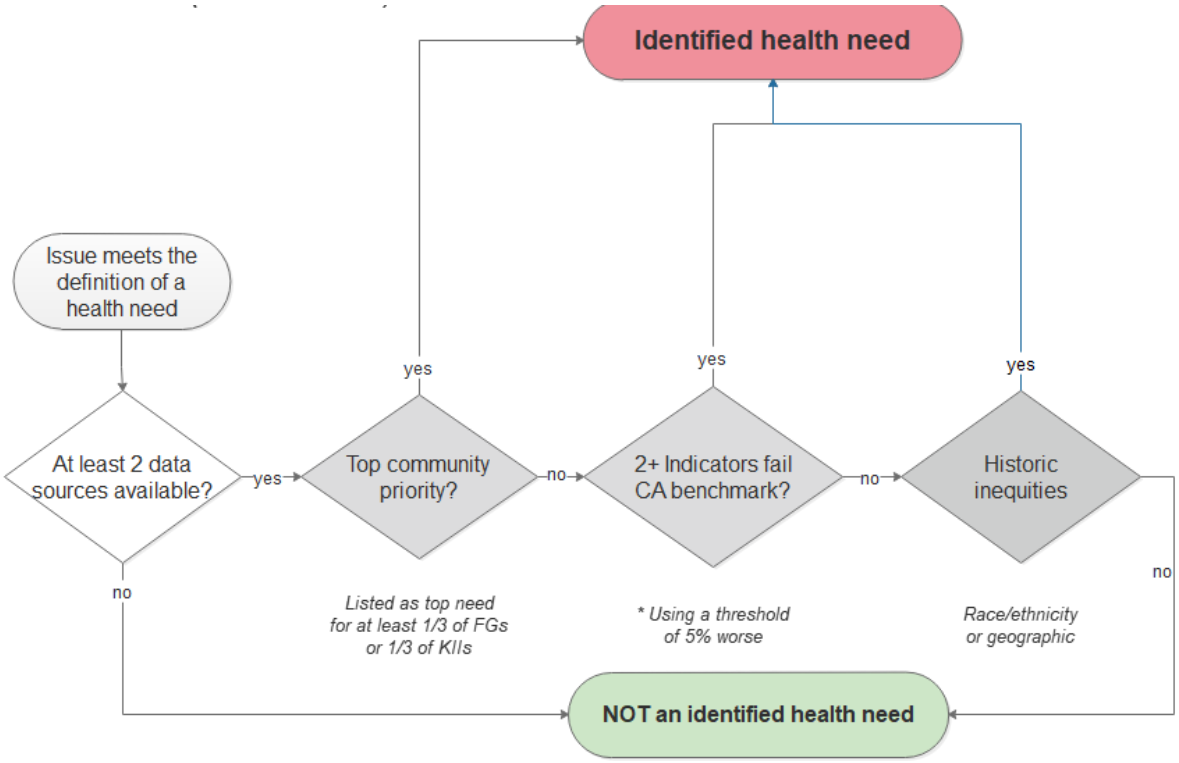
Health needs described in this report are either a poor health outcome and its health driver(s), or a health driver associated with a poor health outcome. El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which 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.<br>• Income inequality in Silicon Valley is 1.5 times higher than at the state level.<br>• 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.<br>• Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards.<br>• 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.<br>● Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work.<br>● 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.<br>● Geographic disparities and inequities:<br>○ 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]<br>○ 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).<br>○ 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.<br>○ 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).<br>○ 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%).<br>○ 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).<br>○ In East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).<br>● Racial/ethnic disparities and inequities:<br>○ 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%).<br>○ 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.<br>● 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.<br>● 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).<br>● 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).<br>● 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.<br>● Key informants and focus group attendees described youth isolation and lack of interaction with peers due to the pandemic as preventing normal adolescent development.<br>● CHNA participants suggested that many students were anxious about returning to school, in part because of the chance of infection.<br>● 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.<br>● 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.<br>● Experts said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.<br>● 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.<br>● Some noted that many hospitals no longer provide mental health services and there are very few inpatient psychiatric beds for acute/high needs.<br>● It was stated that services for people without health insurance can be expensive and difficult to access.<br>● Racial/ethnic disparities and inequities:<br>○ 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).<br>○ 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).<br>○ 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).<br>○ 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).<br>○ 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).<br>● While homeowners statewide are spending approximately 31% of their income on their mortgage, at the county level homeowners are spending over 36%.<br>● The housing affordability index for Santa Clara County (73.0) is lower (i.e., worse) than for California (88.1).[5]<br>● 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.<br>● Some CHNA participants said high costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID.<br>● 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%).<br>● 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.<br>● Geographic disparities and inequities:<br>○ 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%.<br>○ 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).<br>○ 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] |

[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

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| 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%).<br>○ 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%).<br>○ 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.<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>● 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.<br>● 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%.<br>● 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).<br>● Many key informants and focus group participants mentioned that low-income residents may be required to prioritize rent and food over healthcare.<br>● 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.<br>● It was stated that low-income and undocumented county residents especially have difficulty accessing insurance.<br>● Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern.<br>● CHNA participants identified the lack of information for patients about healthcare costs as a barrier to accessing care.<br>● 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).<br>● 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.<br>● Other delivery issues included the need for healthcare worker education around public charge issues, and the need for greater language capacity.<br>● More than one in ten (11%) Santa Clara County residents speak limited English, compared to less than 10% in California overall.<br>● 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.<br>● 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.<br>● Geographic disparities and inequities:<br>○ 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%).<br>○ 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%).<br>○ 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.<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>● 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.<br>● 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.<br>● 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.<br>● The county's walkability index (9.9) is worse than the state's (11.2).<br>● 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.<br>● 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%).<br>● Multiple residents made the connection between unhealthy eating and mental health—what's going on "in their head and their heart."<br>● Geographic disparities and inequities:<br>○ SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%).<br>○ 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).<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>● 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).<br>● 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).<br>● Racial/ethnic disparities:<br>○ There are persistent disparities in cancer incidence rates and other cancer statistics.<br>○ 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%).<br>○ 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.<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>○ A maternal and child health expert suggested that cultural norms and access issues may play into differences in teen birth statistics.<br>○ 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%).<br>○ Infant mortality is higher among Black babies.<br>○ A smaller proportion of Black (79%) and Latinx (78%) mothers in Santa Clara County receive early prenatal care than all Californian mothers (84%).<br>○ 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.<br>● 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:<br>○ Lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care.<br>○ Few pediatric dentists in the county, still fewer take Denti-Cal due to the low reimbursement rates, leading to a gap in services.<br>○ The special needs population as underserved by oral health specialists.<br>○ 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:<br>○ 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).<br>● 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%).<br>● 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).<br>● 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.<br>● Geographic disparities and inequities:<br>○ In East San José a smaller percentage of workers commute by transit, bicycle, or walking (5.8%) than in California overall (8.1%).<br>○ 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).<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>○ 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]<br>○ 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).<br>● 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.<br>● Racial/ethnic disparities and inequities:<br>○ 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).<br>○ 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.<br>● 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.<br>● 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).<br>● Racial/ethnic disparities and inequities:<br>○ 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). |

[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).<br>○ 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).<br>○ 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).<br>○ 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.<br>● HIV diagnoses among younger men (ages 13-24 and 25-44) are trending up in the county.<br>● Racial/ethnic disparities and inequities:<br>○ 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.<br>● Health conditions such as cardiovascular disease, cancer, and respiratory problems are among the top 10 causes of death in the county.<br>● The level of asthma prevalence for people of all ages is higher for Santa Clara County (10%) than the state (9%).<br>● One key informant noted that asthma rates have been worsening. |

| | |
|---|---|
| | ● An expert in chronic disease mentioned a rise in dementia-related issues.<br>● 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.<br>● Racial/ethnic disparities and inequities:<br>○ An expert in Black health cautioned about high rates of asthma in areas with poor air quality.<br>○ 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.

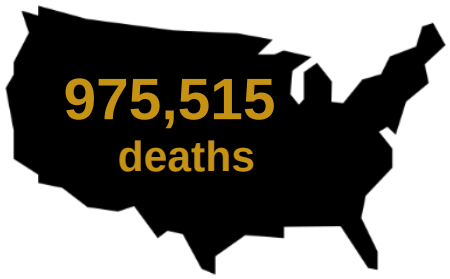
**Access to Healthcare:** El Camino Health has focused on access to healthcare in every CHNA because access is crucial to improving the health of community members, in terms of both prevention and intervention. The Affordable Care Act and subsequent Medi-Cal expansion provided more opportunities for 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.

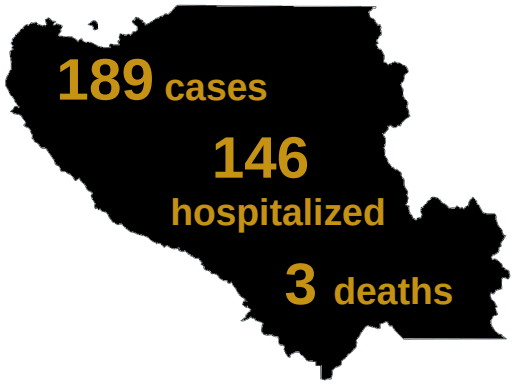
[9] Recent news reports state: "Roughly a quarter of Santa Clara County households don't have access to the internet. In San José, 36% of Latino families and 47% of African American families lacked broadband internet, according to a 2017 study. Approximately 70,000 county residents don't have access 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]




### Santa Clara County Daily Averages[14]




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**

[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

[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

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[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.

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[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

[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

[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.

[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 | | |

[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.

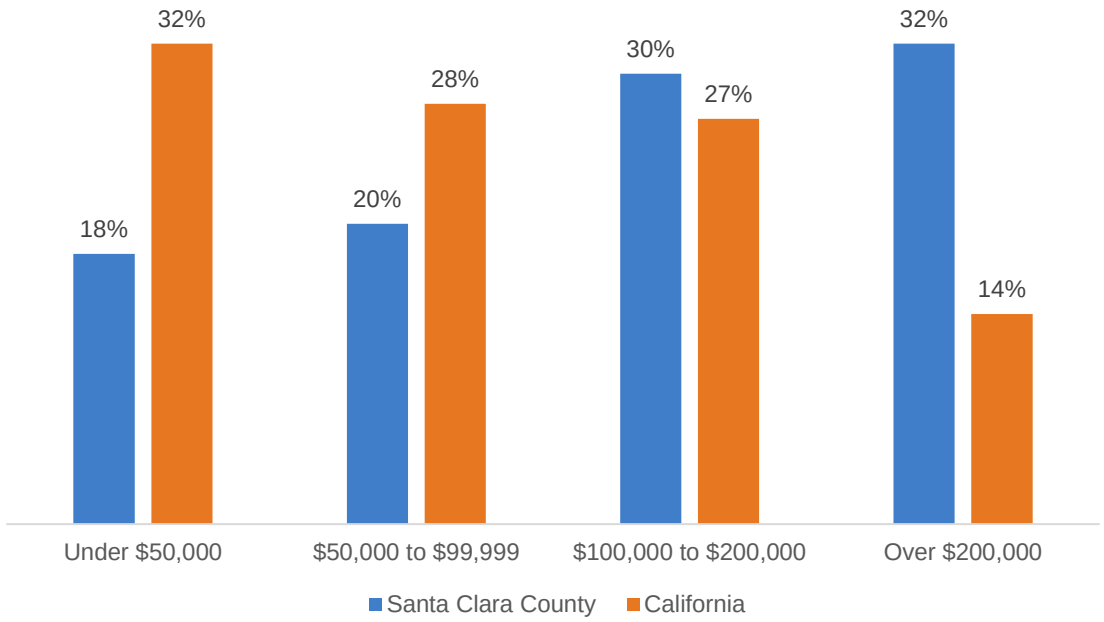
Nearly four in ten (39%) people in Santa Clara County were born outside the United States. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[40] Our communities earn some of the highest annual median incomes in the U.S., but they also bear some of the highest 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

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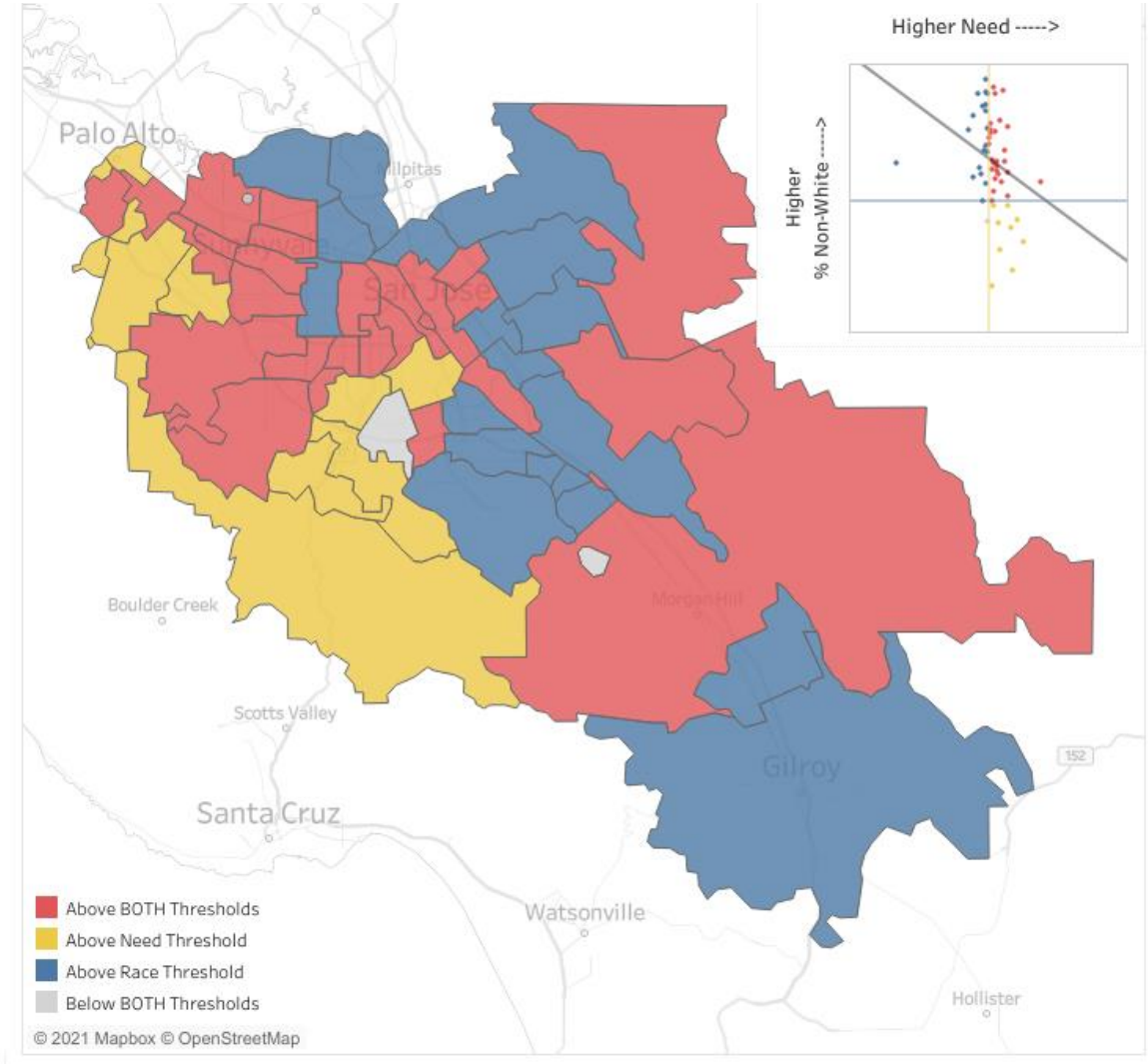
[42] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org

[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

[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.

[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]

[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.


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

[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

[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.

[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.

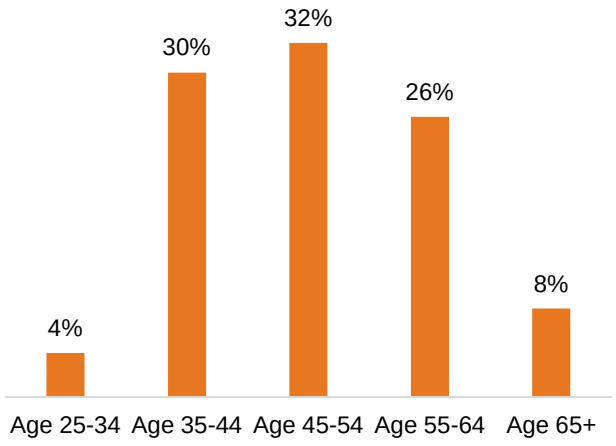
[52] Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

### CHNA Participant Demographics

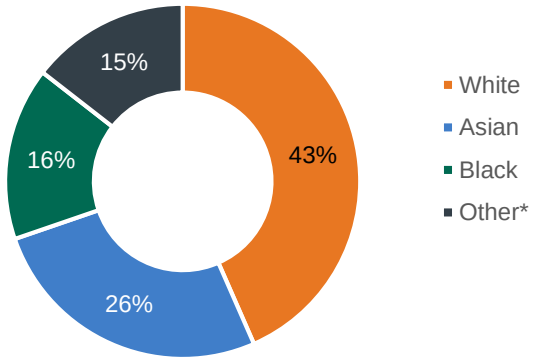
A total of 77 people participated in focus groups or interviews for the CHNA. More than three out of every four (77%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder represented Santa Clara County only (23%).

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.

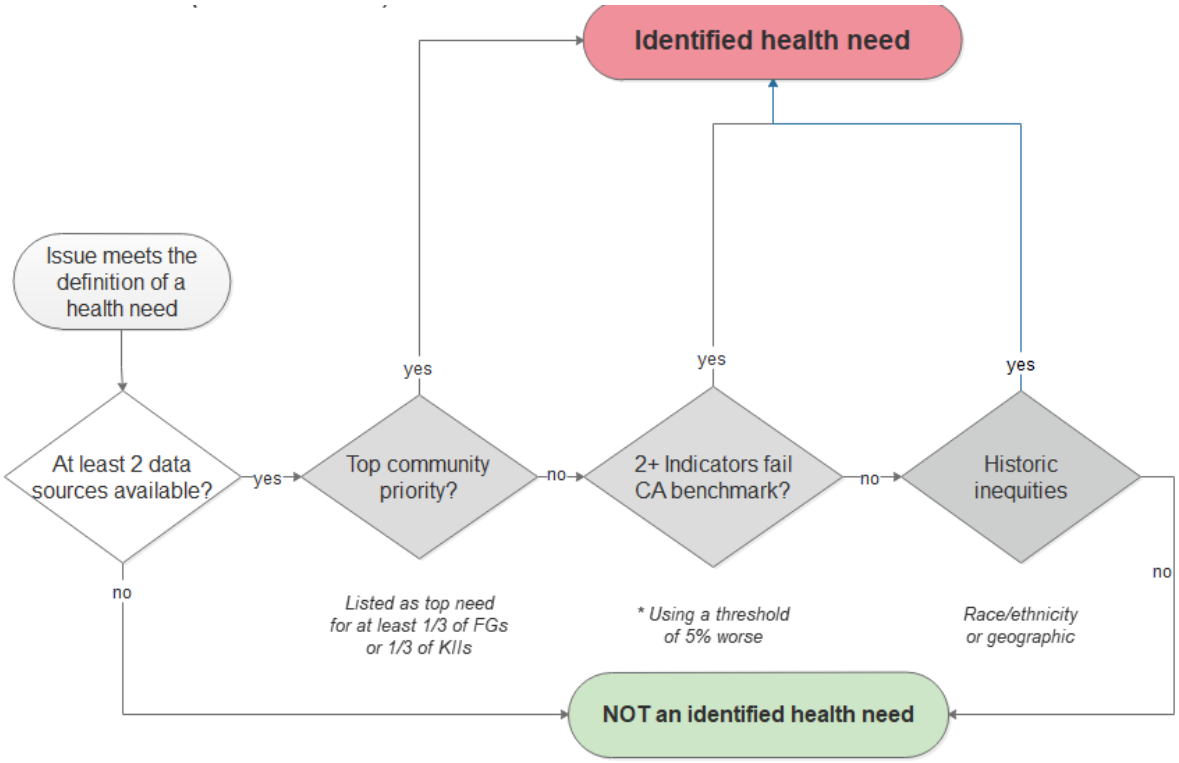
**Health driver:** A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes. May be a social determinant of health.

**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

[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

[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

[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).

[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

[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]

[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:


- 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]

[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 |

[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<br><br>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:<br>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:<br>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).

[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 equity 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:<br>• 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.<br>• May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions.<br>• 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)<br>(b)(3)<br>(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)<br>(b)(5)(i)<br>(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)<br>(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% |

| 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 |
|---|---|---|---|---|---|---|---|---|
| | **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 |
| HEALTHY BODY | **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 |
|---|---|---|---|---|---|---|---|---|
| | | (defined as at least one point change on the CANS 50 assessment), among the students served who have school attendance issues | | | | | | |
| HEALTHY MIND | | 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% |