AGENDA

FINANCE COMMITTEE MEETING
OF THE EL CAMINO HOSPITAL BOARD
Thursday, May 26, 2022 – 6:30 pm

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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:

Dial-In: 1-669-900-9128. Meeting Code: 916 1676 0739#. No participant code. Just press #.

MISSION: To provide oversight, information sharing and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital Board of Directors. In carrying out its review, advisory and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER / ROLL CALL	John Zoglin, Chair		**6:30 – 6:31pm**
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	John Zoglin, Chair		**information 6:31– 6:32**
3. PUBLIC COMMUNICATION a. Oral Comments *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.* b. Written Correspondence	John Zoglin, Chair		**information 6:32 – 6:35**
4. CONSENT CALENDAR *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Finance Committee (04/25/2022) b. Finance Committee Charter ***Information*** c. FY2022 Progress Against Committee Goals d. FY2022 Pacing Plan e. Article of Interest	John Zoglin, Chair		**motion required 6:35-6:40**
5. REPORT ON BOARD ACTIONS	John Zoglin, Chair		**information 6:40 – 6:45**
6. PERIOD 10 FINANCIAL REPORT	Carlos Bohorquez, CFO	*public comment*	**motion required 6:45-6:55**
7. COMMUNITY BENEFIT a. FY2023 Community Benefit Program Update b. 2022 El Camino Health Community Health Needs Assessment	Jon Cowan, Sr. Dir. Government Relations & Community Partnerships		**motion required 6:55-7:15**
8. REVENUE CYCLE PROCESS UPDATE	Carlos Bohorquez, CFO Brian Fong, Sr. Dir. Revenue Cycle		**discussion 7:15-7:35**

A copy of the agenda for the Regular 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 650-988-8483 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
9. FY2023 COMMITTEE PLANNING a. Proposed FY2023 Committee Goals b. Proposed FY2023 Pacing Plan c. Proposed FY2023 Committee Meeting Dates	John Zoglin, Chair		**motion required** **7:35 – 7:45**
10. ADJOURN TO CLOSED SESSION	John Zoglin, Chair	*public comment*	**motion required** **7:45 – 7:46**
11. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	John Zoglin, Chair		**information** **7:46-7:47**
12. CONSENT CALENDAR *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2*: a. Minutes of the Closed Session of the Finance Committee (04/25/2022) ***Information*** *Health and Safety Code Section 32106(b):* Physician Contracts b. MV General Surgery Call Panel Renewal c. Enterprise Pathology Medical Director Renewal d. Enterprise Cancer Program Medical Director Renewal e. MV Cath Lab Medical Director Renewal f. MV Respiratory Care Services Medical Director Renewal g. MV Cardiac Rehab Medical Director Renewal h. MV Prenatal Diagnostic Center (PDC) Expansion Agreement i. Enterprise Vascular Surgery Call Panel Renewal	John Zoglin, Chair		**motion required** **7:47-7:48**
13. *Health and Safety Code Section 32106(b)* – for a report and discussion involving healthcare facility trade secrets: **SERVICE LINE REPORT: PATHWAYS**	Carlos Bohorquez, CFO		**information** **7:48-8:13**
14. *Health and Safety Code Section 32106(b)* – for a report and discussion involving healthcare facility trade secrets: **SERVICE LINE REPORT: CARDIOLOGY**	Omar Chughtai, VP of Operations Josh Schreckengost, Sir. Dir. Service Lines		**information** **8:13-8:38**
15. *Gov't Code Sections 54957* for report and discussion on personnel matters – Senior Management: - Executive Session	John Zoglin, Chair		**discussion** **8:38-8:43**
16. ADJOURN TO OPEN SESSION	John Zoglin, Chair		**motion required** **8:43-8:44**
17. RECONVENE OPEN SESSION / REPORT OUT	John Zoglin, Chair		**information** **8:44-8:45**
To report any required disclosures regarding permissible actions taken during Closed Session.			

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
18. CONTRACTS & AGREEMENTS ***Approval*** a. MV Prenatal Diagnostic Center (PDC) Expansion Agreement b. Enterprise Vascular Surgery Call Panel Renewal ***Recommended for Board Approval*** c. MV General Surgery Call Panel Renewal d. Enterprise Pathology Medical Director Renewal e. Enterprise Cancer Program Medical Director Renewal f. MV Cath Lab Medical Director Renewal g. MV Respiratory Care Services Medical Director Renewal h. MV Cardiac Rehab Medical Director Renewal	Mark Adams, MD, CMO		**motion required** **8:45 – 8:50**
19. CLOSING COMMENTS	John Zoglin, Chair		**information** **8:50 – 8:55**
20. ADJOURNMENT	John Zoglin, Chair	*public comment*	**motion required** **8:55-8:56pm**

Upcoming Meetings:
Regular Meetings: August 15, 2022, September 27, 2022, November 21, 2022, January 30, 2023 (Joint FC-IC), March 27, 2023, May 22, 2023

Minutes of the Open Session of the
Finance Committee of the
El Camino Hospital Board of Directors
Monday, April 25, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	**Members Absent**
John Zoglin, Chair	**Wayne Doiguchi**
Joseph Chow**	
Peter Fung, MD	
Bill Hooper	
Cynthia Stewart	
Don Watters	**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Finance Committee of El Camino Hospital (the "Committee") was called to order at 5:30 pm by Chair John Zoglin. A verbal roll call was taken. All members were present at roll call, excluding committee member Peter Fung, MD. 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.	
2. POTENTIAL CONFLICT OF INTEREST	Chair Zoglin asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICATION	There were no comments from the public.	
4. CONSENT CALENDAR	**Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Finance Committee meeting (03/28/2022) and for information: (b) Progress Against FY 2022 Committee Goals (c) FY2022 Pacing Plan (d) Article of Interest. **Movant:** Watters **Second:** Fung **Ayes:** Chow, Fung, Hooper, Stewart, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Doiguchi **Recused:** None	***Consent Calendar was approved.***
5. REPORT ON BOARD ACTIONS	Chair Zoglin asked the Committee for any questions or feedback on the Report on Board Actions, as further detailed in the packet.	
6. FY2023 COMMITTEE PLANNING (a) FY 2023 Committee Goals (b) FY 2023 Pacing Plan (c) FY 23 Meeting Dates	Carlos Bohorquez, Chief Financial Officer opened the discussion by stating the Governance Committee has recommended eliminating one Hospital Board Meeting along with one Finance Committee Meeting as discussed and presented to the full Board in previous meetings. Mr. Bohorquez stated, that the proposed FY2023 Meeting dates do not reflect this recommendation of reducing the Finance Committee meetings down to six meetings. Mr. Zoglin recommended changing the Aug 29th Finance Committee meeting to Aug 15th and pushing the board meeting to Aug 17th. Mr. Woods stated he is aware of this change and has confirmed it with Director Chen. Mr. Bohorquez agreed to the recommendation.	

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	Mr. Zoglin has recommended adding the following service lines to the FY 23 Goals: Oncology and Urology to present: strategy, goals, and performance. Mr. Zoglin recommended discussing during the May meeting a new cadence for goal #4. Mr. Zoglin stated possibly pushing this goal to be presented earlier in the fiscal year to assist with having more time to review and discuss any issues that come up. Mr. Zoglin stated should a motion be taken? in response, Mr. Bohorquez stated all updates will be added and will be presented to the Finance Committee in May.	

7. PERIOD 9 FINANCIAL REPORT	Mr. Bohorquez, presented the Period 9 Financial Report and opened the discussion by discussing volume and overall patient activity across the health system and highlighted the following:
	
	• Overall very strong volumes across the organization, but outpatient volume has been particularly strong.
	
	• Mr. Bohorquez stated the following services had significant variance to budget and last year:
	  o **ER:** Significant rebound stronger than pre-Covid levels. Mr. Bohorquez stated for March we were favorable to budget by 24.9% and 42.6% better than the same period last year.
	  o **Outpatient Surgery:** 40.6% favorable to budget and 11.2% better than the same period last year.
	• Mr. Bohorquez stated inpatient volume was solid as well and highlighted the following:
	  o Average Daily Census of 293 was favorable to budget by 12.5% and 22.9% better than last year.
	  o Total inpatient discharges were favorable to budget by 8.3% and 19.4% better than the same period last year.
	
	Mr. Bohorquez stated we expect volumes to level off in Q4 of FY2022 which attributes to spring break and anticipated vacation activities by patients and physicians.
	
	<u>Operational Metrics:</u>
	• From an overall operational standpoint given the significant volume increase, the ongoing impact of Covid, and workforce challenges, Mr. Bohorquez stated we are favorable to budget and better than last year. This is attributed to operational leaders who have been proactive in ensuring adequate staffing levels.
	• One item that we are unfavorable to budget from an operational standpoint is Days in A/R. We are at 54.1. Its higher than the target by 5 days and Mr. Bohorquez stated about 3 days is directly attributed to the very strong volumes in March and we are expecting to level up closer to the target by end of this fiscal year.
	Mr. Bohorquez continued the discussion by presenting the Financial Performance Overview and highlighted the following:	

	• March total operating revenue of $127M is attributed to strong volumes as we just discussed the fact March had 23 business days. Overall favorable to budget by 23.6% and 25.6% over the same period last fiscal year. • Operating EBIDA $27.8M favorable to budget by $13.8M and $13.2M better than the same period last fiscal year, Mr. Bohorquez stated last March we were coming off the impact of a Covid wave. • Net income was favorable to budget by 8.9% and it was mainly driven by strong operating performance. **<u>YTD Financial Results through March 31st</u>** • Total operating revenue of $1.0B which is 13.1% favorable to budget and 20.1% better than the same period last fiscal year. • Operating EBIDA of $198M favorable to budget by $74.8M and $87.5M better than the same period last year. Mr. Bohorquez stated one area that has been a significant challenge and not favorable to budget is non-operating income which is primarily compromised of investment income. The capital markets have been challenged over the last 9 months: o YTD for non-operating income Mr. Bohorquez stated we are unfavorable to budget by $116.4M and compared to the same period last fiscal year we are unfavorable to by $227.8M. **Motion:** To approve the Period 9 Financials **Movant:** Fung **Second:** Watters **Ayes:** Chow, Fung, Hooper, Stewart, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Doiguchi **Recused:** None	
8. ECHMN QUARTERLY FINANCIAL REPORT	Vince Manoogian, Interim President of El Camino Health Medical Network, and David Neapolitan, VP of ECHMN Finance presented a Quarterly Financial Report update and highlighted the following: • Multi-year improvement in overall ECHMN financial performance continues as demonstrated by a $2.9 million improvement in Operating EBIDA over YTD FY2021. • YTD FY2022 Operating EBIDA $312K favorable to budget and Net Income is $204K unfavorable to budget. • Total wRVU production is 9.3% favorable to budget. • Increased number of providers above the P50 threshold in FY2022 over FY2021. • Capitation revenue is unfavorable to budget by $1.4M but favorable to the prior year by $292K. This is attributed to longer than expected negotiations with a key payor and a decrease in membership in sub-capitated agreements.	

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	• Operating expenses are unfavorable to budget, $50K but favorable to the prior year by $5.0M.	
9. MV WIRELESS & DAS SYSTEM UPGRADE	Deb Muro, Chief Information Officer presented an update on the MV Wireless & DAS System Upgrade. Ms. Muro stated go-live for the upgrade will be happening this week and the DAS is in the works as well. Cost for the project, Ms. Muro stated we are under budget.	
10. CARDIAC REHAB MOVE	Ken King, Chief Administrative Services Officer presented an update regarding the Cardio-Pulmonary Wellness Center Relocation and stated the project is completed. Beginning March 6th patients were scheduled for appointments.	
11. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:39 pm. **Movant:** Fung **Second:** Stewart **Ayes:** Chow, Fung, Hooper, Stewart, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Doiguchi **Recused:** None	***Adjourned to closed session at 6:39 pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	During the Closed Session, the Finance Committee approved the following items: The Closed Session Minutes of March 28th Finance Committee Meeting By a unanimous vote of all Committee Members present: Mr. Chow, Mr. Hooper, Ms. Stewart, Director Watters, Director Zoglin, Director Fung and Mr. Doiguchi was absent.	
13. AGENDA ITEM 18: PHYSICIAN CONTRACTS & AGREEMENTS	**Motion:** To approve MV & LG Gastroenterology Call Panels **Movant:** Watters **Second:** Fung **Ayes:** Chow, Fung, Hooper, Stewart, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Doiguchi **Recused:** None	
14. AGENDA ITEM 19: CLOSING COMMENTS	None	
15. AGENDA ITEM 18: ADJOURNMENT	**Motion:** To adjourn at 7:44 pm. **Movant:** Fung **Second:** Watters **Ayes:** Chow, Fung, Hooper, Stewart, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Doiguchi **Recused:** None	***Meeting adjourned at 7:44 pm***

Attest as to the approval of the foregoing minutes by the Finance Committee of El Camino Hospital:

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John Zoglin
Chair, Finance Committee

Prepared by: Samreen Salehi, Executive Assistant II, Administrative Services

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El Camino Hospital Board of Directors
Finance Committee Charter

Purpose

The purpose of the Finance Committee (the "Committee") is to assist the El Camino Hospital (ECH) Board of Directors to ("Board") provide oversight, information sharing and financial reviews related to operating and capital budgeting, financial planning, financial reporting, capital structure, banking relationships and certain contractual agreements for El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). In carrying out its review, advisory and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

Authority

All governing authority for the Organization resides with the Board and, except as specifically provided in Sections E and F of "Specific Duties," the Committee serves as an advisory body only. The Committee will report to the Board at the next scheduled meeting any recommendation made or action taken within the Committee's authority. The Committee has the authority to select, engage, and supervise any consultant it deems necessary to advise the Committee on issues related to its responsibilities. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Finance Committee may also include 2-4 Community members[1] with expertise which is relevant to the Committee's areas of responsibility, such as banking, financial management, planning and real estate development, etc.

- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year, expiring on June 30th, renewable annually.

- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

Staff Support and Participation

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team may participate in the Committee meetings as deemed necessary.

General Responsibilities

The Committee's primary role is to provide oversight and to advise the management team and the Board on matters brought to this Committee. With input from the Committee, the management team shall develop dashboard metrics that will be used to measure and track financial performance for the Committee's review. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for ensuring that performance metrics which are not being met to the Board's expectations are reported to the Board.

Specific Duties

The specific duties of the Committee are:

A. Budgeting

- Review the annual operating and capital budgets for alignment with the mission and vision of the Organization and make recommendations to the Board.
- Review any financial requests in excess of the CEO's signing authority and make recommendations to the Board.
- Review the Organization's long-range forecasts and financial plans and make recommendations to management regarding steps advisable to improve the Organization's financial strength.

B. Financial Reporting

- Review each accounting period's financial statements and ensure the Board is advised of any necessary corrective actions.
- Obtain a clear understanding of the Organization's financial reporting process by reviewing the hospital's dashboard items and periodic financial reports and advise management on how to improve its financial reporting in order to improve accountability and ease of reading and understanding.

C. Financial Planning and Forecasting

- Semi-annually receive an update on management's assessment of expected results as well as potential risks related to the payor contracts.
- Evaluate the financial implications of emerging payment processes and provide advice to management regarding associated risk management concerns.

- Evaluate financial planning and forecasting to help ensure it remains in alignment with the mission and strategic direction of the Organization.

D. Treasury, Pension Plans, and Contracting Concerns

- Review and make recommendations to the Board regarding all new debt issuances and derivative instruments in excess of $1 million.

- Monitor compliance with debt covenants and evaluate the Organization's capital structure.

- Review and make recommendations to the Board regarding changes in banking relationships, including, without limitation, depository accounts, investment accounts and major credit facilities. The term "major credit facilities" does not include management-approved trade credit facilities offered in the ordinary course of business by vendors to the hospital. The Committee may recommend delegation of approval authority for specified changes to the CFO, but must maintain reporting and oversight of any such changes

- Review and make recommendations to the Board regarding proposed plan design or benefit design changes in excess of management authority limits to employee retirement plans, excluding changes to investments within those plans.

- Review and make recommendations to the Board regarding contractual agreements with persons considered to be "insiders" under IRS regulations, and those which are in excess of the CEO's signing authority

E. Capital and Program Analysis

- Review and make recommendations to the Board with respect to the business plans of all capital items or proposed business ventures in excess of the CEO's signing authority, and all variances to budget in excess of the CEO's signing authority on projects in process.

- Review retrospective analyses of all strategic business ventures and all strategic capital expenditures in excess of $2.5 million, as presented by management or as per the review schedule set forth by the Committee, to assess the reasonableness of business plans that were developed at the time of original approval and to promote learning as a result of any identified issues or concerns.

- Review and recommend approval for the acquisition or disposition of capital which is in excess of $5 million.

- Approve unbudgeted capital expenditures exceeding the CEO's signature authority but not in excess of $5 million.

- Approve the annual ECH Community Benefit Plan including grants to outside organizations, sponsorships and placeholder funds, combined which shall not exceed $5 million annually.

F. Physician Financial Arrangements

- Review and recommend for Board approval Physician Financial Arrangements in excess of 75% of fair market value in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.

- Approve Physician Financial Arrangements in excess of 250,000 annually or if upon renewal or amendment, the annual increase is greater than 10% in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.

- Approve the Annual Summary Report of Physician Financial Arrangements.

G. Financial Policies

- Review and recommend approval of any Board-level financial policies, excluding any financial policies for which responsibility has been specifically assigned to another Board Committee.

H. Ongoing Education

- Endorse and encourage Committee education and dialogue relative to emerging healthcare issues that will impact the viability and strategic direction of the Organization,

I. Management Partnership

- Work in partnership with the CFO and other hospital executives to assist in the development of financial policies which will help ensure the Organization's success.

- Provide ongoing counsel to the CFO regarding areas of opportunity for either personal or organizational improvement.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee strives for continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan and the operational requirements of the organization. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24-hour notice.

FY2022 COMMITTEE GOALS
Finance Committee

PURPOSE

The purpose of the Finance Committee (the "Committee") is to provide oversight, information sharing, and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital (ECH) Hospital Board of Directors ("Board"). In carrying out its review, advisory, and oversight responsibilities, the Finance Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

STAFF: **Carlos Bohorquez**, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

GOALS	TIMELINE	METRICS
1. Evaluate Financial Performance Compared to Budget and Moody's 'A1' Medians	Q1, Q2, Q3 and Q4	Presentations in **August -2021**, **September - 2021 November - 2021, January - 2022**, March - 2022, April - 2022, May - 2022
2. Evaluate FY2023 Operating and Capital Budget Assumptions	Q3 and Q4	March - 2022, April - 2022, May - 2022
3. Review Progress on Opportunities / Risks identified by Management for FY2022	Q2	**November - 2021**
4. Review strategy, goals, and performance of business affiliates and service lines: 1) Joint Venture – Satellite Healthcare, 2) Orthopedics, 3) Cardiology, 4) Joint Venture – Pathways, 5) ECHMN, 6) CONCERN, 7) Hospital Community Benefits Program	Q1	Joint Venture - Satellite (August - 2021), ECHMN (September -2021)
	Q2	**Orthopedics** (November 2021)
	Q3	Cardiology and ECHMN (January - 2022), CONCERN (March 2022), Hospital Community Benefits Program (March 2022) **In Progress**
	Q4	ECHMN (April -2022), Joint Venture – Pathways (May - 2022) **In Progress**
5. Review and evaluate ongoing customer service/patient experience tactics / metrics and use of AI to improve the process and customer experience for the Revenue Cycle	Q3	Monitor customer service and patient satisfaction metrics – March (2022)

SUBMITTED BY: **Chair**: John Zoglin | **Executive Sponsor**: Carlos Bohorquez, CFO

FY2022 Finance Committee Pacing Plan

FY2022 FC Pacing Plan – Q1		
July 2021	**August 9, 2021**	**September 27, 2021**
No Scheduled Finance Committee Meeting	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Candidate Interviews and Recommendation to Appoint • Financial Report (FY2021 Periods 11 and 12) **Discussion Items** • Financial Report (Pre-Audit Fiscal Year End 2021 Results) • Service Line / Business Affiliate Review: JV Satellite Healthcare • Update on Kindred IP Rehab JV • Medical Staff Development Plan • Report on Board Actions • Other Standing Agenda Items • Executive Session • Post Implementation Review (“PIR”) Per Attached Schedule	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2022 Periods 1 and 2) • Financial Report Fiscal Year End 2021 Results **Discussion Items** • Service Line / Business Affiliate Review: ECHMN Update • Progress Against FY2022 Committee Goals & Pacing Plan • AdHoc Committee Update on Finance Committee Member Recruitment • Project Update: Women’s and Newborn Hospital Project • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session
FY2022 FC Pacing Plan – Q2		
October 2021	**November 22, 2021**	**December 2021**
No Scheduled Finance Committee Meeting	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2022 Periods 3 and 4) **Discussion Items** • Service Line Review: Orthopedics • Foundation Update • FY2023 Community Benefit Grant Application Guiding Principles / Process • Review Progress on Opportunities / Risks Identified for FY2022 • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**

Updated 5/20/22

FY2022 Finance Committee Pacing Plan

FY2022 FC Pacing Plan – Q2		
January 31, 2022	**February 2022**	**March 28, 2022**
5:30pm **Joint Meeting with the Investment Committee:** **Topic: Long Term Financial Forecast** **6:30pm** **Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2022 Periods 5 and 6) **Discussion** • Service Line / Business Affiliate Review: ECHMN Update • Managed Care Update • PIR • MV Campus Completion Plan • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2022 Periods 7 and 8) **Discussion Items** • FY2023 Budget Part # 1 Process and Assumptions • ~~Service Line Review: CONCERN~~ • Community Benefit Grant Program Update • Summary Physician Financial Arrangements (Year-End) • FY2023 Committee Planning: Goals, Pacing Plan and Meeting Dates • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session

FY2022 FC Pacing Plan – Q4		
April 25, 2022	**May 26, 2022**	**June 2022**
Approval Items • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2022 Period 9) **Discussion Items** • FY2023 Budget Preview Part 2 • Service Line Report – ECHMN Update • Review Cycle Progress Report • Progress Against FY2022 Committee Goals & Pacing Plan • FY2023 Committee Planning: Goals, Pacing Plan and Meeting Dates • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**5:30pm** **Joint Meeting with the Hospital Board** **Approval Items: FY2023 Operating & Capital Budget** **6:15pm** **Approval Items** • Financial Report (FY2022 Period 10) • FY2023 Organizational Goals • FY2023 Committee Planning: Goals, Pacing Plan and Meeting Dates • FY2023 El Camino Hospital Community Benefit Grant Program **Discussion Items** • Service Line Report: Pathways JV / ~~CONCERN~~/ Cardiology • Review Cycle Progress Report • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**

Updated 5/20/22

FY2022 Finance Committee Pacing Plan

Last 30 Months Capital Project Approvals

APPROVAL DATE	APPROVING BODY	PROJECT NAME	APPROVED AMOUNT	PROPOSED FC PROJECT UPDATE / POST-IMPLEMENTATION REVIEW DATE
2/13/2019	ECH Board	Women's Hospital Planning	$10.0M (Total Now $16M)	09/2020
2/13/2019	ECH Board	SVMD Clinic Site Tenant Improvements	$8.0M	09/2020
2/13/2019	ECH Board	Interventional Equipment Replacement	$13.0M	09/2020
2/13/2019	ECH Board	Imaging Equipment Replacement	$16.9M	09/2020
2/13/2019	ECH Board	SVMD Asset Acquisition	$1.2M	11/2020 (w/SVMD Financials)
3/25/2019	Finance Committee	SVMD Clinic IT Infrastructure	$4.6M	11/2020 (w/SVMD Financials)
5/28/2019	Finance Committee	MV Campus Signage	$1.1M	N/A < $2 M
8/21/2019	ECH Board	Medical Staff Development Plan	$6.1M	01/2021
8/21/2019	ECH Board	ED Remodel	$6.75M	01/2021
10/10/2020	ECH Board	MV Campus Completion (Old Main Demo)	$24.9M	03/2021
1/25/2020*	Finance Committee	Satellite Dialysis*	*No approval on /1/25/2020 presented only	07/2021
7/27/2020	Finance Committee	Sterile Processing Equipment	$1.85M	N/A < $2 M
8/12/2020	ECH Board	Radiation Oncology Replacement Equipment	$10.3M (add'l $3.55 M)	01/2022
1/25/2021	Finance Committee	Real Estate Transaction	$1.875M	09/2021
1/25/2021	Finance Committee	Cardiopulmonary Wellness Center (CPWC) Relocation	$5.0M	03/2022
2/10/2021	ECH Board	Women's Hospital Expansion Project	$149M	09/2021
5/24/2021	Finance Committee	MV Wireless / DAS Network Upgrades	$3.3M	04/2022
8/9/2021	ECH Board	MV Cath. Lab Replacement Project	$19.5M	05/2022
8/9/2021	ECH Board	Pyxis MedStation Replacement Project	$6.64M	04/2022
8/9/2021	Finance Committee	ECHMN Clinic Relocation	$3.09M	01/2022
10/13/2021	ECH Board	Real Estate Transaction	$14.65M	01/2022
11/22/2021	Finance Committee	LG Interventional radiology Equipment Replacement	$3.86M	01/2023
11/22/2021	Finance Committee	LG Nuclear Medicine Equipment Replacement & Code Upgrades	$2.4M	01/2023
11/22/2021	Finance Committee	LG Operating Room Sterile Processing Update	$2.386M	01/2023
1/31/2022	Finance Committee	MV Lab Chemistry Line	$2.8M	02/2023

Updated 5/20/22

KaufmanHall

MAY 2022

The Financial Effects of Hospital Workforce Dislocation

A Special Workforce Edition of the National Hospital Flash Report

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The Financial Effects of Hospital Workforce Dislocation: A Fact Base

The pandemic and its complex social and economic effects have dislocated the modern workforce, creating an intense and likely long-term problem for employers across industries and for the people who rely on the workforce for important goods and services.

In healthcare, the problem is especially profound. During the pandemic, almost 1 in 5 healthcare workers quit their jobs.[1] One-third of nurses plan to leave their current roles by the end of 2022, with more than a quarter of those intending to become traveling nurses.[2]

At the same time, hospitals find themselves competing with non-hospital employers that are aggressively pursuing hourly staff—companies that can pass along wage increases to consumers in the form of higher prices in a way that healthcare organizations cannot.

The resulting labor shortages are a top concern for hospitals' efforts to remain financially stable and to deliver safe, high-quality care.[3]

As we speak with CEOs around the country, their first word is usually "workforce."

We hear a number of observations about what may be contributing to the problem, about the damage the problem is causing, and about the short-term and long-term actions that need to be taken to stabilize the workforce.

However, the first desire expressed by healthcare executives and boards is for a fact base on which to base their next moves.

Leaders seek to understand the dimension of the problem: how their local situation compares with other hospitals regionally and nationally, and what the effects have been on an expense base already under pressure and on margins already narrow to negative from the pandemic.

In a Special Workforce Edition of Kaufman Hall's *National Hospital Flash Report*, we provide that critical fact base.

Sources:
1. Galvin, G.: "Nearly 1 in 5 Health Care Workers Have Quit Their Jobs During the Pandemic," *Morning Consult*, Oct. 4, 2021.
2. *Study: 34% of Nurses Plan to Leave their Current Role by the End of 2022*, Incredible Health, 2021.
3. Special Report: Top 10 Patient Safety Concerns 2022. ECRI and the Institute for Safe Medication Practices, 2022.

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The Financial Effects of Hospital Workforce Dislocation: A Fact Base (continued)

Following are some of our key findings:

- **Nationally, hospital labor expenses increased by more than one-third from pre-pandemic levels**
- **The largest increases were in the South and West, while the highest expense levels consistently were in the West and Northeast/Mid-Atlantic**
- **Contract labor as a percentage of total labor expenses increased more than five times the rate from pre-pandemic levels**
- **As of March 2022, the median wage rate for contract nurses had risen to more than three times that of employed nurses**
- **In the first three months of 2022, hospitals saw dramatic declines in YTD operating margin in a perfect storm of expense, volume, and revenue pressures attributable largely to the effects of COVID**

These findings suggest that healthcare leaders will need to confront the workforce challenge on multiple levels. Financial plans will need to be reworked to accommodate higher labor expenses moving forward. Recruitment and retention strategies will need to be sensitive to subtly different segments of people and jobs. Real-time data will need to be used to improve process and workforce efficiency. And the nature of work itself will have to be redefined for the new socio-economic environment.

For the sake of patients and communities, and for the workers who have given so much of themselves during the unbelievable stress of the pandemic, healthcare executives will need to bring their most flexible attitudes and their most creative thinking to a challenge of great dimension and even greater complexity.

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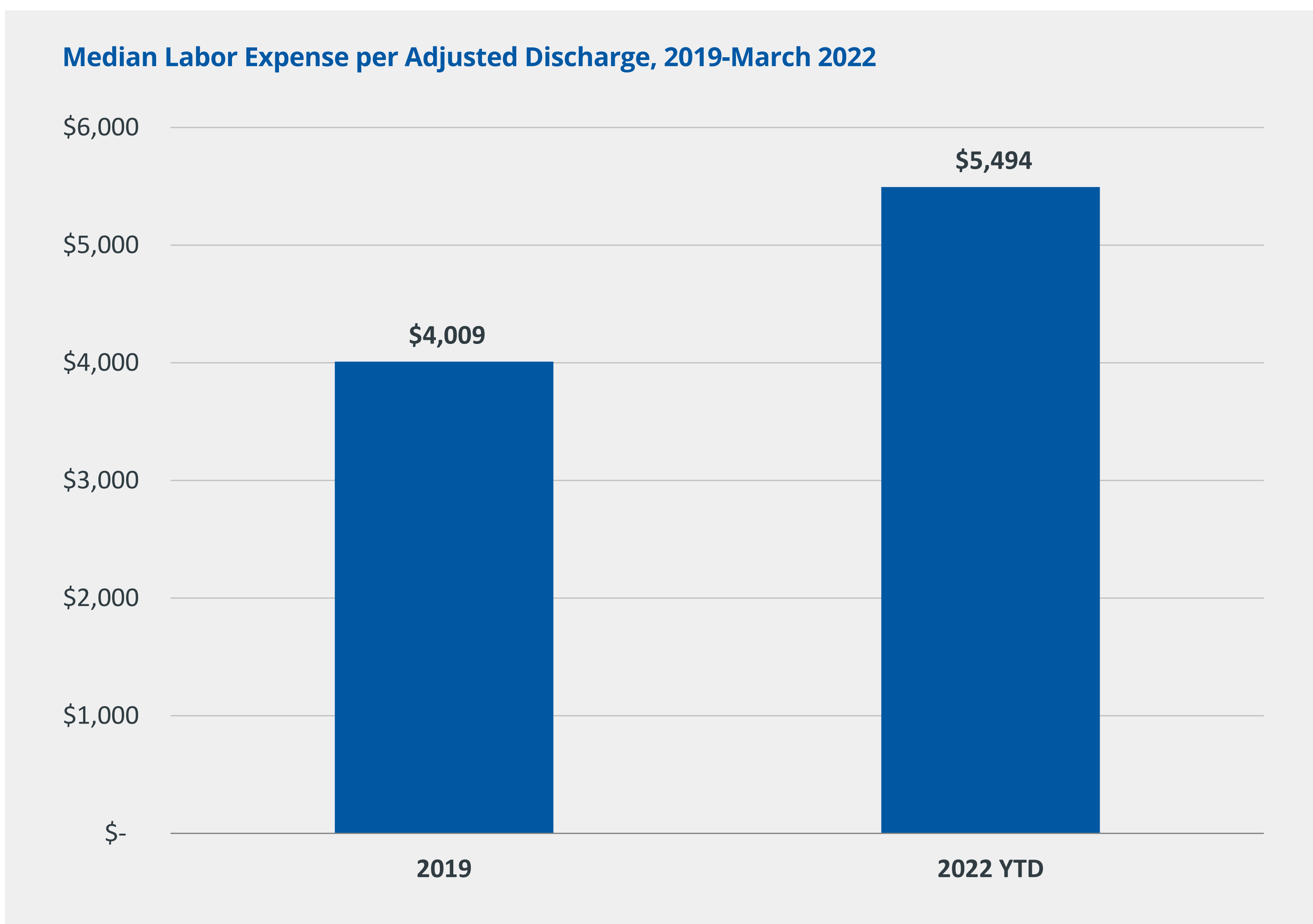
Labor Expenses Increased More than One-Third from Pre-Pandemic Levels



- Labor expense per adjusted discharge increased by more than one-third from pre-pandemic levels through March 2022
- Labor as a percentage of total expenses increased from 46% to 49% during this same period
- These expense increases were due largely to labor shortages, leading to the increased use of more expensive contract labor, as shown in the following pages

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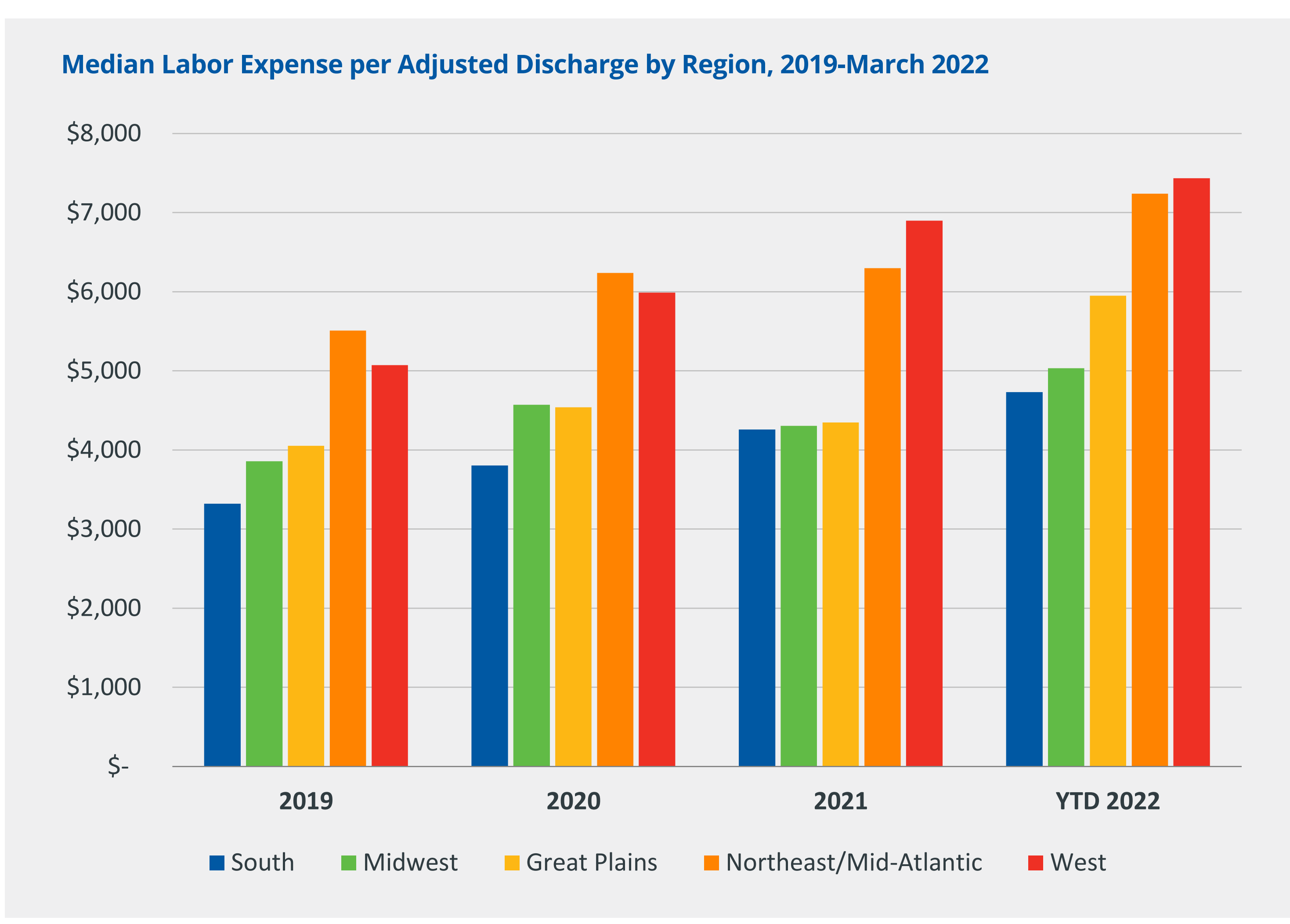
The South and West Had the Biggest Increases in Labor Expenses



- All regions had notable increases in labor expenses from pre-pandemic levels through March 2022
- The South and West had the highest percentage increases in labor costs, 43% and 42% respectively
- The West and Northeast/ Mid-Atlantic regions consistently had the highest labor expenses across this time period

Source: Kaufman Hall

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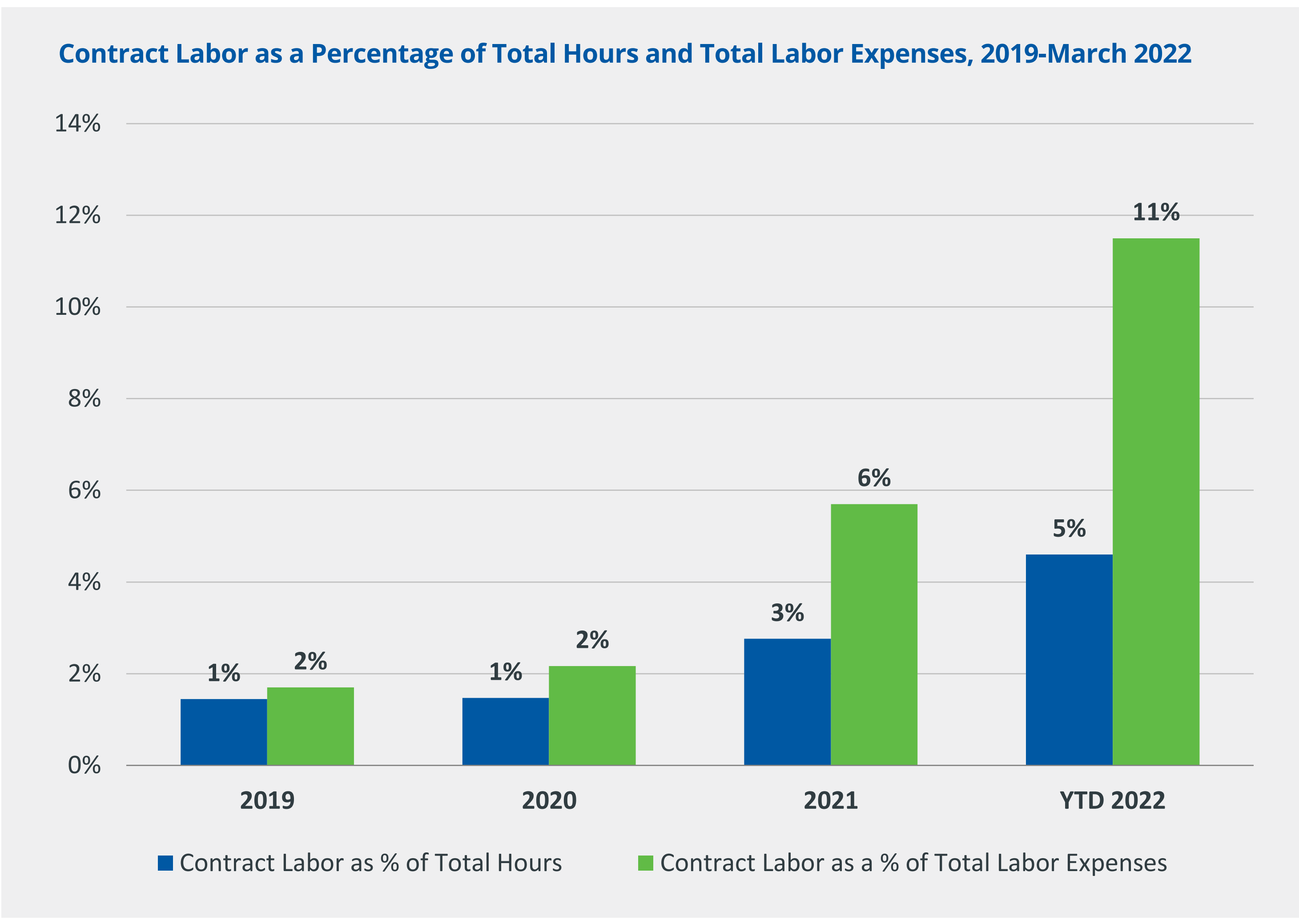
Contract Labor Was a Major Factor in Rising Hospital Expenses



- The use of contract labor rose significantly from 2019 through March 2022, while the cost of contract labor rose even more dramatically
- Contract labor as a percentage of total labor expenses increased more than five times the rate from pre-pandemic levels

Source: Kaufman Hall

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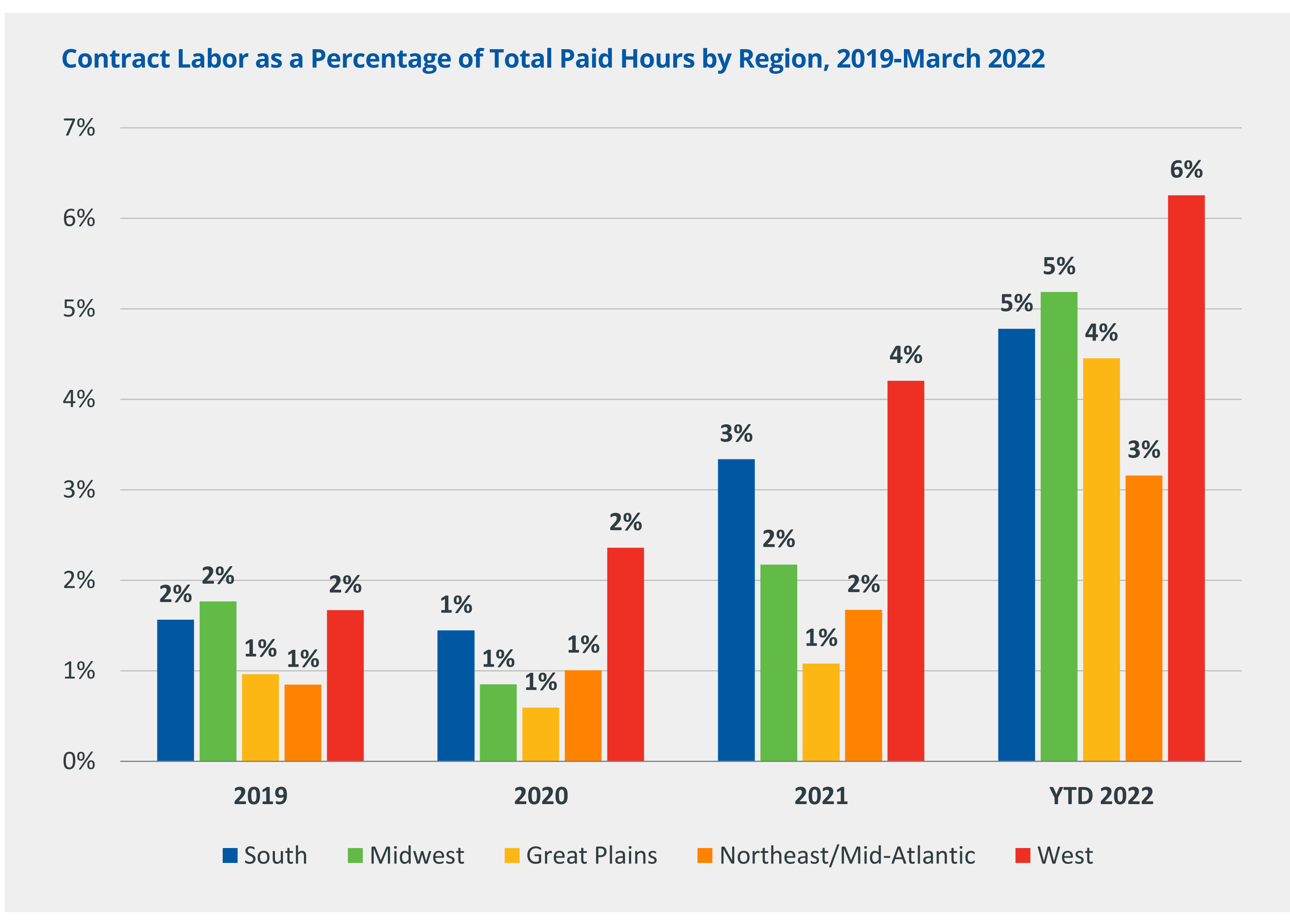
Use of Contract Labor Increased at Least Two Times Pre-Pandemic Levels in All Regions



- Hospitals in all regions used far more contract labor in 2021 and 2022
- Contract labor as a percentage of total paid hours increased more than two times the rate from pre-pandemic levels in the South and Midwest, and from three to four times pre-pandemic level rates in the Great Plains, Northeast/ Mid-Atlantic, and West

Source: Kaufman Hall

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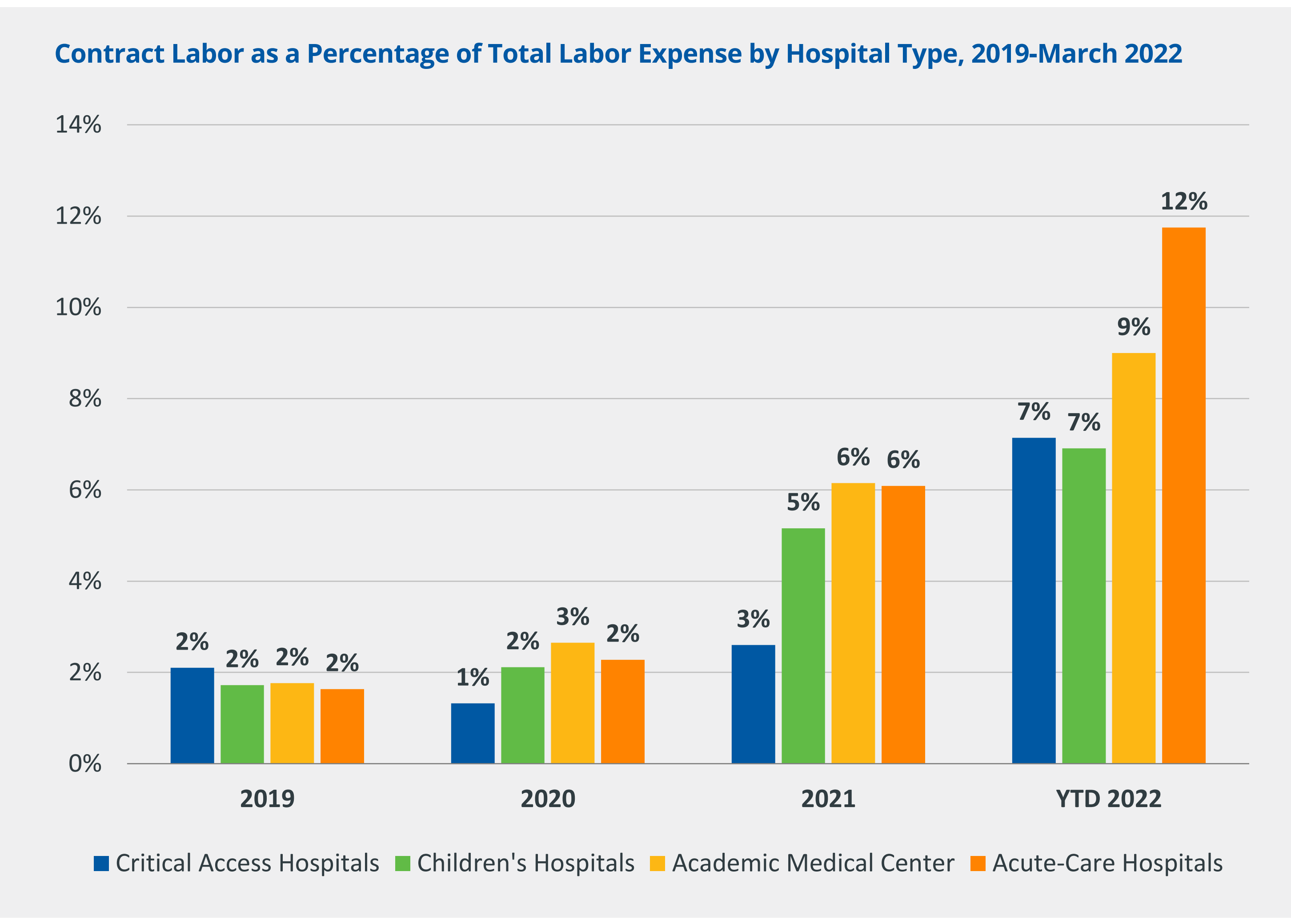
In All Hospital Types, Contract Labor Expenses Increased Dramatically as a Portion of Total Labor Expense



- All hospital types had major increases in contract labor as a percentage of total labor expense
- Contract labor as a percentage of total labor expense increased more than three times the rate from pre-pandemic levels for critical access and children's hospitals, more than four times for academic medical centers, and six times for acute-care hospitals

Source: Kaufman Hall

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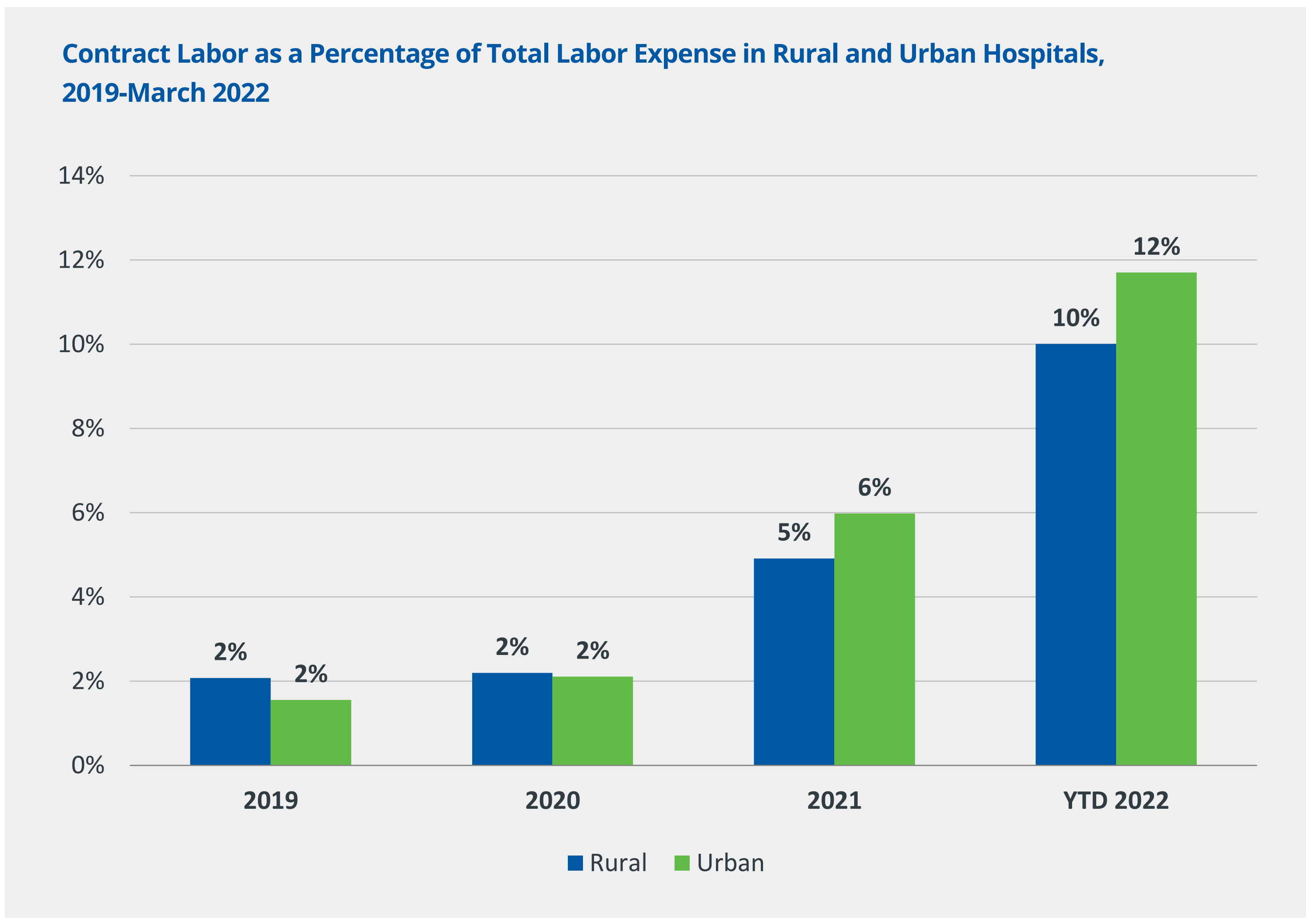
Rural and Urban Hospitals Both Experienced Increases in Contract Labor Expenses



- Both rural and urban hospitals experienced a dramatic increase in contract labor as a percentage of total labor expenses
- The increase was somewhat greater for hospitals in urban areas

Source: Kaufman Hall

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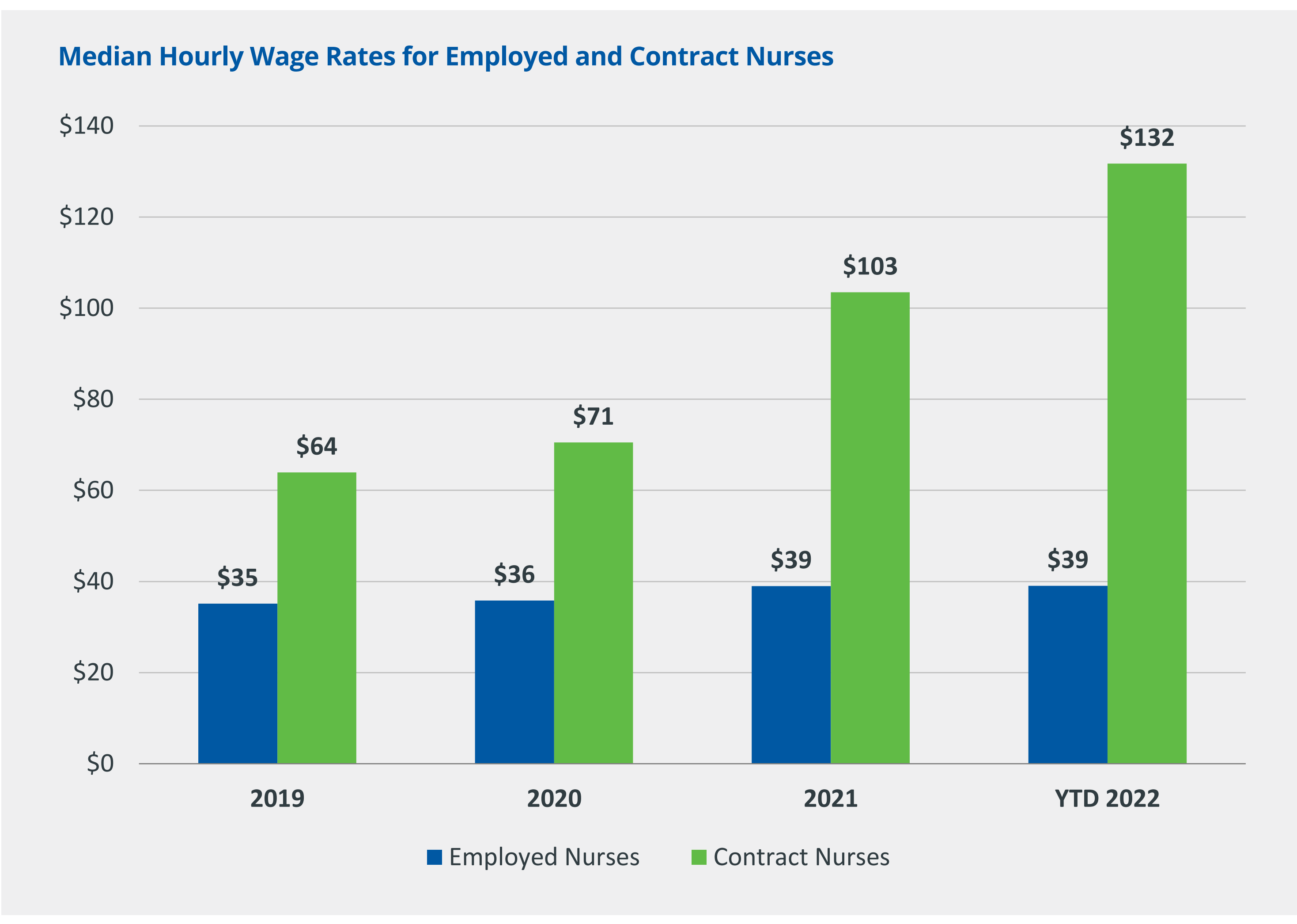
As Demand for Contract Labor Increased, So Did Its Wage Rates



- Pre-pandemic, wage rates for contract nurses were almost double those for employed nurses
- As the pandemic continued and labor shortages intensified, that wage gap increased significantly
- As of March 2022, the median wage rate for contract nurses was more than three times higher than the wage rate for employed nurses

Source: Kaufman Hall

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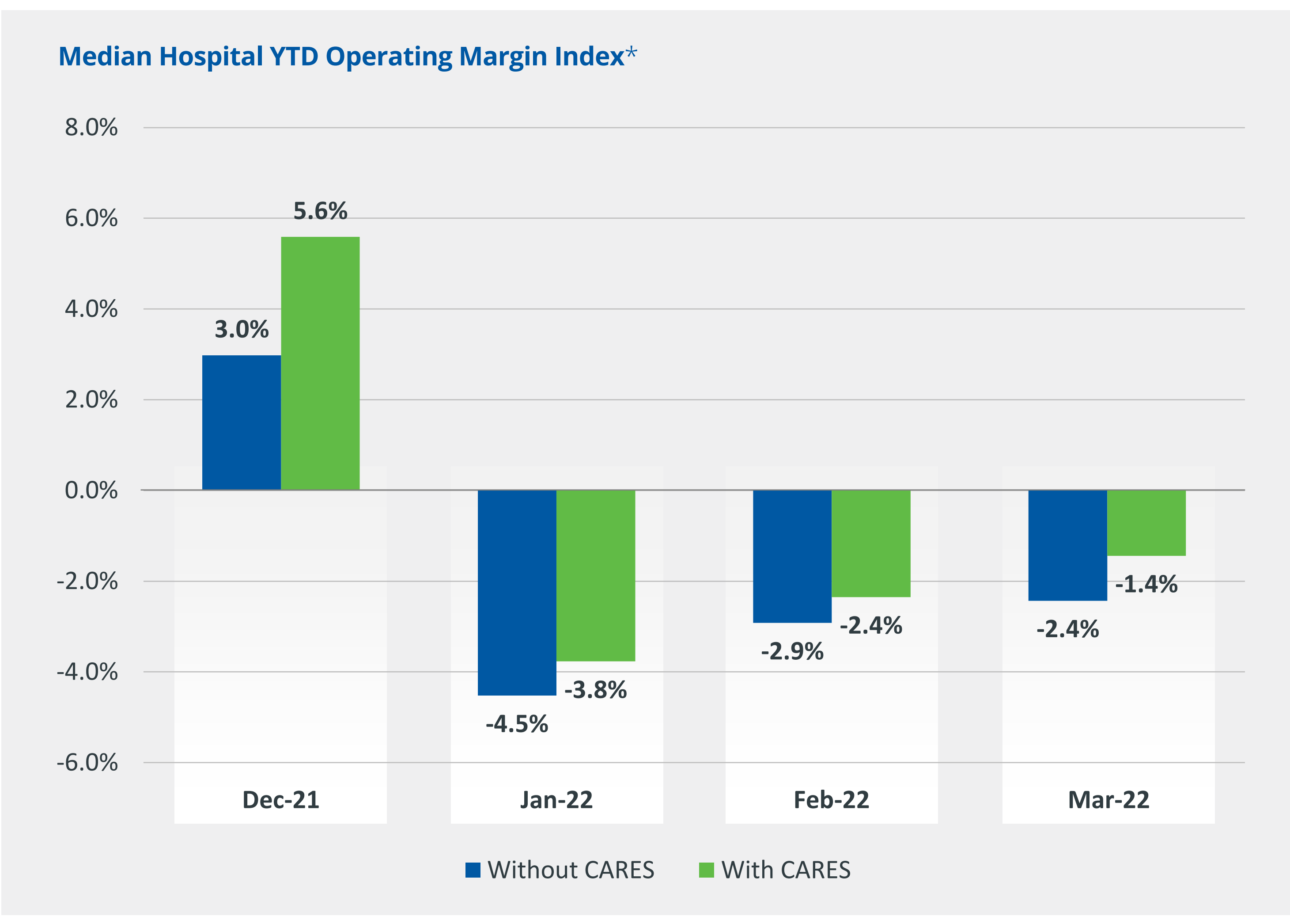
A Combination of Expense, Volume, and Revenue Pressures Led to Steep Margin Declines So Far in 2022



- In the first three months of 2022, hospitals saw dramatic declines in YTD operating margin
  - Between December 2021 and March 2022, median operating margins with CARES funding fell from 5.6% to -1.4%
  - Not including CARES funding, margins fell from 3% to -2.4% during that same period
- These declines came from a perfect storm of expense, volume, and revenue pressures attributable largely to the effects of COVID

*Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.
Source: Kaufman Hall National Hospital Flash Report

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About the Data

This Special Workforce Edition of the National Hospital Flash Report uses actual data over the last three years, sampled from more than 900 hospitals on a recurring monthly basis from Syntellis Performance Solutions.

The sample of hospitals for this report is representative of all hospitals in the United States both geographically and by bed size. Additionally, hospitals of all types are represented, from large academic to small critical access. Advanced statistical techniques are used to standardize data, identify and handle outliers, and ensure statistical soundness prior to inclusion in the report.

While this report presents data in the aggregate, Syntellis Performance Solutions also has real-time data down to individual department, job code, pay type, and account levels, which can be customized into peer groups for comparisons to drive operational decisions and performance improvement initiatives.

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BECKER'S
Hospital CFO Report

Hospitals' finances are hurting

Alia Paavola – May 12, 2022

Many hospitals and health systems across the U.S. are feeling the effects of higher expenses and market volatility in the first quarter of 2022.

Several health systems recently reported their financial results for the quarter ended March 31, posting both operating deficits and investment losses.

Altamonte Springs, Fla.-based AdventHealth, for example, recorded a $417.7 net loss in the first quarter of 2022, driven by both investment and operating losses. Although the 48-hospital system saw its revenue increase, its expenses grew by 15 percent. After factoring in the $3.7 billion in expenses, AdventHealth ended the first quarter of 2022 with an operating loss of $46.8 million. The health system also faced market volatility, posting a $372.2 million investment loss.

And AdventHealth is not alone.

Another example is Oakland, Calif.-based Kaiser Permanente, which recorded a net loss of $961 million in the first quarter of 2022. For the quarter ended March 31, the integrated healthcare system saw an operating loss of $72 million and $889 million in losses for nonoperating items, including investment losses. The health system attributed the operating loss to an increase in overall expenses, which rose 9.5 percent to $24.3 billion.

Additionally, St. Louis-based Ascension ended the first quarter of 2022 with an operating loss of $671.1 million and a net loss of $884.7 million. Ascension said its operating expenses ballooned during the first quarter to $7.3 billion, up from $6.6 billion recorded the same period one year prior. It also reported investment losses.

Single payer in California in governor's court after release of feasibility report

Jakob Emerson – April 28, 2022

Gov. Gavin Newsom's commission on the feasibility of a single-payer healthcare system in California released its final report April 25, but it leaves more questions than answers, according to *CalMatters.*

The Healthy California for All Commission endorsed "unified financing" that would pay for a single-payer system in the nation's largest state, but it did not offer a specific proposal for legislation going forward.

While campaigning for governor, Mr. Newsom called for a state-sponsored single-payer system that would cover all 39 million Californians with little to no out-of-pocket expenses.

"I'm tired of politicians saying they support single-payer but that it's too soon, too expensive or someone else's problem," Mr. Newsom said in 2017.

The California Senate passed a single-payer bill the same year, but it lacked a financing system and stalled out. Mr. Newsom commissioned the report to study how to implement a single-payer system in the state. In 2022, similar legislation with a financing system also stalled out in the state's legislature.

The report said that if the state took all current federal, state and local government healthcare spending and then raised taxes, a single-payer system could slow the increase in costs, which total $517 billion annually, and still extend coverage to all state residents.

The report included a list of options to get to single payer rather than a single proposal, leaving questions such as how the state would gain approval from the federal government, which taxes would be raised and on whom, what services the system would cover, if the new system would include copays, and how care would be structured, according to *CalMatters.*

California would have to convince the federal government to continue giving it the tens of billions spent on Medicare, Medi-Cal, the ACA and other federally financed programs, and raise at least $200 billion in new taxes.

"A system of unified financing is uniquely positioned to transform care delivery and to shift the power that lies in health and healthcare to benefit those who have too often been overlooked," commission chair Mark Ghaly, MD, said.

https://www.beckerspayer.com/payer/single-payer-in-california-in-governor-s-court-after-release-of-feasibility-report.html?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=0328I8610890I9O

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Finance Committee
From: Stephanie Iljin, Manager of Administration
Date: May 26, 2022
Subject: Report on Board Actions

Purpose: To keep the Committee informed regarding actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. Situation: It is essential to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive; still, it includes agenda items the Board voted on that are most likely to be of interest to or pertinent to El Camino Hospital's Board Advisory Committees.
2. Authority: This is being brought to the Committees at the request of the Board and the Committees.
3. Background: Since the last time we provided this report to the Finance Committee, the Hospital Board has met two times, and the District Board has met once. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	April 27, 2022	- Education Session to discuss the Enterprise Strategy with the Board and Advisory Committee Members • Strategic Framework focused on the three major areas (ACE) o Alignment with Physicians o Leadership in Clinical Program o Expanding our Reach
	May 11, 2022	- Resolution 2022-05: Recognizing retired auxiliary member Judy Van Dyck - Board Officer Elections Procedure - Credentialing and Privileges Report - FY 22 Period 9 Financials - Resolution 2022-06: Approving OB/GYN Call Panel Agreement for Carol A. Somersille, MD

Report on Board Actions
May 26, 2022

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECHD Board	May 17, 2022	- Resolution 2022-04: El Camino Health District Mission Statement Review Ad Hoc Committee Formation, Appointment of Director John Zoglin - Resolution 2022-06: Community Benefit Spotlight: Women SV - Community Benefits Mid-Year Update - Report on COVID-19 Community Program - FY 23 El Camino Healthcare District Policy Bylaw Review Ad-Hoc Committee Recommendation: • P.2 Compliance Review Process • P.3 Director Compensation Policy • P.6 Appointment of Board Members to El Camino Hospital Board
Executive Compensation Committee	May 18, 2022	- FY 23 Committee Planning (goals, pacing plan, meetings dates, charter) - Proposed FY23 Organizational Performance Incentive Goals - Proposed FY 23 Individual Executive Strategic Pick Goals - Proposed Salary Range Change & Base Salary Change for VP Payor Relations - Executive Performance Incentive Plan
Compliance and Audit Committee	May 19, 2022	- FY 23 Committee Goals - Review Internal Audit Assessment & Proposed FY 23 Internal Audit Work Plan - Compliance Work Plan Updates FY 22
Finance Committee	- N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Summary of Financial Operations

Fiscal Year 2022 – Period 10

7/1/2021 to 04/30/2022

Executive Summary - Overall Commentary for Period 10

- **Solid financial results for Period 10:**
  - Revenue driven by continued strong outpatient procedural volumes complimented by solid Inpatient activity
    - Outpatient activity driven by Radiation Oncology, Emergency Room, Surgery and Interventional Services
  - Continued effective cost control. When adjusted for volume, overall costs are below target levels
    - Cost per CMI Adjusted Discharge was 8.7% favorable to budget
    - Third consecutive month with improved Overtime/Premium pay performance
  - Consistent Payor Mix
- Total gross charges were favorable to budget by $43.9M / 11.6% and $45.9M / 12.2% higher than the same period last year
  - Outpatient charges were favorable by $32.7M / 19.1% while Inpatient charges were favorable by $9.3M / 4.7%.
- Net patient revenue was favorable to budget by $9.1M / 9.6% and $9.8M / 10.4% higher than the same period last year
- Operating margin was favorable to budget by $3.2M / 47.6% and $2.7M / 37.4% higher than the same period last year
- Operating EBIDA was favorable to budget by $4.1M / 30.2% and $3.6M / 24.8% better than the same period last year
- Net income was unfavorable to budget by $61.0M / (417.0%) and $82.8M / (227.2%) lower than the same period last year. This is attributed the continued instability in the capital markets which negatively impacts investment income.

Operational / Financial Results: Period 10 – April 2022 (as of 04/30/2022)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	268	258	11	4.2%	235	33	14.1%	---	---	---
	Total Acute Discharges	1,802	1,674	128	7.7%	1,624	178	11.0%	---	---	---
	Adjusted Discharges	3,559	3,107	451	14.5%	3,282	277	8.4%	---	---	---
	Emergency Room Visits	5,421	4,357	1,064	24.4%	4,750	671	14.1%	---	---	---
	OP Procedural Cases	12,159	10,334	1,825	17.7%	15,115	(2,956)	(19.6%)	---	---	---
	Gross Charges ($)	421,254	377,400	43,854	11.6%	375,480	45,774	12.2%	---	---	---
Operations	Total FTEs	3,180	3,063	116	3.8%	2,894	286	9.9%	---	---	---
	Productive Hrs. / APD	30.2	31.2	(1.0)	(3.3%)	30.9	(0.7)	(2.2%)	---	---	---
	Cost Per CMI AD	16,390	17,952	(1,562)	(8.7%)	15,987	402	2.5%	---	---	---
	Net Days in A/R	55.2	49.0	6.2	12.6%	50.6	4.6	9.2%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	104,774	95,630	9,145	9.6%	94,903	9,872	10.4%	138,547	82,105	
	Total Operating Revenue ($)	109,067	99,108	9,960	10.0%	98,595	10,472	10.6%	152,743	109,602	
	Operating Margin ($)	**10,020**	**6,787**	**3,233**	47.6%	**7,294**	**2,726**	37.4%	**1,915**	**3,836**	
	Operating EBIDA ($)	**17,851**	**13,715**	**4,136**	30.2%	**14,301**	**3,550**	24.8%	**11,188**	**10,741**	
	Net Income ($)	(46,369)	14,627	(60,996)	(417.0%)	36,445	(82,814)	(227.2%)	8,124	7,343	
	Operating Margin (%)	**9.2%**	**6.8%**	**2.3%**	34.1%	**7.4%**	**1.8%**	24.2%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**16.4%**	**13.8%**	**2.5%**	18.3%	**14.5%**	**1.9%**	12.8%	**8.3%**	**9.8%**	
	DCOH (days)	292	325	(33)	(10.1%)	374	(82)	(21.9%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021. Dollar amounts have been adjusted to reflect monthly averages.
DCOH total includes cash, short-term and long-term investments.

Legend
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: YTD FY2022 (as of 04/30/2022)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	273	254	19	7.7%	241	32	13.2%	---	---	---
	Total Acute Discharges	17,679	16,716	963	5.8%	15,644	2,035	13.0%	---	---	---
	Adjusted Discharges	34,578	30,929	3,649	11.8%	29,526	5,052	17.1%	---	---	---
	Emergency Room Visits	55,427	43,598	11,829	27.1%	41,838	13,589	32.5%	---	---	---
	OP Procedural Cases	127,926	102,396	25,530	24.9%	134,593	(6,667)	(5.0%)	---	---	---
	Gross Charges ($)	4,231,360	3,782,874	448,487	11.9%	3,519,291	712,070	20.2%	---	---	---
Operations	Total FTEs	3,076	3,074	2	0.1%	2,825	251	8.9%	---	---	---
	Productive Hrs. / APD	28.8	31.6	(2.8)	(8.8%)	31.3	(2.4)	(7.8%)	---	---	---
	Cost Per CMI AD	16,476	17,952	(1,476)	(8.2%)	17,070	(594)	(3.5%)	---	---	---
	Net Days in A/R	55.2	49.0	6.2	12.6%	50.6	4.6	9.2%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	1,081,231	953,727	127,505	13.4%	900,131	181,101	20.1%	1,385,473	821,046	
	Total Operating Revenue ($)	1,117,871	990,677	127,195	12.8%	938,471	179,401	19.1%	1,519,093	1,096,021	
	Operating Margin ($)	**140,532**	**66,763**	**73,769**	110.5%	**54,659**	**85,873**	157.1%	**19,148**	**38,361**	
	Operating EBIDA ($)	**215,859**	**136,878**	**78,981**	57.7%	**124,789**	**91,070**	73.0%	**111,883**	**107,410**	
	Net Income ($)	36,373	143,193	(106,820)	(74.6%)	258,791	(222,418)	(85.9%)	81,244	73,433	
	Operating Margin (%)	**12.6%**	**6.7%**	**5.8%**	86.5%	**5.8%**	**6.7%**	115.8%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**19.3%**	**13.8%**	**5.5%**	39.8%	**13.3%**	**6.0%**	45.2%	**8.3%**	**9.8%**	
	DCOH (days)	292	325	(33)	(10.1%)	374	(82)	(21.9%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
DCOH total includes cash, short-term and long-term investments.

Legend
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Key Statistics: Period 10 and YTD (as of 04/30/2022)

Key Metrics	Month to Date PY	Month to Date CY	Month to Date Budget	Variance (%) CY vs PY	Variance (%) CY vs Budget	Year to Date PY	Year to Date CY	Year to Date Budget	Variance (%) CY vs PY	Variance (%) CY vs Budget
ADC	235	268	258	14.1%	4.2%	241	273	254	13.2%	7.7%
Utilization MV	63%	71%	68%	12.8%	3.9%	63%	72%	67%	14.4%	7.5%
Utilization LG	29%	34%	33%	20.2%	5.6%	31%	34%	31%	8.6%	8.4%
Utilization Combined	52%	59%	57%	14.1%	4.2%	53%	60%	56%	13.3%	7.7%
Adjusted Discharges	3,282	3,559	3,107	8.4%	14.5%	29,526	34,578	30,929	17.1%	11.8%
Total Discharges (Exc NB)	1,624	1,802	1,674	11.0%	7.7%	15,644	17,679	16,716	13.0%	5.8%
Total Discharges	1,947	2,176	2,040	11.8%	6.7%	18,876	21,624	20,461	14.6%	5.7%
Inpatient Case Activity										
MS Discharges	1,125	1,252	1,125	11.3%	11.3%	10,708	11,922	11,172	11.3%	6.7%
Deliveries	342	406	384	18.7%	5.9%	3,457	4,262	3,943	23.3%	8.1%
BHS	124	104	122	(16.1%)	(14.4%)	1,074	1,113	1,161	3.6%	(4.2%)
Rehab	33	38	44	15.2%	(13.6%)	407	370	440	(9.1%)	(15.9%)
Outpatient Case Activit										
Total Outpatient Cases	18,471	16,537	13,564	-10.5%	21.9%	165,117	170,828	134,815	3.5%	26.7%
ED	3,356	4,378	3,230	30.5%	35.5%	30,524	42,902	32,419	40.6%	32.3%
OP Surg	628	575	435	(8.4%)	32.1%	5,256	5,924	4,501	12.7%	31.6%
Endo	228	213	200	(6.6%)	6.5%	2,116	2,349	2,126	11.0%	10.5%
Interventional	234	182	181	(22.2%)	0.6%	1,769	1,941	1,747	9.7%	11.1%
All Other	14,025	11,189	9,518	(20.2%)	17.6%	125,452	117,712	94,022	(6.2%)	25.2%
Hospital Payor Mix										
Medicare	50.8%	49.2%	48.3%	(3.0%)	1.9%	48.6%	48.1%	47.8%	(1.0%)	0.6%
Medi-Cal	7.6%	7.6%	8.1%	(0.1%)	(6.5%)	8.2%	8.1%	8.0%	(0.7%)	1.6%
Commercial	39.4%	41.0%	41.3%	4.0%	(0.7%)	40.9%	41.7%	42.1%	1.8%	(1.0%)
Other	2.2%	2.2%	2.4%	(0.6%)	(7.4%)	2.3%	2.1%	2.1%	(7.9%)	0.5%

Enterprise Income Statement: Rolling 16 Monthly Trend *($000s)*

	FY2021						FY2022											
	Period 7 Jan-21	Period 8 Feb-21	Period 9 Mar-21	Period 10 Apr-21	Period 11 May-21	Period 12 Jun-21	Period 1 Jul-21	Period 2 Aug-21	Period 3 Sep-21	Period 4 Oct-21	Period 5 Nov-21	Period 6 Dec-21	Period 7 Jan-22	Period 8 Feb-22	Period 9 Mar-22	Period 10 Apr-22	YTD FY2022	Rolling 16 Monthly Average
Operating Revenues:																		
Net Patient Revenue	89,795	85,273	97,171	94,903	95,542	112,238	101,774	104,482	104,776	106,632	107,257	113,033	109,378	105,960	123,165	104,774	1,081,231	103,510
Other Operating Revenue	4,427	3,352	3,537	3,692	5,385	4,706	3,116	3,746	3,479	4,506	3,600	3,648	3,362	3,313	3,577	4,293	36,640	3,859
Total Operating Revenue	**94,222**	**88,625**	**100,708**	**98,595**	**100,927**	**116,945**	**104,889**	**108,228**	**108,256**	**111,138**	**110,857**	**116,681**	**112,741**	**109,273**	**126,741**	**109,067**	**1,117,871**	**107,368**
Operating Expenses:																		
Salaries, Wages and Benefits	53,636	48,592	52,025	50,616	48,138	48,101	53,000	53,940	53,629	56,001	53,709	55,947	59,347	55,256	60,098	57,347	558,274	53,711
Supplies	13,888	13,587	15,421	14,256	15,241	15,156	15,109	14,569	14,862	14,502	14,941	16,060	16,051	15,296	17,661	15,225	154,275	15,114
Fees & Purchased Services	15,825	14,770	15,139	15,761	15,923	19,915	14,390	14,182	14,800	14,760	15,210	14,955	14,291	16,550	17,352	15,127	151,617	15,559
Other Operating Expenses	3,819	1,097	3,536	3,662	3,496	6,002	3,598	3,577	3,676	3,586	3,842	4,112	3,829	4,290	3,821	3,517	37,847	3,716
Interest	1,428	1,392	1,399	1,400	1,400	1,367	1,419	1,418	1,418	1,418	1,420	1,419	1,421	1,380	1,384	1,394	14,090	1,405
Depreciation	5,689	5,903	4,931	5,606	4,808	5,740	4,727	7,157	5,902	5,798	6,440	6,173	6,046	6,311	6,246	6,438	61,236	5,870
Total Operating Expenses	**94,284**	**85,341**	**92,450**	**91,301**	**89,006**	**96,281**	**92,242**	**94,844**	**94,286**	**96,065**	**95,561**	**98,665**	**100,984**	**99,084**	**106,561**	**99,048**	**977,339**	**95,375**
Operating Margin	**(62)**	**3,285**	**8,258**	**7,294**	**11,921**	**20,664**	**12,648**	**13,384**	**13,970**	**15,073**	**15,297**	**18,016**	**11,756**	**10,189**	**20,180**	**10,020**	**140,532**	**11,993**
Non-Operating Income	39	14,349	18,965	29,151	16,666	20,041	(4,099)	14,319	(18,378)	24,361	(21,232)	17,581	(31,539)	(32,720)	3,935	(56,388)	(104,159)	(309)
Net Margin	**(23)**	**17,633**	**27,223**	**36,445**	**28,588**	**40,705**	**8,549**	**27,703**	**(4,408)**	**39,435**	**(5,935)**	**35,596**	**(19,783)**	**(22,531)**	**24,115**	**(46,369)**	**36,373**	**11,684**
Operating EBIDA	**7,055**	**10,580**	**14,588**	**14,301**	**18,130**	**27,771**	**18,793**	**21,959**	**21,289**	**22,290**	**23,156**	**25,608**	**19,223**	**17,881**	**27,810**	**17,851**	**215,859**	**19,268**
Operating Margin (%)	-0.1%	3.7%	8.2%	7.4%	11.8%	17.7%	12.1%	12.4%	12.9%	13.6%	13.8%	15.4%	10.4%	9.3%	15.9%	9.2%	12.6%	11.2%
Operating EBIDA Margin (%)	**7.5%**	**11.9%**	**14.5%**	**14.5%**	**18.0%**	**23.7%**	**17.9%**	**20.3%**	**19.7%**	**20.1%**	**20.9%**	**21.9%**	**17.1%**	**16.4%**	**21.9%**	**16.4%**	**19.3%**	**17.9%**

Financial Overview: Period 10 – April 2022

Period ending 4/30/2022

Financial Performance

- April operating margin was $10.0M compared to a budget of $6.8M, resulting in a favorable variance of $3.2M
- April volumes and revenues continued to be ahead of budgeted levels:
  - Favorable variance of gross charges of $42.0M was driven primarily by Outpatient activity:
    - Inpatient gross charges: Favorable to budget by $9.3M / 4.7% variance primarily driven by interventional and surgical inpatient services, neonatal intensive care, and corresponding ancillary services
    - Outpatient gross charges: Favorable to budget by $32.7M / 19.1% variance primarily driven by radiation oncology, emergency, outpatient surgery, interventional services, and corresponding ancillary services
  - Operating Expenses were unfavorable to budget by $6.7M / 7.3% driven by the high level of patient activity
    - SWB were unfavorable by $4.9M / 9.4%
    - Supplies were unfavorable by $622K / 4.3%
      - Supply expenses attributed to Covid-19 were $605K in March and $8.2M YTD
    - All other discretionary non-volume driven expenses were unfavorable to budget by $1.2M
- Unfavorable market performance drove unrealized losses for the investment portfolio, which resulted in negative net income for period 10

Financial Overview: Period 10 – April 2022 (cont.)

Period ending 4/30/2022

Financial Performance

Hospital Operations:

- Adjusted Discharges (AD): Favorable to budget by 452 ADs / 14.5% and above prior year by 277 ADs / 8.4%:
  - Mountain View: Favorable to budget by 338 ADs / 13.3% and above prior year by 142 ADs / 5.9%
  - Los Gatos: Favorable to budget by 114 ADs / 16.0% and above prior year by 135 ADs / 19.6%
- Operating Expense Per CMI Adjusted Discharge: $16,390 which is 8.7% favorable to budget
  Note: Excludes depreciation and interest

El Camino Health Medical Network (ECHMN) Operations:

- April's total visits of 16,069 reflect a decrease of 11.6% over the prior month of 18,183. April's visit per day of 745 also reflect a decrease of 4% over the prior month of 776. Decreases occurred in Willow Glen, McKee and Winchester. However, there were increases occur in Mountain View and Cupertino Urgent Care compared to prior month.
- April's total visits were unfavorable to budget by 3%. April's YTD total visits were also unfavorable to budget by 3%. The YTD budget variance is related to the loss of several OB/GYN providers and closure of Gilroy clinic.
- Net Income for the month of April was favorable to budget by $240K or 8.7%. YTD Net Income was favorable to budget by $36K or 0.1%. Compared to last year, April FY2022's Net Income was favorable by $711K or 22% and the YTD was favorable by $2.8M or 9%.

Financial Overview: YTD FY2022 (as of 4/30/2022)

Consolidated Financial Performance

- YTD FY2022 operating margin is $140.5M compared to the budget of $66.7M
- Operating expense is $977.3M / 5.8% unfavorable to budget
  - When adjusted for volume levels, Operating Expense per CMI Adjusted Discharge is $16,476 which is 8.2% favorable to budget. This continues to demonstrate effective management of variable expenses and the impact of initiatives implemented by management

  Note: Excludes depreciation and interest expense
- Year-over-year operating margin is $85.9M higher than the same period last year, which is primarily due to the strength in volumes as exhibited by year over year growth in:
  - Outpatient Surgeries: +12.7% primarily driven my Heart/Vascular, Orthopedic & Spine, and Urology surgery activity and their associated ancillary activity.
  - Emergency Room Visits: 40.6%
  - Deliveries - Maternal Child services: 23.3%
- Year-over-year net margin is $222.4M lower than the same period last year, which is attributed to lower investment income.

APPENDIX

YTD FY2022 Financial KPIs – Monthly Trends

Consolidated Operating Margin ($000s)

Current & Prior Fiscal Year

Thousands

$25,000
$20,000
$15,000
$10,000
$5,000
$0
($5,000)

JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN

Actual — Prior Year — Budget

Hospital Adjusted Discharges

4,000
3,500
3,000
2,500
2,000
1,500
1,000

JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN

Actual — Prior Year — Budget

Hospital Payor Mix

60%
50%
40%
30%
20%
10%
0%

2021 MAY, 2021 JUN, 2022 JUL, 2022 AUG, 2022 SEP, 2022 OCT, 2022 NOV, 2022 DEC, 2022 JAN, 2022 FEB, 2022 MAR, 2022 APR

Medicare — Medi-Cal — HMO/PPO/Indemnity — Other

Consolidated Net Days in AR

65
60
55
50
45
40
35

JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN

Actual — Prior Year — Budget

Investment Scorecard (as of 03/31/2022)

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY22 Budget	Expectation Per Asset Allocation
Investment Performance		**CY 1Q 2022 / FY 3Q 2022**		**Fiscal Year-to-Date 2022**		**9y 5m Since Inception (annualized)**		**FY 2022**	**2019**
Surplus cash balance*		$1,407.1	--	--	--	--	--	--	--
Surplus cash return		-5.2%	-4.5%	-3.4%	-2.0%	6.0%	6.0%	4.0%	5.6%
Cash balance plan balance (millions)		$336.3	--	--	--	--	--	--	--
Cash balance plan return		-6.8%%	-4.6%	-4.4%	-1.2%	7.9%	7.5%	6.0%	6.0%
403(b) plan balance (millions)		$740.2	--	--	--	--	--	--	--
Risk vs. Return		**3-year**				**9y 5m Since Inception (annualized)**			**2019**
Surplus cash Sharpe ratio		0.75	0.83	--	--	0.86	0.89	--	0.34
Net of fee return		7.2%	7.6%	--	--	6.0%	6.0%	--	5.6%
Standard deviation		8.6%	8.2%	--	--	6.2%	6.0%	--	8.7%
Cash balance Sharpe ratio		0.74	0.84	--	--	0.91	0.94	--	0.32
Net of fee return		8.7%	9.0%	--	--	7.9%	7.5%	--	6.0%
Standard deviation		10.9%	9.7%	--	--	8.0%	7.3%	--	10.3%
Asset Allocation		**CY 1Q 2022 / FY 3Q 2022**							
Surplus cash absolute variances to target		3.9%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Cash balance absolute variances to target		6.2%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Manager Compliance		**CY 1Q 2022 / FY 3Q 2022**							
Surplus cash manager flags		20	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		20	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds, District assets (~$41 mm), and balance sheet cash not in investable portfolio (~$185 mm). Includes Foundation (~$42 mm) and Concern (~$14 mm) assets.

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Period 10 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 04/30/2022)

($000s)

	Period 10- Month			Period 10- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	12,922	6,954	5,968	131,737	67,206	64,531
Los Gatos	(327)	2,932	(3,259)	36,981	29,464	7,516
Sub Total - El Camino Hospital, excl. Afflilates	**12,595**	**9,885**	**2,710**	**168,718**	**96,671**	**72,047**
Operating Margin %	**12.0%**	**10.4%**		**15.8%**	**10.2%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**(54,244)**	**7,546**	**(61,790)**	**(103,015)**	**73,506**	**(176,521)**
El Camino Hospital Net Margin	**(41,649)**	**17,432**	**(59,081)**	**65,703**	**170,177**	**(104,474)**
ECH Net Margin %	**-39.7%**	**18.4%**		**6.1%**	**18.0%**	
Concern	(486)	72	(558)	(342)	699	(1,041)
Foundation	(1,721)	(123)	(1,597)	(1,496)	(155)	(1,341)
El Camino Health Medical Network	(2,513)	(2,753)	240	(27,492)	(27,528)	36
Net Margin Hospital Affiliates	**(4,720)**	**(2,804)**	**(1,915)**	**(29,330)**	**(26,984)**	**(2,346)**
Total Net Margin Hospital & Affiliates	**(46,369)**	**14,627**	**(60,996)**	**36,373**	**143,193**	**(106,820)**

Consolidated Statement of Operations *($000s)*

Period 10 ending 04/30/2022

Period 10 FY 2021	Period 10 FY 2022	Period 10 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
375,480	421,254	377,400	43,854	11.6%	**Gross Revenue**	3,519,291	4,231,360	3,782,874	448,487	11.9%
(280,577)	(316,480)	(281,770)	(34,709)	(12.3%)	**Deductions**	(2,619,160)	(3,150,129)	(2,829,147)	(320,982)	(11.3%)
94,903	**104,774**	**95,630**	**9,145**	**9.6%**	**Net Patient Revenue**	**900,131**	**1,081,231**	**953,727**	**127,505**	**13.4%**
3,692	4,293	3,478	815	23.4%	**Other Operating Revenue**	38,340	36,640	36,950	(310)	(0.8%)
98,595	**109,067**	**99,108**	**9,960**	**10.0%**	**Total Operating Revenues**	**938,471**	**1,117,871**	**990,677**	**127,195**	**12.8%**
					OPERATING EXPENSE					
50,616	57,347	52,429	(4,918)	(9.4%)	**Salaries & Wages**	492,231	558,274	521,830	(36,444)	(7.0%)
14,256	15,225	14,602	(623)	(4.3%)	**Supplies**	141,317	154,275	145,488	(8,787)	(6.0%)
15,761	15,127	14,332	(795)	(5.5%)	**Fees & Purchased Services**	145,008	151,617	144,023	(7,594)	(5.3%)
3,662	3,517	4,029	512	12.7%	**Other Operating Expense**	35,124	37,847	42,458	4,611	10.9%
1,400	1,394	1,410	17	1.2%	**Interest**	14,192	14,090	14,032	(59)	(0.4%)
5,606	6,438	5,518	(920)	(16.7%)	**Depreciation**	55,938	61,236	56,083	(5,153)	(9.2%)
91,301	**99,048**	**92,321**	**(6,727)**	**(7.3%)**	**Total Operating Expenses**	**883,812**	**977,339**	**923,913**	**(53,426)**	**(5.8%)**
7,294	**10,020**	**6,787**	**3,233**	**47.6%**	**Net Operating Margin**	**54,659**	**140,532**	**66,763**	**73,769**	**110.5%**
29,151	(56,388)	7,840	(64,228)	(819.2%)	**Non Operating Income**	204,132	(104,159)	76,430	(180,589)	(236.3%)
36,445	**(46,369)**	**14,627**	**(60,996)**	**(417.0%)**	**Net Margin**	**258,791**	**36,373**	**143,193**	**(106,820)**	**(74.6%)**
14,301	**17,851**	**13,715**	**4,136**	**30.2%**	**Operating EBIDA**	**124,789**	**215,859**	**136,878**	**78,981**	57.7%
14.5%	16.4%	13.8%	2.5%		**Operating EBIDA Margin**	13.3%	19.3%	13.8%	5.5%	
7.4%	9.2%	6.8%	2.3%		**Operating Margin**	5.8%	12.6%	6.7%	5.8%	
37.0%	-42.5%	14.8%	(57.3%)		**Net Margin**	27.6%	3.3%	14.5%	(11.2%)	

El Camino Hospital – Mountain View
Statement of Operations *($000s)*

Period 10 ending 04/30/2022

Period 10 FY 2021	Period 10 FY 2022	Period 10 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUES					
280,407	315,022	293,994	21,028	7.2%	**Gross Revenue**	2,686,024	3,194,754	2,950,480	244,274	8.3%
(209,687)	(232,665)	(220,141)	(12,524)	(5.7%)	**Deductions**	(1,997,328)	(2,363,362)	(2,216,611)	(146,751)	(6.6%)
70,720	**82,357**	**73,853**	**8,504**	**11.5%**	**Net Patient Revenue**	**688,695**	**831,392**	**733,869**	**97,523**	**13.3%**
1,413	2,648	1,536	1,112	72.4%	**Other Operating Revenue**	14,865	16,070	17,148	(1,078)	(6.3%)
72,133	**85,005**	**75,389**	**9,616**	**12.8%**	**Total Operating Revenues**	**703,561**	**847,462**	**751,016**	**96,445**	**12.8%**
					OPERATING EXPENSES					
40,045	44,526	41,514	(3,012)	(7.3%)	**Salaries & Wages**	387,813	439,098	413,908	(25,190)	(6.1%)
10,173	10,780	11,315	535	4.7%	**Supplies**	106,028	112,467	111,721	(746)	(0.7%)
8,363	7,814	7,107	(707)	(9.9%)	**Fees & Purchased Services**	70,888	75,920	71,347	(4,573)	(6.4%)
2,395	2,501	2,739	238	8.7%	**Other Operating Expense**	22,394	26,606	28,556	1,950	6.8%
1,400	1,394	1,410	17	1.2%	**Interest**	14,192	14,090	14,032	(59)	(0.4%)
4,243	5,069	4,350	(719)	(16.5%)	**Depreciation**	44,231	47,544	44,247	(3,297)	(7.5%)
66,620	**72,083**	**68,435**	**(3,648)**	**(5.3%)**	**Total Operating Expenses**	**645,546**	**715,724**	**683,810**	**(31,914)**	**(4.7%)**
5,513	**12,922**	**6,954**	**5,968**	**85.8%**	**Net Operating Margin**	**58,014**	**131,737**	**67,206**	**64,531**	**96.0%**
28,085	(54,244)	7,546	(61,790)	(818.8%)	**Non Operating Income**	196,740	(103,038)	73,506	(176,544)	(240.2%)
33,599	**(41,322)**	**14,500**	**(55,822)**	**(385.0%)**	**Net Margin**	**254,755**	**28,699**	**140,713**	**(112,013)**	(79.6%)
11,157	**19,385**	**12,713**	**6,671**	**52.5%**	**Operating EBIDA**	**116,437**	**193,371**	**125,485**	**67,886**	54.1%
15.5%	22.8%	16.9%	5.9%		Operating EBIDA Margin	16.5%	22.8%	16.7%	6.1%	
7.6%	15.2%	9.2%	6.0%		Operating Margin	8.2%	15.5%	8.9%	6.6%	
46.6%	-48.6%	19.2%	(67.8%)		Net Margin	36.2%	3.4%	18.7%	(15.3%)	

El Camino Hospital – Los Gatos
Statement of Operations *($000s)*

Period 10 ending 04/30/2022

Period 10 FY 2021	Period 10 FY 2022	Period 10 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
84,556	97,391	76,339	21,052	27.6%	**Gross Revenue**	743,740	947,934	753,663	194,271	25.8%
(63,830)	(77,896)	(57,205)	(20,691)	(36.2%)	**Deductions**	(561,904)	(727,367)	(563,047)	(164,320)	(29.2%)
20,725	**19,495**	**19,134**	**361**	**1.9%**	**Net Patient Revenue**	**181,836**	**220,567**	**190,617**	**29,951**	**15.7%**
258	294	271	23	8.3%	**Other Operating Revenue**	3,314	2,849	2,708	141	5.2%
20,983	**19,789**	**19,405**	**384**	**2.0%**	**Total Operating Revenue**	**185,150**	**223,417**	**193,325**	**30,092**	**15.6%**
					OPERATING EXPENSE					
8,365	10,842	8,887	(1,956)	(22.0%)	**Salaries & Wages**	83,405	99,007	86,906	(12,101)	(13.9%)
3,634	4,029	3,063	(966)	(31.5%)	**Supplies**	30,865	38,258	31,103	(7,155)	(23.0%)
2,796	3,693	3,201	(492)	(15.4%)	**Fees & Purchased Services**	29,469	34,826	32,095	(2,731)	(8.5%)
329	471	402	(69)	(17.3%)	**Other Operating Expense**	3,785	3,567	4,452	885	19.9%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
955	1,080	921	(159)	(17.3%)	**Depreciation**	9,086	10,778	9,304	(1,474)	(15.8%)
16,079	**20,116**	**16,473**	**(3,642)**	**(22.1%)**	**Total Operating Expense**	**156,610**	**186,436**	**163,861**	**(22,576)**	**(13.8%)**
4,904	**(327)**	**2,932**	**(3,259)**	**(111.2%)**	**Net Operating Margin**	**28,540**	**36,981**	**29,464**	**7,516**	**25.5%**
0	0	0	0	0.0%	**Non Operating Income**	0	23	0	23	0.0%
4,904	**(327)**	**2,932**	**(3,259)**	**(111.2%)**	**Net Margin**	**28,540**	**37,004**	**29,464**	**7,539**	**25.6%**
5,859	**753**	**3,853**	**(3,100)**	**(80.5%)**	**Operating EBIDA**	**37,625**	**47,759**	**38,769**	**8,990**	23.2%
27.9%	3.8%	19.9%	(16.0%)		**Operating EBIDA Margin**	20.3%	21.4%	20.1%	1.3%	
23.4%	-1.7%	15.1%	(16.8%)		**Operating Margin**	15.4%	16.6%	15.2%	1.3%	
23.4%	-1.7%	15.1%	(16.8%)		**Net Margin**	15.4%	16.6%	15.2%	1.3%	

El Camino Health Medical Network
Statement of Operations *($000s)*

Period 10 ending 04/30/2022

Period 10 FY 2021	Period 10 FY 2022	Period 10 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUES					
10,517	8,840	7,067	1,774	25.1%	**Gross Revenue**	89,527	88,673	78,731	9,942	12.6%
(7,060)	(5,918)	(4,425)	(1,494)	(33.8%)	**Deductions**	(59,928)	(59,400)	(49,489)	(9,911)	(20.0%)
3,457	**2,922**	**2,642**	**280**	**10.6%**	**Net Patient Revenue**	**29,599**	**29,272**	**29,241**	**31**	**0.1%**
976	658	871	(213)	(24.5%)	**Other Operating Revenue**	11,948	9,330	9,095	236	2.6%
4,433	**3,580**	**3,514**	**67**	**1.9%**	**Total Operating Revenues**	**41,547**	**38,603**	**38,336**	**267**	**0.7%**
					OPERATING EXPENSES					
1,791	1,523	1,545	22	1.4%	**Salaries & Wages**	16,715	15,812	16,181	370	2.3%
447	408	214	(194)	(90.9%)	**Supplies**	4,324	3,478	2,562	(916)	(35.8%)
4,167	3,261	3,437	176	5.1%	**Fees & Purchased Services**	40,151	36,642	35,785	(857)	(2.4%)
857	473	839	366	43.6%	**Other Operating Expense**	8,416	7,069	8,955	1,887	21.1%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
395	277	232	(45)	(19.4%)	**Depreciation**	2,494	2,796	2,380	(416)	(17.5%)
7,657	**5,942**	**6,267**	**325**	**5.2%**	**Total Operating Expenses**	**72,100**	**65,796**	**65,864**	**67**	**0.1%**
(3,224)	**(2,362)**	**(2,753)**	**391**	**14.2%**	**Net Operating Margin**	**(30,553)**	**(27,194)**	**(27,528)**	**334**	**1.2%**
0	(151)	0	(151)	0.0%	**Non Operating Income**	229	(298)	0	(298)	0.0%
(3,224)	**(2,513)**	**(2,753)**	**240**	**8.7%**	**Net Margin**	**(30,324)**	**(27,492)**	**(27,528)**	**36**	**0.1%**
(2,828)	**(2,085)**	**(2,521)**	**436**	**17.3%**	**Operating EBIDA**	**(28,059)**	**(24,398)**	**(25,148)**	**750**	3.0%
-63.8%	-58.2%	-71.8%	13.5%		**Operating EBIDA Margin**	-67.5%	-63.2%	-65.6%	2.4%	
-72.7%	-66.0%	-78.4%	12.4%		**Operating Margin**	-73.5%	-70.4%	-71.8%	1.4%	
-72.7%	-70.2%	-78.4%	8.2%		**Net Margin**	-73.0%	-71.2%	-71.8%	0.6%	

Consolidated Balance Sheet (as of 04/30/2022)

($000s)

ASSETS	April 30, 2022	Audited June 30, 2021
CURRENT ASSETS		
Cash	176,840	151,641
Short Term Investments	159,434	284,262
Patient Accounts Receivable, net	202,482	166,283
Other Accounts and Notes Receivable	6,553	9,540
Intercompany Receivables	16,092	15,116
Inventories and Prepaids	29,535	23,079
Total Current Assets	**590,937**	**649,921**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	19,810	20,932
Plant & Equipment Fund	303,359	258,191
Women's Hospital Expansion	30,261	30,401
Operational Reserve Fund	182,907	123,838
Community Benefit Fund	18,084	18,412
Workers Compensation Reserve Fund	17,002	16,482
Postretirement Health/Life Reserve Fund	31,382	30,658
PTO Liability Fund	34,649	32,498
Malpractice Reserve Fund	1,944	1,977
Catastrophic Reserves Fund	25,966	24,874
Total Board Designated Assets	**665,364**	**558,264**
FUNDS HELD BY TRUSTEE	**0**	**5,694**
LONG TERM INVESTMENTS	**515,495**	**603,211**
CHARITABLE GIFT ANNUITY INVESTMENTS	**889**	**728**
INVESTMENTS IN AFFILIATES	**33,204**	**34,170**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,861,284	1,799,463
Less: Accumulated Depreciation	(775,441)	(742,921)
Construction in Progress	95,656	94,236
Property, Plant & Equipment - Net	**1,181,499**	**1,150,778**
DEFERRED OUTFLOWS	23,788	21,444
RESTRICTED ASSETS	31,355	29,332
OTHER ASSETS	109,428	86,764
TOTAL ASSETS	**3,151,960**	**3,140,306**

LIABILITIES AND FUND BALANCE	April 30, 2022	Audited June 30, 2021
CURRENT LIABILITIES		
Accounts Payable	45,810	39,762
Salaries and Related Liabilities	34,297	50,039
Accrued PTO	35,350	33,197
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,707	12,990
Intercompany Payables	13,484	14,704
Malpractice Reserves	1,665	1,670
Bonds Payable - Current	9,905	9,430
Bond Interest Payable	4,858	8,293
Other Liabilities	13,404	16,953
Total Current Liabilities	**174,780**	**189,338**
LONG TERM LIABILITIES		
Post Retirement Benefits	31,382	30,658
Worker's Comp Reserve	17,002	17,002
Other L/T Obligation (Asbestos)	6,564	6,227
Bond Payable	469,639	479,621
Total Long Term Liabilities	**524,588**	**533,509**
DEFERRED REVENUE-UNRESTRICTED	**27,640**	**67,576**
DEFERRED INFLOW OF RESOURCES	**45,862**	**28,009**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,141,958	2,097,010
Board Designated	200,710	193,782
Restricted	36,422	31,082
Total Fund Bal & Capital Accts	**2,379,091**	**2,321,874**
TOTAL LIABILITIES AND FUND BALANCE	**3,151,960**	**3,140,306**

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Finance Committee
From: Jon Cowan, Senior Director, Government Relations & Community Partnerships
Date: May 26, 2022
Subject: FY23 El Camino Health Implementation Strategy Report and Community Benefit Plan

Recommendation:

To approve the FY23 El Camino Health (ECH) Implementation Strategy Report and Community Benefit Plan (Plan).

Summary:

1. Situation: The Plan reflects a total request of $3,410,000 and includes funding recommendations for grants, sponsorships and placeholder.
   - The Plan outlines strategies to address the top unmet health needs identified in the 2022 ECH Community Health Needs Assessment (CHNA)
   - Grant proposals in the Plan set metrics aimed at reducing these unmet health needs
   - Sponsorships and placeholder funds are separate from grants and approved in aggregate amounts

2. Authority: Per the Community Benefit Grants Policy approved by the ECH Board of Directors, the Finance Committee is to review and approve the annual Plan.

3. Background: Plan includes grant proposals, sponsorships and placeholder.
   Grant proposals review process:
   - December 2021: Community Benefit (CB) FY23 application and Grant Guide released online with announcement to community and current grantees.
   - February 25, 2022: Submission deadline

- Funding overview *(see Appendix to the Plan, Attachment 2)*:
  Grant Proposals: 47 recommended at $3,310,000
  - Total Proposals: 60 (12% decrease over prior year)
  - Total Requested: $5,432,510 (11% decrease over prior year)
  - Total Funded: $3,310,000 (1% increase over prior year)
    - Total Unfunded: $2,122,510 (27% decrease over prior year)
  - Note, some programs apply to both ECH and the El Camino Healthcare District (*see Attachment 4)*

  Sponsorships: Recommended = $75k

Placeholder: Recommended = $25k

- **Placeholder process:** Designated funds to be used in accordance with the ECH Community Benefit Grants Policy/Placeholder

FY23 ECH Total Plan Request: $3,410,000

4. Assessment: N/A

5. Other Reviews: Hospital Community Benefit Committee (HCBC) reviewed proposals and provided funding recommendations.

6. Outcomes: Committee reviews and approves Plan, which includes funding for grants, sponsorships and placeholder. Committee votes to fund original Plan or Plan with approved amendments.

7. **List of Attachments:**

1. FY23 ECH Implementation Strategy Report and Community Benefit Plan
2. FY23 ECH Proposal Index & Summaries
3. Dual Funded Programs Summary

Suggested Committee Discussion Questions: N/A

FY2023 El Camino Health Implementation Strategy Report and Community Benefit Plan

Finance Committee

Jon Cowan, Senior Director, Government Relations and Community Partnerships

May 26, 2022

Recommendation

To approve the FY2023 El Camino Health Implementation Strategy Report and Community Benefit Plan:

- Currently recommending a total of $3,410,000, including Grants ($3,310,000), Sponsorships ($75k) and Placeholder ($25k), or
- An amended Plan per Committee motions up to available funds of $3,410,000.

Recommended Funding Methodology

- Internal controls have been implemented to ensure that the hospital grants program will not generate a negative margin in FY2023 or future years
- Using the historical funding formula, FY2023 funding would have decreased by ~$2.0M

Hospital Grants Revenue	FY2018	FY2019	FY2020	FY2021	FY2022	Funding Based on Existing Formula FY2023	Recommended Funding FY2023
Hospital Annual Contribution	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 2,871,000
Interest Income from Endowment	$ 252,083	$ 1,187,782	$ 872,060	$ 936,262	$ 1,743,237	$ (675,000)	$ -
CONCERN 40% Profit	$ 644,473	$ 513,668	$ 1,113,787	$ 724,508	$ 139,744	$ 539,000	$ 539,000
Total Revenue	**$ 2,396,556**	**$ 3,201,450**	**$ 3,485,847**	**$ 3,160,770**	**$ 3,382,981**	**$ 1,364,000**	**$ 3,410,000**
Grants	$ 2,993,773	$ 3,565,000	$ 3,399,948	$ 3,396,000	$ 3,236,000	$ 3,310,000	$ 3,310,000
Sponsorships	$ 195,000	$ 200,000	$ 200,000	$ 100,000	$ 85,000	$ 75,000	$ 75,000
Placeholder	$ 100,000	$ 100,000	$ 100,000	$ 200,000	$ 220,000	$ 25,000	$ 25,000
Total Expense	**$ 3,288,773**	**$ 3,865,000**	**$ 3,699,948**	**$ 3,696,000**	**$ 3,541,000**	**$ 3,410,000**	**$ 3,410,000**
Hospital Grants - Net Margin	**$ (892,217)**	**$ (663,550)**	**$ (214,101)**	**$ (535,230)**	**$ (158,019)**	**$ (2,046,000)**	**$ -**

Timeline & Process

Applications Released
December 2021

Applications Due
Last Friday of February
2022

Staff Review of Proposals
February – April 2022

FY2023 Plan presented to
Finance Committee
May 26, 2022

Notification of Award or Denial
June 2022

- Hospital Community Benefit Committee (HCBC) meets in April
- HCBC's recommendations for funding are provided to the Finance Committee (FC) as part of CB Annual Plan & Implementation Strategy
- FC approves grant funding through the FY2023 ECH Implementation Strategy Report and Community Benefit Plan

Guiding Principles for Evaluating and Prioritizing Appropriateness of Grant Proposals

Required

1. Serve those who live, work or go to school in El Camino Health'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 Health'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

ECH Ranked & Prioritized Health Needs

Health Need	FY2021 Approved	FY2022 Approved	FY2023 Approved
Healthcare Access & Delivery (including oral health)	29%	30%	~30%
Behavioral Health (including domestic violence trauma)	30%	31%	~30%
Diabetes & Obesity	27%	21%	~30%
Chronic Conditions (other than Diabetes & Obesity)	5%	8%	~5%
Economic Stability (including food insecurity, housing & homelessness)	4%	5%	~5%

*Dropped health need includes cognitive decline (5% in FY2021 and FY2022)

Proposal Evaluation Process

Top three factors that are referenced during the grant evaluation process

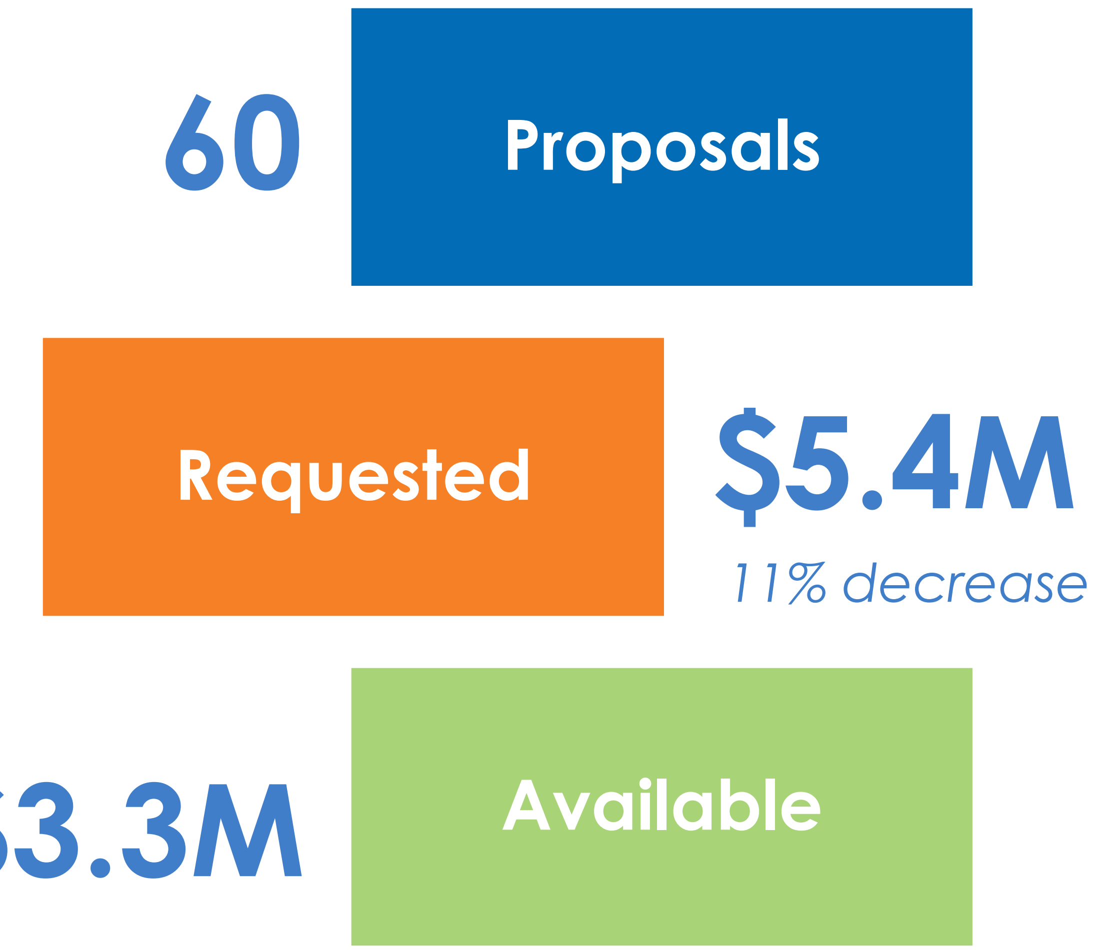
Proposal Evaluation Criteria

Proposals are evaluated by:

- Alignment with ECH 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 were also evaluated in context of those in each health need, then grouped by their proximity to the median for review in the grant index.

FY2023 Summary of Proposal Portfolio



ECH Grants Grouped by Health Need*

	Health Need	FY2022 Approved	FY2022 %	FY2023 Proposed	FY2023 %
Healthcare Access & Delivery (including oral health)	Healthcare Access & Delivery	$894,500	28%	$867,000	26%
	Oral Health	$70,000	2%	$95,000	3%
Behavioral Health (including domestic violence trauma)	Behavioral Health	$917,000	28%	$931,000	28%
	Domestic Violence	$90,000	3%	$90,000	3%
Diabetes & Obesity	Diabetes & Obesity	$664,000	21%	$992,000	30%
Chronic Conditions (other than Diabetes & Obesity)	Chronic Conditions (other than Diabetes & Obesity)	$266,000	8%	$165,000	5%
Economic Stability (including housing and food)	Economic Stability	$162,500	5%	$170,000	5%
Cognitive Decline	Cognitive Decline	$172,000	5%	N/A	N/A
	Total	**$3,236,000**		**$3,310,000**	

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

FY23 Strategy Highlights

- **Diabetes and Obesity**- Categorical funding increase approved due to demonstrated need in the CHNA
- **School Nurse and Behavioral Health Programs**- Maintaining support of critical school-based services with existing partners while not entering new partnerships with new school districts at this time
- **Community Service Agencies**- Continued investment as they fill significant community needs in response to the pandemic
- **Staff Innovation Grants**:
    - **Food Pharmacy:** Addressing re-hospitalization by establishing an intervention program targeting ECH patients with both food insecurity and malnutrition and/or diabetes/pre-diabetes
    - **DEI & Economic Opportunity Program:** Addressing economic security and helping build a diverse healthcare workforce through internship and mentorship opportunities for local young adults

FY2023 New Applications

16 applications for new programs

Recommended for funding

- **Adolescent Counseling Services (ACS)**
- **American Diabetes Association**
- **Bay Area Community Health**
- **Catholic Charities of Santa Clara County**
- **Tower Foundation of San Jose State University – Behavioral Health Program**
- **El Camino Health DEI & Economic Opportunity Program**
- **El Camino Health Food Pharmacy**

Not recommended for funding

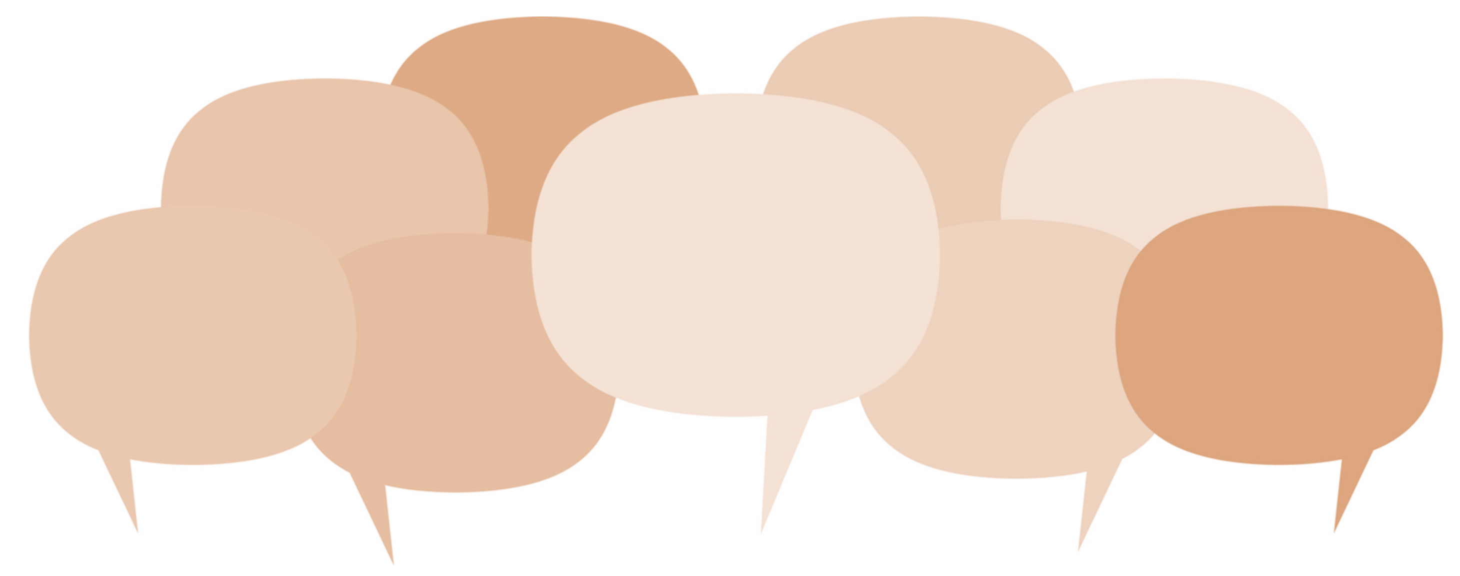
- Cambrian School District – Mental Health Program
- Eating Disorders Resource Center
- Sacred Heart Community Services
- School of Arts and Culture at Mexican Heritage Plaza
- South Bay Kidpower Teen Power Fullpower
- Teen Success
- Tower Foundation of San Jose State University – Access & Delivery Program
- Fremont Union High School District
- Union School District

FY23 Acknowledgement of Funds Process Update

Grant partners will be asked to acknowledge ECH's contribution through the following channels.

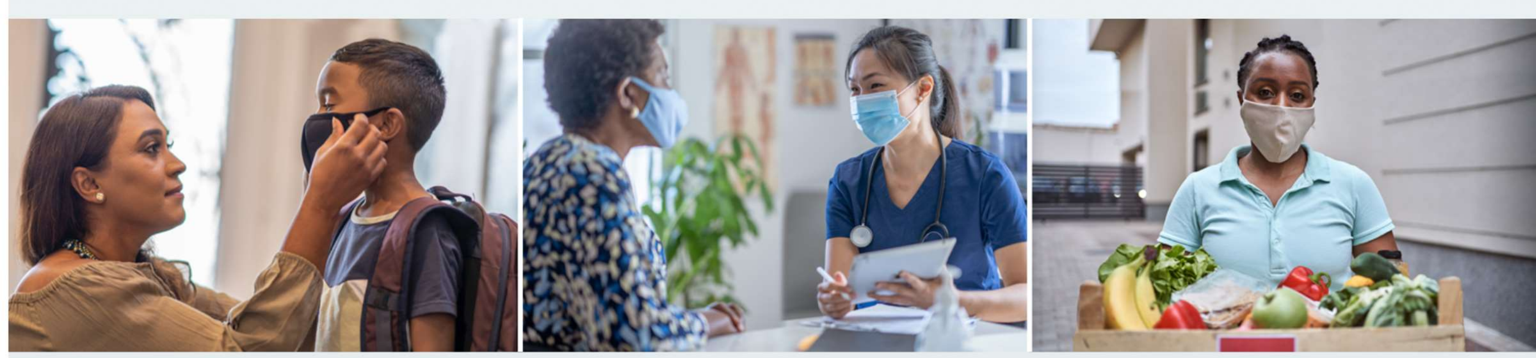
a. Building signage: For programs receiving grants ≥ $200,000
b. Mobile van signage: For programs receiving grants ≥ $50,000
c. Email signatures: For grants that fund ≥ 0.75 FTE in program personnel
d. Annual reports: All funded programs
e. Website partnership pages: All funded programs
f. Social media when posting about the grant program: All funded programs
g. Printed collateral about the grant program: All funded programs
h. Media coverage about the grant program: All funded programs

Discussion



Implementation Strategy Report and Community Benefit Plan, FY2023

June 2022



I. GENERAL INFORMATION

Contact Person:	Brennan Phelan
Years the Plan Refers to:	Fiscal year 2023
Date Written Plan Was Adopted by Authorized Governing Body:	June 14, 2022
Authorized Governing Body that Adopted the Written Plan:	El Camino Hospital Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	El Camino Hospital EIN 94-3167314
Address of Hospital Organization:	El Camino Hospital 2500 Grant Road Mountain View, CA 94040-4302

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II. ABOUT EL CAMINO HEALTH

El Camino Health[1] 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. Key medical specialties of El Camino Health include cancer, heart and vascular, men's health, mental health and addictions, pulmonary, mother-baby, neurology, orthopedic and spine, 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.

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.[2]

III. EL CAMINO HEALTH'S SERVICE AREA

El Camino Health is located in Santa Clara County, and its community encompasses most of the cities in that county, including Santa Clara, San José, Mountain View, and Los Gatos. 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. Santa Clara County is also very diverse, with sizable proportions of Asian, Latinx, and white populations. 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%).

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.[3] Yet the California Self-Sufficiency Standard,[4] set by the Insight Center for Community Economic Development, suggests that many households in Santa Clara County are unable to meet their basic needs.[5] (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[6] and the median rent was $2,374.[7] 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.

The minimum wage in Santa Clara County[8] 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.

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.[9] Although the county is quite diverse and has substantial resources (see our CHNA 2022 report, Attachment 3), there is significant inequality in the population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality, is higher in certain zip codes compared to others.[10] 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 focused particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

IV. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

Per state and federal law, a Community Health Needs Assessment (CHNA) must be conducted every three years by nonprofit hospitals. In 2022, El Camino Health Community Benefit staff conducted a Community Health Needs Assessment in collaboration with the Santa Clara County Community Benefit Coalition. This assessment resulted in the identification of community health needs. The 2022 CHNA serves as a tool for guiding policy and program planning efforts and is available to the public. For information about El Camino Health's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit https://www.elcaminohospital.org/about-us/community-benefit.

IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years. Section 1.501(r)(3)(c) of the IRS regulations pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address.

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Health's planned response to the needs identified through the 2022 CHNA process. Per IRS requirements, the following descriptions of the actions (strategies) El Camino Health intends to take include the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

This 2023 IS Report and CB Plan is based on the 2022 CHNA and outlines El Camino Health'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 Health Community Benefit Plan:

- 47 Grants: $3,310,000
  - Requested Grant Funding: $5,432,510
- Sponsorships: $75,000
- Placeholder: $25,000
- Plan Total: $3,410,000

V. 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.[11] 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

VI. 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.

VII. HEALTH NEEDS THAT EL CAMINO HEALTH 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)

DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTH 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%.[12] 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).[12] 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[13]) 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%).[14] 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%)[14], but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).[14]

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.[14] 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.[14] 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).[15] 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).[16] 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)[17] 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).[18] 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).[19] 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).[20] 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."[21] 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."[22] 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).[23]

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.[24] 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.[25] 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%).[26]

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.[27] 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).[28] 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%).[29] 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."[30]

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).[31] 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%).[32] 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%).[33] 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).[31] 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."[34]

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."[35]

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.[36] 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).[37] In addition, the East San José area experiences higher levels of Neighborhood Deprivation[38] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0).[37] 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.[39] 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).[37]

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%).[40] Also, a smaller percentage of local Latinx 11th graders met or exceeded math standards (28%) versus California's 11th-graders (32%).[40] 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%).[41] 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%).[37] Educational inequities, often related to neighborhood segregation[42], 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).[43]

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.[44] Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards.[44] 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).[36] 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.[45] 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.[46] Economic insecurity affects single-parent households more than dual-parent households[47]; in East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).[37]

VIII. EL CAMINO HEALTH'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Health'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 Health 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 Health 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 Health 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

Reduce health care access disparities

INITIATIVES

Increase access to primary and specialty care

Increase health care access in schools

Support navigator programs

Increase use of telehealth

ANTICIPATED IMPACTS

Better access to health care

Improved health care utilization

Improved ED & hospital use

Better access to health care for school children

Improved access to plan-of-care resources

Improved health care utilization

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[48, 49, 50, 51, 52, 53, 54, 55, 56, 57]	(i) Individuals experience better access to health care (ii) Improved health care utilization (iii) Reduced unnecessary ED visits and hospitalizations
	B. Support greater access to healthcare in schools[58]	(i) Improved access to health care for school-aged children and youth
	C. Support clinical and community health navigator programs[59, 60, 61]	(i) Community members access clinical and community resources that support their plan of care
	D. Support increased use of telehealth and other technology solutions[62, 63, 64]	

GOAL

INITIATIVE

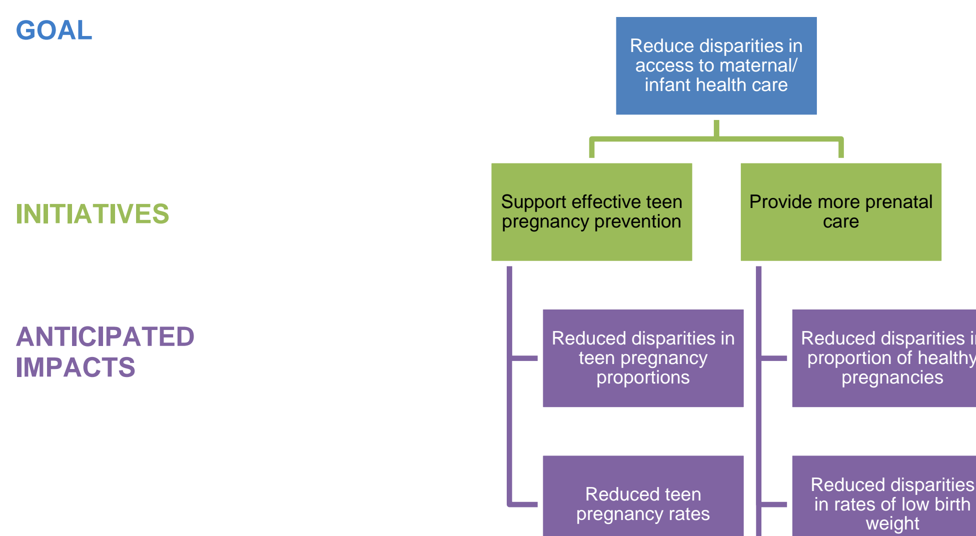
ANTICIPATED IMPACT

Increase access to oral health care

Support dental screening & follow-up

Improved oral health

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[65, 66, 67, 68]	(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[69, 70, 71]	(i) Reduced disparities in the proportion of teens who are pregnant (ii) Reduced proportions of teens who are pregnant
	B. Increase access to and utilization of adequate prenatal care[72, 73, 74, 75, 76]	Reduced disparities in: (i) Proportions of women with healthy pregnancies (ii) Rates of low birth weight (iii) Rates of infant mortality

GOAL

INITIATIVE

ANTICIPATED IMPACTS

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[77, 78, 79, 80]	(i) Increased access to culturally competent health care services among underserved community members, including LGBTQ+ and community members with limited English proficiency (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)	HCBC Rec.
Campbell Union School District - School Nurse Program				$231,000	$215,000	$215,000
County of Santa Clara Health System - Better Health Pharmacy				$75,000	$75,000	$75,000
Healthier Kids Foundation				$60,000	$30,000	$60,000
Mt. Pleasant School District - School Nurse Program				$124,000	$122,000	$122,000
Asian Americans for Community Involvement				$208,830	$100,000	$100,000
Bay Area Community Health	X			$100,000	N/A	$ 50,000
Cambrian School District - School Nurse Program				$175,000	$125,000	$125,000
Cupertino Union School District - School Nurse Program			X	$120,367	$100,000	$100,000
Health Mobile			X	$150,000	$55,000	$75,000
Tower Foundation of San Jose State University	X	X		$49,000	N/A	$ -
Vista Center for the Blind and Visually Impaired			X	$83,138	$40,000	$40,000

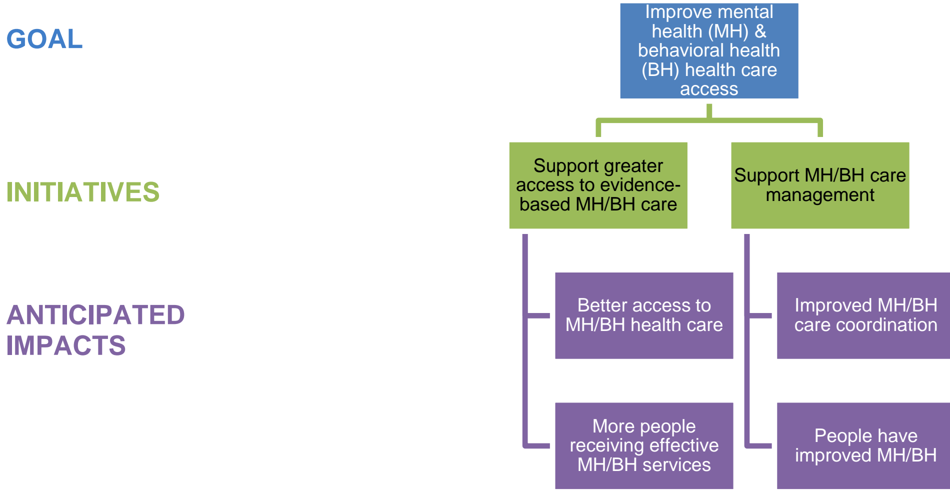
*Green represents higher proposal strength, Blue represents medium proposal strength, and Grey represents lower proposal strength

**Proposals within each color grants are organized alphabetically

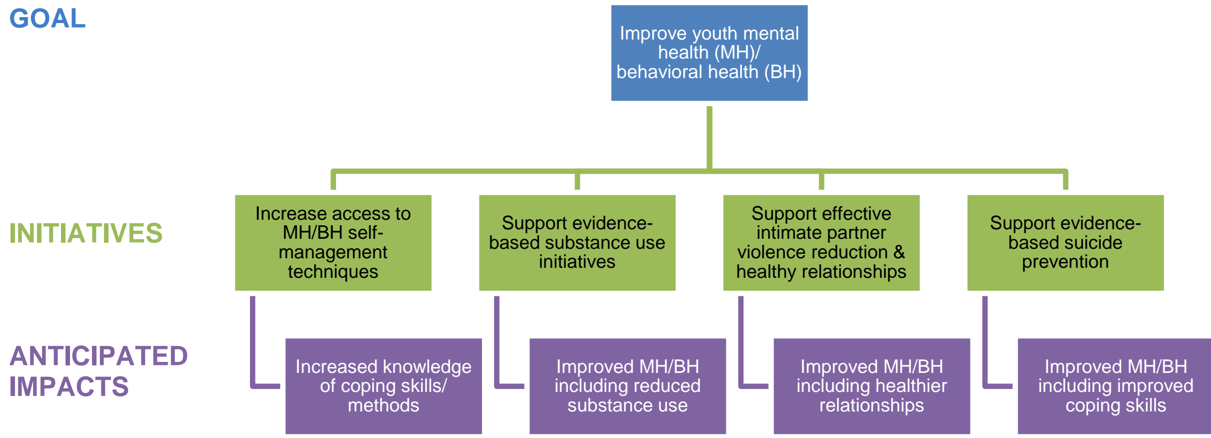
***HCBC is the Hospital Community Benefit Committee

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

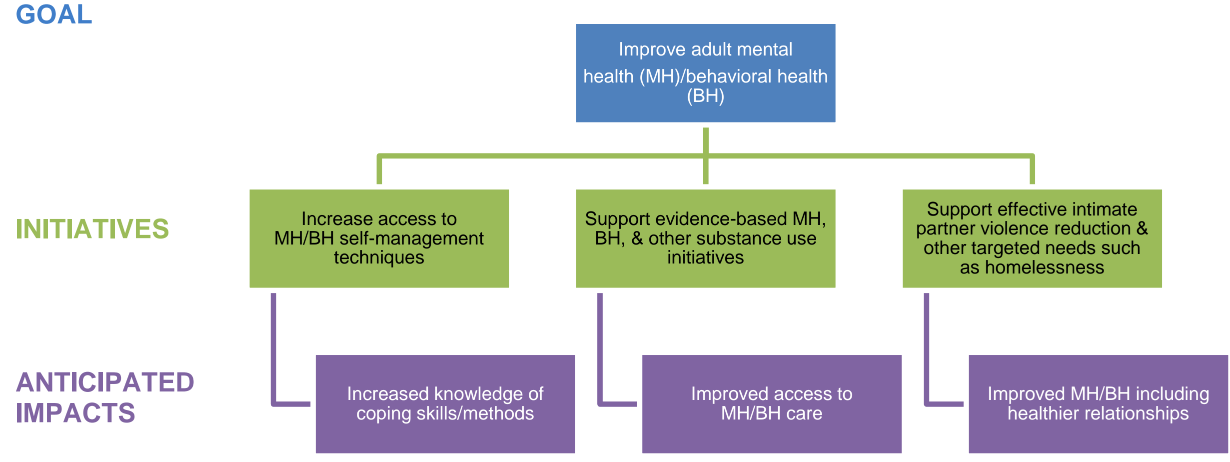
Even prior to the pandemic, data indicated that behavioral health (including mental health, trauma, and substance use) was a significant health need, especially with respect to the supply of providers. Community input during the 2022 CHNA emphasized how much worse and more widespread behavioral health 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 Health 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 Health 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. [81, 82, 83, 84, 85]	(i) Improved access to mental/behavioral health programs and services (ii) More community members receiving effective mental/ behavioral health services
	B. Care management to support community members' self-management and mental health[86, 87]	(i) Improved coordination of mental/behavioral services (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[88, 89]	(i) Increased knowledge among youth served about methods of coping with stress and depression
	B. Support for substance abuse initiatives with evidence of effectiveness[90, 91, 92]	(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[93, 94]	(i) Improved mental health among those served, including healthier relationships
	D. Programs that reduce or prevent suicide with evidence of effectiveness[95, 96]	(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[97, 98, 99]	(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[100, 101, 102]	(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[103, 104]	(i) Improved mental health among those served (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)	HCBC Rec.
Almaden Valley Counseling Service				$80,000	$70,000	$36,000
Alzheimer's Disease and Related Disorders Association		X		$70,000	$70,000	$ -
Cupertino Union School District - Mental Health Program			X	$137,000	$120,000	$120,000
Jewish Family Services of Silicon Valley				$95,000	$82,000	$75,000
LifeMoves			X	$60,000	$60,000	$50,000
Tower Foundation of San Jose State University	X			$50,000	N/A	$25,000
ACT for Mental Health				$50,000	$60,000	$40,000
Bill Wilson Center				$25,000	$25,000	$25,000
Cancer CAREpoint				$36,000	$30,000	$30,000
Child Advocates of Silicon Valley				$40,000	$40,000	$40,000
Momentum for Health			X	$46,000	$46,000	$40,000
Next Door Solutions to Domestic Violence				$95,000	$90,000	$90,000
Peninsula Healthcare Connection				$100,000	$90,000	$90,000
South Bay Kidpower Teenpower Fullpower	X	X		$30,000	N/A	$ -
Adolescent Counseling Services (ACS)	X			$30,000	N/A	$25,000
Cambrian School District - Mental Health Program	X	X		$150,000	N/A	$ -
Community Health Partnership		X		$50,000	$40,000	$ -
Eating Disorders Resource Center	X	X	X	$22,500	N/A	$ -
Fremont Union High School District	X	X		$155,000	N/A	$ -
LGS (Los Gatos Saratoga) Recreation				$31,790	$20,000	$15,000
Los Gatos Union School District - Mental Health Program				$110,000	$110,000	$110,000
Union School District	X	X		$380,000	N/A	$ -
Uplift Family Services at Campbell Union High School District				$230,000	$210,000	$210,000

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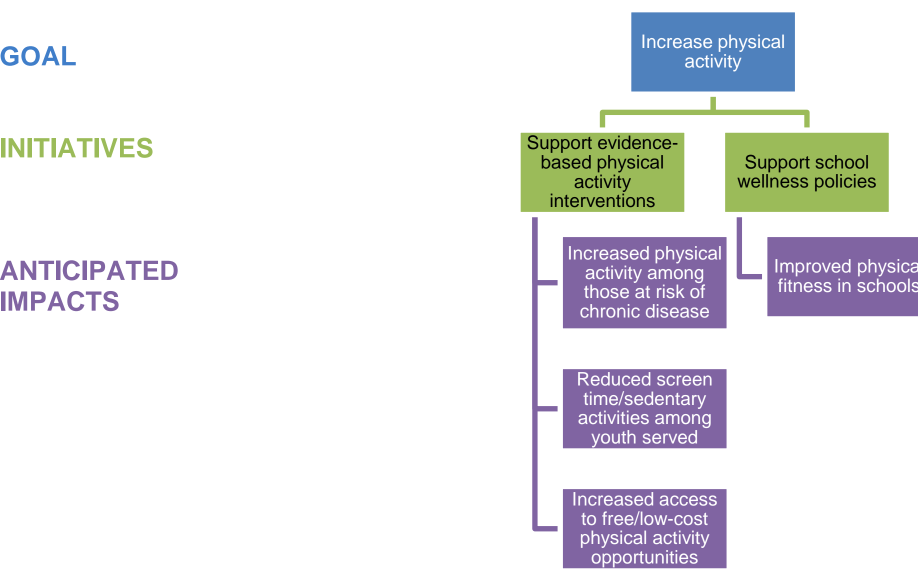
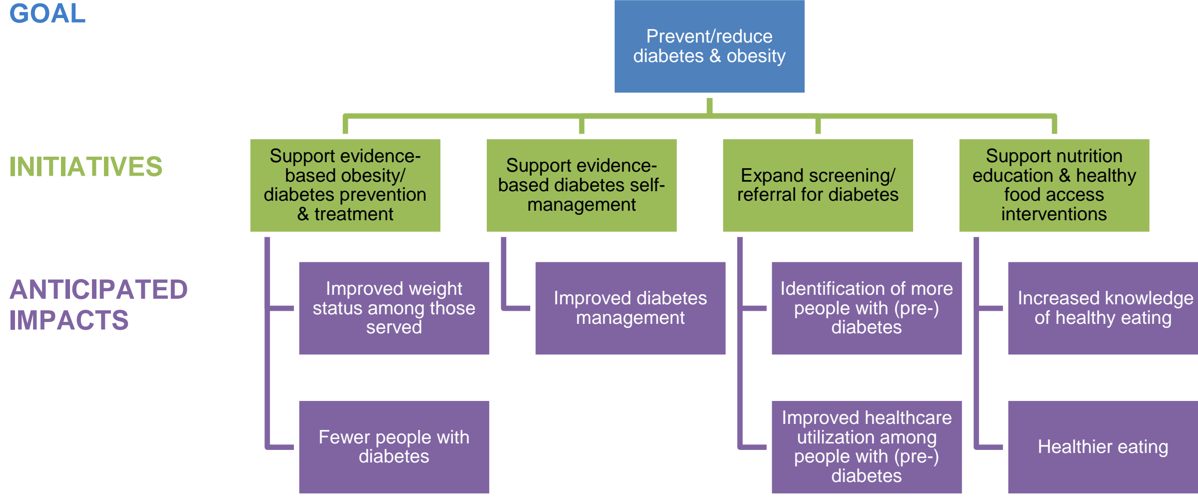
DIABETES & OBESITY

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 Health 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[105, 106, 107, 108]	(i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions (ii) Reduced screen time & time on sedentary activities among youth served (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[109]	(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[110, 111, 112, 113, 114, 115, 116, 117, 118]	(i) Improved weight status in youth and adults served (ii) Long-term reduction in the number of community members with diabetes
	B. Support diabetes treatment/self-management programs with evidence of effectiveness[119, 120, 121, 122, 123]	(i) Improved diabetes management in participants served
	C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[124, 125]	(i) Identification of more individuals with diabetes and pre-diabetes (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.)[126, 127, 128, 129]	(i) Increased knowledge and understanding about healthy eating among people served (ii) Healthier eating among community members receiving interventions

DIABETES & OBESITY PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY22 Approved (if applicable)	HCBC Rec.
Gardner Family Health Network				$271,469	$230,000	$254,500
Indian Health Center of Santa Clara Valley				$125,000	$87,000	$111,500
Playworks			X	$81,000	$86,000	$40,000
Valley Verde				$60,000	$45,000	$60,000
African American Community Service Agency				$60,398	$28,000	$43,000
Chinese Health Initiative			X	$45,000	$42,000	$20,000
El Camino Health - Food Pharmacy	X			$148,591	N/A	$148,500
GoNoodle				$114,000	$113,000	$40,000
South Asian Heart Center			X	$110,000	$100,000	$50,000
West Valley Community Services				$275,000	$160,000	$184,500
American Diabetes Association	X			$50,000	N/A	$25,000
Bay Area Women's Sports Initiative			X	$60,000	$15,000	$15,000
Palo Alto Medical Foundation		X	X	$25,000	$20,000	$ -

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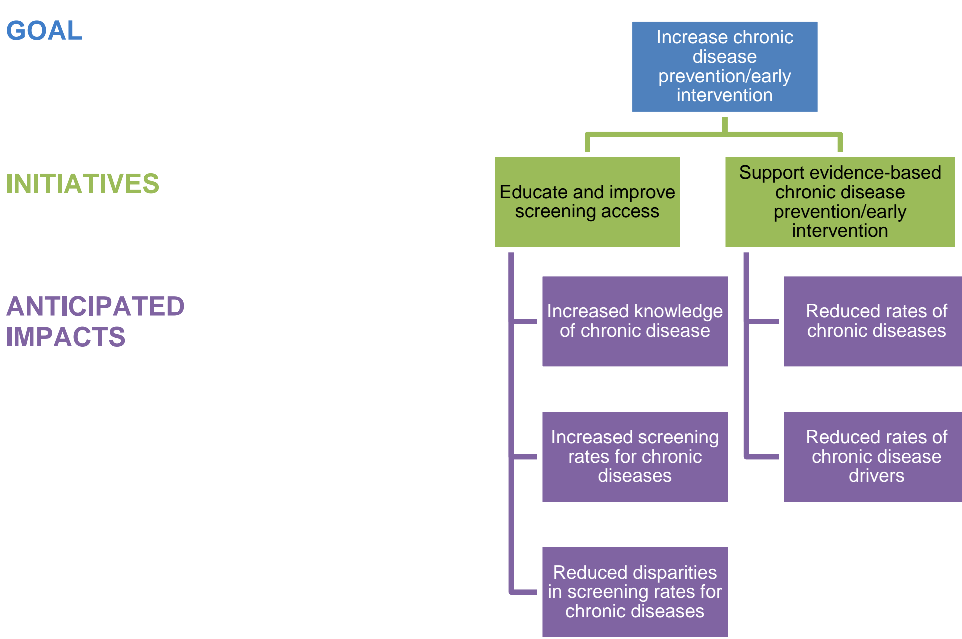
OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

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 Health 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 Health 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[130, 131, 132, 133, 134, 135, 136]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening for chronic disease (iii) Reduced disparities in chronic disease screening rates
	B. Support evidence-based chronic disease prevention and early intervention programs[137, 138, 139]	(i) Reduced rates of chronic diseases (ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc.

GOAL

INITIATIVES

ANTICIPATED IMPACTS

Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[140, 141, 142]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication and treatment adherence (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)	HCBC Rec.
American Heart Association			X	$60,000	$50,000	$60,000
Breathe California				$40,000	$40,000	$40,000
Pink Ribbon Girls				$25,000	$25,000	$25,000
Latinas Contra Cancer				$75,000	$35,000	$40,000

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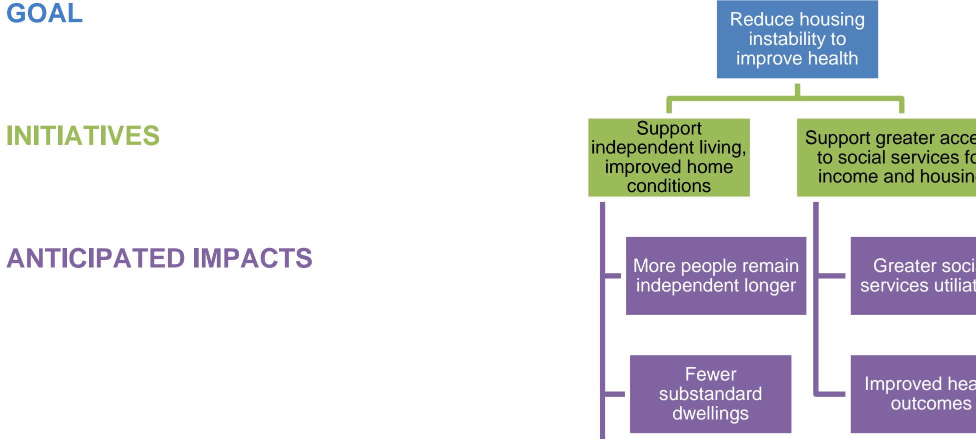
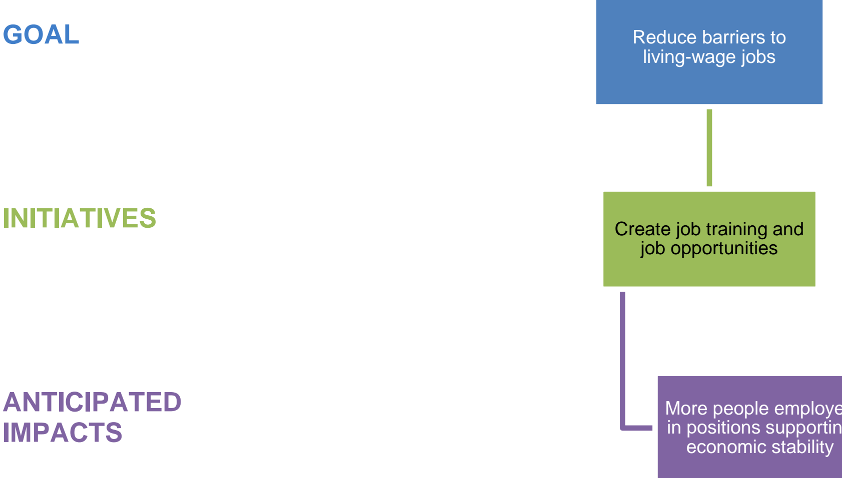
ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS)

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 Health 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 Health 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[143, 144, 145]	(i) More community members remain independent longer (ii) Reduced number of sub-standard dwellings (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[146, 147, 148]	(i) Increase in social services utilization (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[149, 150, 151, 152]	(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[153, 154]	(i) Improved access to healthy food options (ii) Reduced food insecurity

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

Agency	New	DNF	Dual Request	Requested	FY22 Approved (if applicable)	HCBC Rec.
Rebuilding Together Silicon Valley				$30,000	$30,000	$30,000
Sacred Heart Community Service	X	X		$20,000	N/A	$ -
West Valley Community Services - Senior Services				$45,000	$45,000	$45,000
Catholic Charities of Santa Clara County	X			$50,000	N/A	$30,000
Downtown Streets Team				$30,000	$30,000	$30,000
Teen Success	X	X		$25,000	N/A	$ -
El Camino Health - DEI & Economic Opportunity Program	X			$37,000	N/A	$35,000
First Community Housing		X		$90,000	$30,000	$ -
School of Arts and Culture at Mexican Heritage Plaza	X	X		$30,427	N/A	$ -

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IX. EVALUATION PLANS

As part of El Camino Health'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 our 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 Health 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 Health 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.

X. HEALTH NEEDS THAT EL CAMINO HEALTH DOES NOT PLAN TO ADDRESS

Cancer: El Camino Health merged the Cancer health need into the "Other Chronic Conditions" health need and will address cancer through addressing other chronic conditions.

Climate/Natural Environment: This topic is outside of El Camino Health's core competencies (i.e., El Camino Health has little expertise in this area) and the hospital feels it cannot make a significant impact on this need through community benefit investment. Also, this need was of lower priority to the community than the needs that El Camino Health selected.

Community Safety (i.e., violence): This need was of lower priority to the community than the needs that El Camino Health selected. While El Camino Health lacks expertise to address this health need, behavioral health issues such as substance abuse, stress, and anxiety have been shown to be drivers of violence. El Camino Health believes that initiatives intended to address the community's behavioral health need have the potential to increase community safety as well.

Maternal & Infant Health: El Camino Health merged the Maternal & Infant Health need into the "Health Care Access & Delivery" health need and will address maternal and infant health through health care access and delivery initiatives.

Oral/Dental Health: El Camino Health merged the Oral/Dental Health need into the "Health Care Access & Delivery" health need and will address oral and dental health through health care access and delivery initiatives.

Sexually Transmitted Infections: El Camino Health is better positioned to address drivers of this need via initiatives related to health care access and delivery. Additionally, this need was of lower priority to the community than the needs that El Camino Health selected.

Unintended Injuries/Accidents: This need was of lower priority to the community than the needs that El Camino Health selected. Moreover, El Camino Health is better positioned to address this need via initiatives related to education about healthy lifestyles (i.e., physical fitness) and health care access and delivery.

APPENDIX A

IRS Implementation Strategy Checklist

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
(1) Implementation Strategy	The implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, either: (i) describes how the hospital facility plans to address the health need; or (ii) identifies the health need as one it does not intend to address and explains why the hospital facility does not intend to address the health need (Treas. Reg. § 1.501(r)-3(c)(1)).		
	A hospital facility will have described a plan to address a significant health need identified through a CHNA if the implementation strategy: (i) describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;	Y	Section VIII
	(ii) identifies the resources the hospital facility plans to commit to address the health need; and	Y	Section VIII
	(iii) describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need (Treas. Reg. § 1.501(r)-3(c)(2)).	Y	Section VIII
	In explaining why the hospital facility does not intend to address a significant health need, a brief explanation for the hospital facility's reason for not addressing the need is sufficient. Under the final regulations, such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority and/or a lack of identified effective interventions to address the need (Treas. Reg. § 1.501(r)-3(c)(3)).	Y	Section X
(2) Joint implementation	A hospital facility may develop an implementation strategy in collaboration with		

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
strategies	other hospital facilities or other organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific resources. However, a hospital facility that adopts a joint CHNA report (described in Checklist § 3(9), above) may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how one or more of the collaborating facilities or organizations plan to address the health need or identifies the health need as one the collaborating facilities or organizations do not intend to address and explains why they do not intend to address the health need. For a collaborating hospital facility to meet the implementation strategy adoption requirement, such a joint implementation strategy adopted for the hospital facility must—		
	(i) Be clearly identified as applying to the hospital facility;	N/A	N/A
	(ii) Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and	N/A	N/A
	(iii) Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility. (Treas. Reg. § 1.501(r)-(3)(c)(4))	N/A	N/A
(3) Adoption of the implementation strategy	Under the final regulations, an implementation strategy must be adopted by an "authorized body of the hospital facility" (see Checklist §	Y	Section I

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
	3(1), above) on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA, regardless of whether the hospital facility began working on the CHNA in a prior taxable year (Treas. Reg. § 1.504(r)-3(a)(2) and (c)(5)(i)).		

Additional regulations not applicable to this hospital:

- Section 6: Exception for acquired, new, and terminated hospital facilities (Treas. Reg. § 1.501(r)-3(d))

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.elcaminohealth.org/about-us/community-benefit

[3] Census data in this and prior paragraphs from https://www.census.gov/quickfacts

[4] 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.

[5] 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

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

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

[8] 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/

[9] 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/

[10] 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

[11] 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.

[12] California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).

[13] U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.

[14] U.S. Census Bureau, American Community Survey. 2015-19.

[15] California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).

[16] California Dept. of Public Health, California EpiCenter. 2015.

[17] Center for Medicare and Medicaid Services, National Provider Identification. (2020).

[18] National Center for Health Statistics - Mortality Files. 2017-2019.

[19] California Dept. of Public Health, California EpiCenter. 2015.

[20] County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-2019.

[21] 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/

[22] 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/

[23] California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. 2018.

[24] 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

[25] UCLA Center for Health Policy Research, California Health Interview Survey. 2019.

[26] U.S. Census Bureau, American Community Survey. 2015-19.

[27] U.S. Environmental Protection Agency, EPA Smart Location Mapping. 2012.

[28] U.S. Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2016.

[29] UCLA Center for Health Policy Research, California Health Interview Survey. 2018.

[30] 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

[31] 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).

[32] U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.

[33] County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

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

[35] 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

[36] Joint Venture Silicon Valley. (2020). 2020 Silicon Valley Index.

[37] U.S. Census Bureau, American Community Survey. 2015-19.

[38] 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).

[39] U.S. Department of Housing and Urban Development, Job Proximity Index. 2014.

[40] California Dept. of Education, Test Results for California's Assessments. 2020.

[41] California Dept. of Education, Graduates by Race and Gender (May 2018).

[42] 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

[43] HUD Policy Development and Research. 2020.

[44] The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.

[45] 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/

[46] California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.

[47] 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

[48] Myers, B., Racht, E., Tan, D., & White, L. (2012). Mobile integrated healthcare practice: a healthcare delivery strategy to improve access, outcomes, and value. Retrieved from: http://media.cygnus.com/files/cygnus/document/EMSR/2013/DEC/medtronic-download-12-9_11273203.pdf

[49] Lattimer, V., Sassi, F., George, S., Moore, M., Turnbull, J., Mullee, M., & Smith, H. (2000). Cost analysis of nurse telephone consultation in out of hours primary care: evidence from a randomised controlled trial. *BMJ*, 320(7241), 1053-1057.

[50] Shi, L., Lebrun, L. A., Tsai, J., & Zhu, J. (2010). Characteristics of ambulatory care patients and services: a comparison of community health centers and physicians' offices. *Journal of Health Care for the Poor and Underserved*, *21*(4), 1169-1183. Retrieved from: https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/2010%20JHCPU.pdf

[51] Piehl M.D., Clemens C.J., Joines J.D. (2000). 'Narrowing the Gap': Decreasing Emergency Department Use by Children Enrolled in the Medicaid Program by Improving Access to Primary Care. *Archives of Pediatric and Adolescent Medicine.* 154(8):791–95. Retrieved from: https://jamanetwork.com/journals/jamapediatrics/fullarticle/350544. See also: Lowe R.A., Localio A.R., Schwarz D.F., Williams S., Wolf Tuton L., Maroney S., Nicklin D., Goldfarb N., Vojta D.D., Feldman H.I. (2005). Association between Primary Care Practice Characteristics and Emergency Department Use in a Medicaid Managed Care Organization. *Medical Care.* 43(8):792–800. And see: Buckley, D. J., Curtis, P. W., & McGirr, J. G. (2010). The effect of a general practice after-hours clinic on emergency department presentations: a regression time series analysis. *Medical Journal of Australia*, 192(8):448-451. Retrieved from: https://www.mja.com.au/system/files/issues/192_08_190410/buc10644_fm.pdf

[52] Unützer, J., Harbin, H, Schoenbaum, M. & Druss, B. (2013). *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. Retrieved from https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

[53] Ginsburg, S. (2008). *Colocating Health Services: A Way to Improve Coordination of Children's Health Care?* (Vol. 41). New York, NY: Commonwealth Fund. Retrieved from www.commonwealthfund.org/usr_doc/Ginsburg_Colocation_Issue_Brief.pdf

[54] McGuire, J., Gelberg, L., Blue-Howells, J., & Rosenheck, R. A. (2009). Access to primary care for homeless veterans with serious mental illness or substance abuse: a follow-up evaluation of co-located primary care and homeless social services. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(4), 255-264.

[55] Connors, G. P., Kressley, S. J., Perrin, J. M., Richerson, J. E., Sankrithi, U. M., Committee on Practice and Ambulatory Medicine, Committee on Pediatric Emergency Medicine, Section on Telehealth Care, Section on Emergency Medicine, Subcommittee on Urgent Care, Task Force on Pediatric Practice Change, Simon, G. R., Boudreau, A. D. A., Baker, C., Barden, G. A., Hackell, J., Hardin, A., Meade, K., Moore, S., Shook, J. E., Callahan, J. M., Chun, T. H., Conway, E. E., Dudley, N. C., Gross, T. K., Lane, N. E., Macias, C. G., Timm, N. L., Alexander, J. J., Bell, D. M., Bunik, M., Burke, B. L., Herendeen, N. E., Kahn, J. A., Mahajan, P. V., Gorelick, M. H., Bajaj, L., Gonzalez del Rey, J. A., Herr, S., Mull, C. C., Schnadower, D., Sirbaugh, P. E., Lumba-Brown, A., Dahl-Grove, D. L., McAnerney, C. M., Remick, K. E., Kharbanda, A., Nigrovic, L., Mullan, P. C., Wolff, M. S., Schor, J. A., Edwards, A. R., Flanagan, P. J., Hudak, M. L., Katkin, J. P., Kraft, C. A., Quinonez, R. A., Shenkin, B. N., Smith, T. K., & Tieder, J. S. (2017). Nonemergency Acute Care: When It’s Not the Medical Home. *Pediatrics.* 139(5): e20170629. Retrieved from: http://doi.org/10.1542/peds.2017-0629

[56] Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care, 15*(6). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/

[57] Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: a systematic review. *Journal of Health Care for the Poor and Underserved*, 24(2), 499-524. Retrieved from https://muse.jhu.edu/article/508571/pdf ; see also: National Health Care for the Homeless Council, Inc. (n.d.). *Santa Clara Medical Respite Program.* Retrieved from: https://nhchc.org/business-directory/226561/santa-clara-medical-respite-program/

[58] Gratz, T., Goldhaber, D., Willgerodt, M., & Brown, N. (2020). The frontline health care workers in schools: Health equity, the distribution of school nurses, and student access. *The Journal of School Nursing*, June 2021. See also Baisch, M. J., Lundeen, S. P., & Murphy, M. K. (2011). Evidence-based research on the value of school nurses in an urban school system. *Journal of School Health*, 81, 74-80. And see Wang, L., Vernon-Smiley, M., Gapinski, M., Desisto, M., Maughan, E., & Sheetz, A. (2014, May 19). Cost-benefit study of school nursing services. *JAMA Pediatrics*, 168(7), 642-648.

[59] Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer, 117*(S15): 3541-3550. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/cncr.26264/full. Yates, P. (2004). Cancer care coordinators: Realizing the potential for improving the patient journey. *Cancer Forum, 28*(3):128-132. Retrieved from http://eprints.qut.edu.au/1739/1/1739.pdf. See also Brown, R. S., Peikes, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, *31*(6), 1156-1166. Retrieved from http://content.healthaffairs.org/content/31/6/1156.full.html

[60] Centers for Disease Control and Prevention. (2016). *Addressing Chronic Disease Through Community Health Workers*. Retrieved from www.cdc.gov/dhdsp/docs/chw_brief.pdf

[61] Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human Resources for Health*, 16(1), 39. Retrieved from https://link.springer.com/article/10.1186/s12960-018-0304-x

[62] Flodgren, G., Rachas, A., Farmer, A. J., Inzitari, M., & Shepperd, S. (2015). *Interactive Telemedicine: Effects on Professional Practice and Health Care Outcomes.* The Cochrane Library. Retrieved from: https://www.researchgate.net/profile/Gerd_Flodgren/publication/281588584_Interactive_telemedicine_effects_on_professional_practice_and_health_care_outcomes/links/57ac28ec08ae0932c9725445.pdf

[63] Bhatt, J, Bathija, P. (2018). Ensuring Access to Quality Health Care in Vulnerable Communities. *Academic Medicine*. 93:1271-1275.

[64] Tomer, A., Fishbane, L, Siefer, A., & Callahan, B. (2020). Digital prosperity: How broadband can deliver health and equity to all communities. *Brookings Institute.* Retrieved from https://www.brookings.edu/research/digital-prosperity-how-broadband-can-deliver-health-and-equity-to-all-communities/ See also: Zuo, G. W. (2021). Wired and Hired:

Employment Effects of Subsidized Broadband Internet for Low-Income Americans. *American Economic Journal: Economic Policy.* 13(3): 447-82. Retrieved from https://www.aeaweb.org/articles?id=10.1257/pol.20190648

[65] Zarod, B. K., & Lennon, M. A. (1992). The effect of school dental screening on dental attendance. The results of a randomised controlled trial. *Community Dental Health,* 9(4), 361-368. Important that there be follow-ups because otherwise there is no evidence that screening improves anything.

[66] Estai, M., Kanagasingam, Y., Tennant, M., & Bunt, S. (2018). A systematic review of the research evidence for the benefits of teledentistry. *Journal of Telemedicine and Telecare*, 24(3), 147-156. Retrieved from https://www.researchgate.net/profile/Mohamed-Estai/publication/312836443_A_systematic_review_of_the_research_evidence_for_the_benefits_of_teledentistry/links/59e06af8a6fdcca9842ec1a0/A-systematic-review-of-the-research-evidence-for-the-benefits-of-teledentistry.pdf
See also: Estai, M., Bunt, S., Kanagasingam, Y., & Tennant, M. (2017). Cost savings from a teledentistry model for school dental screening: an Australian health system perspective. *Australian Health Review*, 42(5), 482-490. Retrieved from https://www.researchgate.net/profile/Mohamed-Estai/publication/316130685_Cost_savings_from_a_teledentistry_model_for_school_dental_screening_An_Australian_health_system_perspective/links/59e06b29a6fdcca9842ecec0/Cost-savings-from-a-teledentistry-model-for-school-dental-screening-An-Australian-health-system-perspective.pdf

[67] Fernández, C. E., Maturana, C. A., Coloma, S. I., Carrasco-Labra, A., & Giacaman, R. A. (2021). Teledentistry and mHealth for promotion and prevention of oral health: a systematic review and meta-analysis. *Journal of Dental Research*, 100(9), 914-927.

[68] Greenberg, B. J., Kumar, J. V., & Stevenson, H. (2008). Dental case management: increasing access to oral health care for families and children with low incomes. *The Journal of the American Dental Association*, 139(8), 1114-1121.

[69] Solomon-Fears, C. (2015). *Teen Pregnancy Prevention: Statistics and Programs.* Congressional Research Service. 7-5700, RS20301. Retrieved from https://www.everycrsreport.com/files/20150226_RS20301_f18f59d89e39e7e9b41d90e82c49a3b39ca8c12c.pdf

[70] Anderson Moore, K. (2010). What If We took Research Seriously: What Would Teen Pregnancy Programs Look Like? *Child Trends.*

[71] Schelar, E., Franzetta, K., & Manlove, J. (2007). Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity. *Child Trends*, Research Brief no. 2007-23.

[72] Roman, L., Raffo, J. A., Zhu, Q., & Meghea, C. I. (2014). A Statewide Medicaid Enhanced Prenatal Care Program Impact on Birth Outcomes. *JAMA Pediatrics.* 168(3): 220-227. Retrieved from: http://doi.org/10.1001/jamapediatrics.2013.4347

[73] Carter, E. B., Temming, L. A., Akin, J., Fowler, S., Macones, G. A., Colditz, G. A., & Tuuli, M. G. (2016). Group Prenatal Care Compared With Traditional Prenatal Care: A Systematic Review and Meta-analysis. Obstetrics and gynecology, 128(3), 551–561. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4993643/

[74] Trudnak, T. E., Arboleda, E., Kirby, R. S., & Perrin, K. (2013). Outcomes of Latina Women in CenteringPregnacy Group Prenatal Care Compared with Individual Prenatal Care. *Journal of Midwifery & Women's Health.* 58(4): 396-403. Retrieved from: doi.org/10.1111/jmwh.12000

[75] Novick, G., Reid, A. E., Lewis, J., Kershaw, T., Rising, S. S., & Ickovics, J. R. (2013). Group Prenatal Care: Model Fidelity and Outcomes. *Journal of Midwifery & Women's Health.* 58(5): 586. Retrieved from: https://doi.org/10.1111/jmwh.12123

[76] Ickovics, J. R., Earnshaw, V., Lewis, J. B., Kershaw, T. S., Magriples, U., Stasko, E., Rising, S. S., Cassells, A., Cunningham, S., Bernstein, P., & Tobin, J. N. (2015). Cluster Randomized Controlled Trial of Group Prenatal Care: Perinatal Outcomes Among Adolescents in New York City Health Centers. *American Journal of Public Health.* 106(2): 359-365. Retrieved from: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.302960

[77] Govere, L., & Govere, E. M. (2016). How effective is cultural competence training of healthcare providers on improving patient satisfaction of minority groups? A systematic review of literature. *Worldviews on Evidence-Based Nursing*, 13(6), 402-410. Retrieved from https://sigmapubs.onlinelibrary.wiley.com/doi/pdfdirect/10.1111/wvn.12176
See also Dykes, D. C., & White, A. A. (2011). Culturally competent care pedagogy: what works? *Clinical Orthopaedics and Related Research*, 469(7), 1813-1816. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3111794/ See also County Health Rankings and Roadmaps. (2020). *Cultural Competence Training for Health Care Professionals*. Retrieved from https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/cultural-competence-training-for-health-care-professionals

[78] Hope, D. A., Mocarski, R., Bautista, C. L., & Holt, N. R. (2016). Culturally competent evidence-based behavioral health services for the transgender community: Progress and challenges. *American Journal of Orthopsychiatry*, 86(4), 361. Retrieved from https://psycnet.apa.org/fulltext/2016-32685-001.pdf

[79] Mannion, R. (2014). Enabling compassionate healthcare: perils, prospects and perspectives. *International Journal of Health Policy and Management,* 2(3), 115-7. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992785/

[80] Lown, B. A., Muncer, S. J., & Chadwick, R. (2015). Can compassionate healthcare be measured? The Schwartz center compassionate care scale™. *Patient Education and Counseling*, 98(8), 1005-1010. Retrieved from https://research.tees.ac.uk/ws/files/6461528/581617.pdf

[81] Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health, 88*(11): 1610-1615. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610

[82] Unützer, J., Harbin, H, Schoenbaum, M., & Druss, B. (2013). The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. *Health Home Information Resources Center.* Retrieved from https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[83] Ginsburg, S. (2008). Colocating health services: a way to improve coordination of children's health care? *The Commonwealth Fund,* July 2008. Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2008/jul/colocating-health-services-way-improve-coordination-childrens

[84] Blandford, A. & Osher, F. (2012). *A Checklist for Implementing Evidence-Based Practices and Programs (EBPs) for Justice-Involved Adults with Behavioral Health Disorders.* Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2013/04/SAMHSA-GAINS.pdf. For more information on Integrated Mental Health and Substance Abuse Services, visit http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367 and http://gainscenter.samhsa.gov/pdfs/ebp/IntegratingMentalHealth.pdf

[85] Community Preventive Services Task Force. (2012). *Recommendation from the Community Preventive Services Task Force for Use of Collaborative Care for the Management of Depressive Disorders*. Retrieved from www.thecommunityguide.org/mentalhealth/CollabCare_Recommendation.pdf

[86] The Community Guide. (2019). *Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders.* Retrieved from https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders

[87] Guide to Community Preventive Services. (2008). *Interventions to Reduce Depression Among Older Adults: Clinic-Based Depression Care Management*. Retrieved from www.thecommunityguide.org/mentalhealth/depression-clinic.html

[88] Chiesa, A. & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research*, 187(3), 441-453. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20846726; also, Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice*, 18(4), 233-252. Retrieved from www.ncbi.nlm.nih.gov/pubmed/22805898

[89] Zenner, C., Herrnleben-Kurz, S., & Walach, H. (2014). Mindfulness-based interventions in schools—a systematic review and meta-analysis. *Frontiers in Psychology*, 5, 603. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC4075476/

[90] The California Evidence-Based Clearinghouse for Child Welfare. (2018). *Adolescent Community Reinforcement Approach (ACRA).* Retrieved from https://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/

[91] The California Evidence-Based Clearinghouse for Child Welfare. (2019). *The Seven Challenges.* Retrieved from https://www.cebc4cw.org/program/the-seven-challenges/

[92] The California Evidence-Based Clearinghouse for Child Welfare. (2019). *Substance Abuse Treatment (Adolescent).* Retrieved from https://www.cebc4cw.org/topic/substance-abuse-treatment-adolescent/

[93] The Community Guide. (2019). *Violence: Primary Prevention Interventions to Reduce Perpetration of Intimate Partner Violence and Sexual Violence Among Youth.* Retrieved from https://www.thecommunityguide.org/findings/violence-primary-prevention-interventions-reduce-perpetration-intimate-partner-violence-sexual-violence-among-youth. See also Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf, and Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, retrieved from https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[94] Community Matters. (2019). *Safe School Ambassadors Program (SSA).* Retrieved from http://community-matters.org/programs-and-services/safe-school-ambassadors

[95] Suicide Prevention Resource Center. (2012). *QPR Gatekeeper Training for Suicide Prevention.* Retrieved from https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention

[96] Suicide Prevention Resource Center. (2016). *SOS Signs of Suicide Middle School and High School Prevention Programs.* Retrieved from https://www.sprc.org/resources-programs/sos-signs-suicide

[97] Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research*, *187*(3): 441-453. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20846726; also, Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice*, *18*(4): 233-252. Retrieved from www.ncbi.nlm.nih.gov/pubmed/22805898

[98] Mavandadi, S., Benson, A., DiFilippo, S., Streim, J. E., & Oslin, D. (2015). A telephone-based program to provide symptom monitoring alone vs symptom monitoring plus care management for late-life depression and anxiety. *JAMA Psychiatry, 72*(12): 1211-1218.

[99] Firth, J., Torous, J., Nicholas, J., Carney, R., Pratap, A., Rosenbaum, S., & Sarris, J. (2017). The efficacy of smartphone-based mental health interventions for depressive symptoms: A meta-analysis of randomized controlled trials. *World Psychiatry, 16*: 287-298. Retrieved from doi.org/10.1002/wps.20472

[100] U.S. Preventive Services Task Force. (2014). *Final Recommendation Statement: Depression in Adults: Screening*. Retrieved from www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening

[101] Although it appears that no comprehensive evidence-based program of ED screening and referral for mental health issues currently exists [However, see this theoretical adaptation of the SBIRT model, expanded for triaging and intervening in suicidal behavior, especially Figure 1 and Table 1: Larkin, G. L., Beautrais, A. L., Spirito, A., Kirrane, B. M., Lippmann, M. J., & Milzman, D. P. (2009). Mental health and emergency medicine: a research agenda. *Academic Emergency Medicine*, *16*(11), 1110-1119. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3679662/], there is evidence that brief screening tools do well in detecting suicidal ideation among pediatric and young adult ED patients [National Institute of Mental Health. (2013). *Emergency Department Suicide Screening Tool Accurately Predicts At-Risk Youth*. Retrieved from www.nimh.nih.gov/news/science-news/2013/emergency-department-suicide-screening-tool-accurately-predicts-at-risk-youth.shtml], and PTSD among pediatric ED patients and their parents [Ward-Begnoche, W. L., Aitken, M. E., Liggin, R., Mullins, S. H., Kassam-Adams, N., Marks, A., & Winston, F. K. (2006). Emergency department screening for risk for post-traumatic stress disorder among injured children. *Injury Prevention, 12*(5), 323-326. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2563451/].

[102] Coffman, J. (2020). Can Paramedics Safely Screen Patients for Transport to a Mental Health Crisis Center? Evidence from California. *Health Services Research*, 55, 101-102. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13474

[103] Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health, 88*(11): 1610-1615. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610

[104] Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf. See also: Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, retrieved from https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[105] The Community Guide. (2019). *Physical Activity: Enhanced School-Based Physical Education.* Retrieved from https://www.thecommunityguide.org/findings/physical-activity-enhanced-school-based-physical-education

[106] Guide to Community Preventive Services. (2014). *Obesity Prevention and Control: Behavioral Interventions That Aim to Reduce Recreational Sedentary Screen Time Among Children*. Retrieved from www.thecommunityguide.org/obesity/behavioral.html

[107] Maniccia, D.M., Davison, K.K., Marshall, S.J., Manganello, J.A., & Dennison, B.A. (2011). A Meta-analysis of Interventions That Target Children's Screen Time for Reduction. *Pediatrics*, 128 (1) e193-e210; DOI: 10.1542/peds.2010-2353. Retrieved from https://pediatrics.aappublications.org/content/128/1/e193.long

[108] Buchanan, L.R., Rooks-Peck, C.R., Finnie, R.K.C., Wethington, H.R., Jacob, V., Fulton, J.E., Johnson, D.B., Kahwati, L.C., Pratt, C.A., Ramirez, G., Mercer, S., Glanz, K., and the Community Preventive Services Task Force. (2016). Reducing recreational sedentary screen time: A Community Guide systematic review. *American Journal of Preventive Medicine*, 50(3):402-15.

[109] Centers for Disease Control and Prevention. (2011). *School Health Guidelines to Promote Healthy Eating and Physical Activity.* MMWR 2011; 60 (No. RR-5):1-76. Retrieved from www.cdc.gov/mmwr/pdf/rr/rr6005.pdf

[110] Community Preventive Services Task Force. (2017). Diabetes: combined diet and physical activity promotion programs to prevent Type 2 diabetes among people at increased risk. *The Community Guide.* Retrieved from thecommunityguide.org/findings/diabetes-combined-diet-and-physical-activity-promotion-programs-prevent-type-2-diabetes

[111] Guide to Community Preventive Services. (2007). *Obesity: Worksite Programs.* Retrieved from https://www.thecommunityguide.org/findings/obesity-worksite-programs

[112] U.S. Preventive Services Task Force. (2018). *Final Update Summary: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions.* Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions

[113] The Community Guide. (2018). *Interventions for the Whole Family Get Kids Moving.* Retrieved from https://www.thecommunityguide.org/content/interventions-whole-family-get-kids-moving

[114] Cochrane Library. (2016). *Diet, Physical Activity, and Behavioural Interventions for the Treatment of Overweight or Obesity in Preschool Children Up to the Age of 6 Years.* Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012105/full.

[115] Cochrane Library. (2017). *Diet, Physical Activity, and Behavioural Interventions for the Treatment of Overweight or Obese Adolescents Aged 12 to 17 Years.* Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012691/full

[116] American Academy of Pediatrics, Institute for Healthy Childhood Weight. (2017). *Evidence-Based Childhood Obesity Treatment Services: Applying Recommendations from the AAP/AHRQ Obesity Treatment & Reimbursement Conference Webinar.* Retrieved from https://ihcw.aap.org/Documents/AHRQWebinar1_FAQs.pdf

[117] Guide to Community Preventive Services. (2009). *Obesity: Technology-Supported Multicomponent Coaching or Counseling Interventions – To Reduce Weight*. Retrieved from https://www.thecommunityguide.org/findings/obesity-technology-supported-multicomponent-coaching-or-counseling-interventions-reduce and *Obesity: Technology-Supported Multicomponent Coaching or Counseling Interventions – To Maintain Weight Loss.* Retrieved from https://www.thecommunityguide.org/findings/obesity-technology-supported-multicomponent-coaching-or-counseling-interventions-maintain

[118] Centers for Medicare and Medicaid Services. (n.d.). *Medicare Diabetes Prevention Program Expanded Model.* Retrieved from https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

[119] Beck, J., Greenwood, D. A., Blanton, L., Bollinger, S. T., Butcher, M. K., Condon, J. E., Cypress, M., Faulkner, P., Fischl, A.J., Francis, T. & Kolb, L.E. (2017). 2017 National standards for diabetes self-management education and support. *Diabetes Care*, 40(10), 1409-1419. Retrieved from https://diabetesjournals.org/care/article/40/10/1409/29569

[120] Community Preventive Services Task Force. (2017). Diabetes management: Mobile phone applications used within healthcare systems for Type 2 diabetes self-management. *The Community Guide.* Retrieved from thecommunityguide.org/findings/diabetes-management-mobile-phone-applications-used-within-healthcare-systems-type-2

[121] Community Preventive Services Task Force. (2017). Health information technology: Text messaging interventions for medication adherence among patients with chronic diseases. *The Community Guide.* Retrieved from thecommunityguide.org/findings/health-information-technology-text-messaging-medication-adherence-chronic-disease

[122] Community Preventive Services Task Force. (2017). Diabetes management: Interventions engaging community health workers. *The Community Guide.* Retrieved from thecommunityguide.org/findings/diabetes-management-interventions-engaging-community-health-workers

[123] Community Preventive Services Task Force. (2017). Diabetes management: Team-based care for patients with Type 2. *The Community Guide.* Retrieved from thecommunityguide.org/findings/diabetes-management-team-based-care-patients-type-2-diabetes

[124] U.S. Preventive Services Task Force. (2015). *Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening*. Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-abnormal-blood-glucose-and-type-2-diabetes

[125] U.S. Preventive Task Force. (2021). *Screening for Prediabetes and Type 2 Diabetes.* Retrieved from: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes

[126] Lohse, B., Pflugh Prescott, M., Cunningham-Sabo, L. (2019). Eating-competent parents of 4th grade youth from a predominantly non-Hispanic white sample demonstrate more healthful eating behaviors than non-eating competent parents. *Nutrients*. 11:1501. Retrieved from https://www.needscenter.org/wp-content/uploads/2019/07/nutrients-11-01501.pdf

[127] Cunningham-Sabo, L., Lohse, B., Smith, S., Browning, R., Strutz, E., Nigg, C., Balgopal, M., Kelly, K., & Ruder, E. (2016). Fuel for Fun: a cluster-randomized controlled study of cooking skills, eating behaviors, and physical activity of 4th graders and their families. *BMC Public Health* 16, 444. Retrieved from https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3118-6

[128] Wall, D.E., Least, C., Gromis, J., & Lohse, B. (2012). Nutrition education intervention improves vegetable-related attitude, self-efficacy, preference, and knowledge of fourth-grade students. *Journal of School Health*. 82(1):37-43. Retrieved from https://pubmed.ncbi.nlm.nih.gov/22142173/

[129] The Community Guide. (2019). *Nutrition: Gardening Interventions to Increase Vegetable Consumption Among Children.* Retrieved from https://www.thecommunityguide.org/findings/nutrition-gardening-interventions-increase-vegetable-consumption-among-children

[130] Guide to Community Preventive Services. (2010). *Reducing Structural Barriers for Clients.* Retrieved from https://www.thecommunityguide.org/findings/

[131] Guide to Community Preventive Services. (2009). *Reducing Client Out-of-Pocket Costs.* Retrieved from https://www.thecommunityguide.org/findings/

[132] National Cancer Institute. (2020). *Evidence-Based Cancer Control Programs (EBCCP).* Retrieved from https://ebccp.cancercontrol.cancer.gov/index.do

[133] Guide to Community Preventive Services. (2006). *Provider Reminder and Recall Systems.* Retrieved from https://www.thecommunityguide.org/findings

[134] Guide to Community Preventive Services. (2005). *Small Media Targeting Clients.* Retrieved from https://www.thecommunityguide.org/findings

[135] National Institutes of Health, National Institute on Aging. (n.d.). *Dementia Resources for Health Professionals: Assessing Cognitive Impairment in Older Patients.* National Institute on Aging. Retrieved from https://www.nia.nih.gov/health/assessing-cognitive-impairment-older-patients#us

[136] Guide to Community Preventive Services. (2019). *Interventions Engaging Community Health Workers.* Retrieved from https://www.thecommunityguide.org/findings

[137] Guide to Community Preventive Services. (2019). *Heart Disease and Stroke Prevention: Tailored Pharmacy-Based Interventions to Improve Medication Adherence.* Retrieved from https://www.thecommunityguide.org/findings/cardiovascular-disease-tailored-pharmacy-based-interventions-improve-medication-adherence

[138] Guide to Community Preventive Services. (2017). *Heart Disease and Stroke Prevention: Mobile Health (mHealth) Interventions for Treatment Adherence Among Newly Diagnosed Patients.* Retrieved from https://www.thecommunityguide.org/findings/cardiovascular-disease-mobile-health-interventions-treatment-adherence-among-newly-diagnosed-patients

[139] Guide to Community Preventive Services. (2015). *Heart Disease and Stroke Prevention: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Used Alone.* Retrieved from https://www.thecommunityguide.org/findings/cardiovascular-disease-self-measured-blood-pressure-when-used-alone

[140] Guide to Community Preventive Services. (2017). *Health Information Technology: Text Messaging Interventions for Medication Adherence Among Patients with Chronic Diseases.* Retrieved from https://www.thecommunityguide.org/findings/health-information-technology-text-messaging-medication-adherence-chronic-disease

[141] Guide to Community Preventive Services. (2017). *Cardiovascular Disease: Interactive Digital Interventions for Blood Pressure Self-Management.* Retrieved from https://www.thecommunityguide.org/findings/cardiovascular-disease-interactive-digital-interventions-blood-pressure-self-management

[142] National Council on Aging. (2021*). Evidence-Based Chronic Disease Self-Management Education Programs.* Retrieved from https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs

[143] ChangeLab Solutions. (2015). *Up to Code: Code Enforcement Strategies for Healthy Housing.* Retrieved from https://changelabsolutions.org/sites/default/files/Up-tp-Code_Enforcement_Guide_FINAL-20150527.pdf

[144] Identified as a "best practice" in community service: Institute for Local Government, League of California Cities, and California State Association of Counties. (2018). *Homelessness Task Force Report: Tools and Resources for Cities and Counties.* Retrieved from: http://www.ca-ilg.org/sites/main/files/htf_homeless_3.8.18.pdf

[145] See, for example, Kercsmar, C. M., Dearborn, D. G., Schluchter, M., Xue, L., Kirchner, H. L., Sobolewski, J., Greenberg, S. J., Vesper, S. J. & Allan, T. (2006). Reduction in asthma morbidity in children as a result of home remediation aimed at moisture sources. *Environmental Health Perspectives*, *114*(10): 1574-1580. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626393/. See also: Sauni, R., Uitti, J., Jauhiainen, M., Kreiss, K., Sigsgaard, T., & Verbeek, J. H. (2013). Remediating buildings damaged by dampness and mould for preventing or reducing respiratory tract symptoms, infections and asthma. *Evidence-Based Child Health: A Cochrane Review Journal*, *8*(3), 944-1000.

[146] Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health, 88*(11): 1610-1615. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610

[147] Fitzpatrick-Lewis, D., Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F., & Hwang, S. W. (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health, 11*(1), 638.

[148] DeSilva, M. B., Manworren, J., & Targonski, P. (2011). Impact of a housing first program on health utilization outcomes among chronically homeless persons. *Journal of Primary Care and Community Health, 2*(1): 16-20; Perlman, J., & Parvensky, J. (2006). *Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report.* Colorado Coalition for the Homeless. Retrieved from https://shnny.org/uploads/Supportive_Housing_in_Denver.pdf; Fichter, M. M., & Quadflieg, N. (2006). Intervention effects of supplying homeless individuals with permanent housing: A 3-year prospective study. *Acta Psychiatrica Scandinavica* (429): 36-40

[149] Holzer, H.J. (2022). *Do Sectoral Training Programs Work? What the Evidence on Project Quest and Year Up Really Shows.* Brookings Institution. Retrieved from https://www.brookings.edu/research/do-sectoral-training-programs-work-what-the-evidence-on-project-quest-and-year-up-really-shows/

[150] Katz, L. F., Roth, J., Hendra, R., & Schaberg, K. (2022). Why do sectoral employment programs work? Lessons from WorkAdvance. *Journal of Labor Economics*, 40(S1), S249-S291. Retrieved from https://www.nber.org/system/files/working_papers/w28248/w28248.pdf

[151] Pathways to Work Evidence Clearinghouse. (2022). *Project Quality Employment Through Skills Training (QUEST).* Retrieved from https://pathwaystowork.acf.hhs.gov/intervention-detail/679

[152] World Health Organization. (2017). Health employment and economic growth: an evidence base. World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/326411/9789241512404-eng.pdf

[153] Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf

[154] Public Health Law & Policy and the California WIC Association. (2009). *Changes in the WIC Food Packages: A Toolkit for Partnering with Neighborhood Stores.* Retrieved from https://alliancetoendhunger.org/wp-content/uploads/2018/03/WIC_Toolkit.pdf

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 Hospital Community Benefit Committee (HCBC) recommendation
  - Funding history and metric performance, if applicable
  - Dual funding information, if applicable
  - FY23 proposed metrics

FY23 ECH Grant Application Index

Total Requested: $5,432,510 | Total Funded: $3,310,000 | Total Unfunded: $2,122,510

Health Need	Agency	Page #	New	DNF	Dual Request	Requested	FY22 Approved (if applicable)	HCBC Rec.
Health Care Access & Delivery Goal % = 30% Recommended % = 29%	Campbell Union School District - School Nurse Program	8				$ 231,000	$ 215,000	$ 215,000
	County of Santa Clara Health System - Better Health Pharmacy	10				$ 75,000	$ 75,000	$ 75,000
	Healthier Kids Foundation	14				$ 60,000	$ 30,000	$ 60,000
	Mt. Pleasant School District - School Nurse Program	15				$ 124,000	$ 122,000	$ 122,000
	Asian Americans for Community Involvement	4				$ 208,830	$ 100,000	$ 100,000
	Bay Area Community Health	6	X			$ 100,000	N/A	$ 50,000
	Cambrian School District - School Nurse Program	7				$ 175,000	$ 125,000	$ 125,000
	Cupertino Union School District - School Nurse Program	11			X	$ 120,367	$ 100,000	$ 100,000
	Health Mobile	13			X	$ 150,000	$ 55,000	$ 75,000
	Tower Foundation of San Jose State University	17	X	X		$ 49,000	N/A	$ -
	Vista Center for the Blind and Visually Impaired	18			X	$ 83,138	$ 40,000	$ 40,000
					TOTALS:	$ 1,376,335		$ 962,000
Behavioral Health Goal % = 30% Recommended % = 31%	Almaden Valley Counseling Service	22				$ 80,000	$ 70,000	$ 36,000
	Alzheimer's Disease and Related Disorders Association	23		X		$ 70,000	$ 70,000	$ -
	Cupertino Union School District - Mental Health Program	30			X	$ 137,000	$ 120,000	$ 120,000
	Jewish Family Services of Silicon Valley	34				$ 95,000	$ 82,000	$ 75,000
	LifeMoves	36			X	$ 60,000	$ 60,000	$ 50,000
	Tower Foundation of San Jose State University	45	X			$ 50,000	N/A	$ 25,000
	ACT for Mental Health	20				$ 50,000	$ 60,000	$ 40,000
	Bill Wilson Center	24				$ 25,000	$ 25,000	$ 25,000
	Cancer CAREpoint	27				$ 36,000	$ 30,000	$ 30,000
	Child Advocates of Silicon Valley	28				$ 40,000	$ 40,000	$ 40,000
	Momentum for Health	40			X	$ 46,000	$ 46,000	$ 40,000
	Next Door Solutions to Domestic Violence	42				$ 95,000	$ 90,000	$ 90,000
	Peninsula Healthcare Connection	43				$ 100,000	$ 90,000	$ 90,000
	South Bay Kidpower Teenpower Fullpower	44	X	X		$ 30,000	N/A	$ -
	Adolescent Counseling Services (ACS)	21	X			$ 30,000	N/A	$ 25,000
	Cambrian School District - Mental Health Program	26	X	X		$ 150,000	N/A	$ -
	Community Health Partnership	30		X		$ 50,000	$ 40,000	$ -
	Eating Disorders Resource Center	32	X	X	X	$ 22,500	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 ECH Grant Application Index

Total Requested: $5,432,510 | Total Funded: $3,310,000 | Total Unfunded: $2,122,510

Health Need	Agency	Page #	New	DNF	Dual Request	Requested	FY22 Approved (if applicable)	HCBC Rec.
	Fremont Union High School District	33	X	X		$ 155,000	N/A	$ -
	LGS (Los Gatos Saratoga) Recreation	35				$ 31,790	$ 20,000	$ 15,000
	Los Gatos Union School District - Mental Health Program	38				$ 110,000	$ 110,000	$ 110,000
	Union School District	46	X	X		$ 380,000	N/A	$ -
	Uplift Family Services at Campbell Union High School District	47				$ 230,000	$ 210,000	$ 210,000
					TOTALS:	$ 2,073,290		$ 1,021,000
Diabetes & Obesity	Gardner Family Health Network	56				$ 271,469	$ 230,000	$ 254,500
	Indian Health Center of Santa Clara Valley	59				$ 125,000	$ 87,000	$ 111,500
	Playworks	62			X	$ 81,000	$ 86,000	$ 40,000
	Valley Verde	66				$ 60,000	$ 45,000	$ 60,000
	African American Community Service Agency	48				$ 60,398	$ 28,000	$ 43,000
	Chinese Health Initiative	53			X	$ 45,000	$ 42,000	$ 20,000
	El Camino Health - Food Pharmacy	55	X			$ 148,591	N/A	$ 148,500
	GoNoodle	57				$ 114,000	$ 113,000	$ 40,000
	South Asian Heart Center	64			X	$ 110,000	$ 100,000	$ 50,000
	West Valley Community Services	68				$ 275,000	$ 160,000	$ 184,500
	American Diabetes Association	50	X			$ 50,000	N/A	$ 25,000
Goal % = 30%	Bay Area Women's Sports Initiative	52			X	$ 60,000	$ 15,000	$ 15,000
Recommended % = 30%	Palo Alto Medical Foundation	60		X	X	$ 25,000	$ 20,000	$ -
					TOTALS:	$ 1,425,458		$ 992,000
	American Heart Association	69			X	$ 60,000	$ 50,000	$ 60,000
	Breathe California	70				$ 40,000	$ 40,000	$ 40,000
	Pink Ribbon Girls	72				$ 25,000	$ 25,000	$ 25,000
Chronic Conditions	Latinas Contra Cancer	71				$ 75,000	$ 35,000	$ 40,000
Goal % = 5% Recommended % = 5%					TOTALS:	$ 200,000		$ 165,000
	Rebuilding Together Silicon Valley	78				$ 30,000	$ 30,000	$ 30,000
	Sacred Heart Community Service	79	X	X		$ 20,000	N/A	$ -
	West Valley Community Services - Senior Services	82				$ 45,000	$ 45,000	$ 45,000
	Catholic Charities of Santa Clara County	73	X			$ 50,000	N/A	$ 30,000
	Downtown Streets Team	75				$ 30,000	$ 30,000	$ 30,000
	Teen Success	81	X	X		$ 25,000	N/A	$ -
Economic Stability	El Camino Health - DEI & Economic Opportunity Program	76	X			$ 37,000	N/A	$ 35,000
Goal % = 5%	First Community Housing	77		X		$ 90,000	$ 30,000	$ -
Recommended % = 5%	School of Arts and Culture at Mexican Heritage Plaza	80	X	X		$ 30,427	N/A	$ -
					TOTALS:	$ 357,427		$ 170,000

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

Asian Americans for Community Involvement (AACI)

Program Title	Increasing Access to Health Care	*Recommended Amount:* $100,000
Program Abstract & Goal	To increase access to care through bicultural and bilingual Medical Assistants (MAs) and a Patient Navigator (PNs) at two clinics in San Jose opoerated by AACI. Most patients are indigent and working poor, and are monolingual in a language other than English. MAs and PNs are the first point of clinical contact for these patients. Patients receive primary care and integrated behavioral health services either in their native language or with interpretation provided by MAs. PNs help patients in their native language learn about their health care benefits, enroll in insurance, access specialty care services, and other community resources. Alleviating the language barrier benefits patients by increasing access to care and improving health outcomes. Agency uses evidence-based programs and services are provided at agency's medical sites in San Jose.	
Agency Description & Address	2400 Moorpark Avenue, Suite 300, San Jose http://www.aaci.org Founded in 1973, AACI serves all members of our diverse community, focusing on those who are marginalized and vulnerable, and who face barriers to accessing health and wellness services. Our many programs advance our belief in providing care that goes beyond health and provides clients with a sense of hope and new possibilities. Current programs include primary care health services, behavioral health and substance abuse prevention and treatment, center for survivors of torture, shelter and services for domestic violence and human trafficking survivors, senior wellness and youth programs, and community advocacy. Our clients are impacted by chronic disease, mental illness, trauma and face many obstacles to health and well-being. Our strategic plan for 2021-2025 is focused on expanding access to culturally sensitive integrated care.	
Program Delivery Site(s)	Services will be provided at AACI West San Jose clinic and AACI East San Jose clinic	
Services Funded By Grant/How Funds Will Be Spent	Services include: • 20-minute appointments with MAs and physicians where patients receive medical care • Follow-up services after each patient appointment • Daily interpretation services at medical appointments • Enrollment for health insurance coverage, like Medi-Cal, Covered California, Primary Care Access Program • Navigation services, like linkage with specialty care, referrals to community resources like food banks, transportation. Full requested amount funds two Medical Assistants and partial salary for a Patient Navigator as well some program expenses.	
FY23 Funding	FY23 Requested: $208,830	FY23 Recommended: $100,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $100,000 FY22 Approved: $100,000 FY22 6-month metrics met: 40%	FY21 Approved: $85,000 FY21 Spent: $85,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 60%	New in FY21

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Asian Americans for Community Involvement

[Continued from previous page]

	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	433	866
	Services provided (medical appointments)	931	2,896
	Patients screened for depression with a positive result who are offered integrated behavioral health services services (if not already receiving behavioral health care).	80%	80%
	Patients who rate their telehealth appointment experience as "good" or "excellent".	70%	70%
	Patients who rate their MA as "excellent" or "good" for their courteousness and professionalism and would recommend AACI's Health Center to their family and friends	90%	90%

FY23 Healthcare Access & Delivery Application Summary

Bay Area Community Health

Program Title	Senior Mobile Health Clinic	*Recommended Amount:* $50,000
Program Abstract & Goal	To provide health services to isolated seniors utilizing a Senior Mobile Health Clinic (SMHC). ADA-accessible, 36-foot-long vehicle is equipped with two medical examination rooms and one reception/triage area. SMHC will offer comprehensive physical and mental healthcare services by appointment and for walk-ins. Services are provided by a registered nurse, behavioral health therapist and/or licensed clinical social worker, and a bilingual licensed driver/intake specialist. Seniors who are generally isolated, and/or lack time, resources and motivation to travel to brick and mortar clinics will benefit when healthcare is brought to them. Services will be provided at community and senior centers in San Jose. Evidence-based model of mobile health clinic is shown to eliminate many logistical barriers to more traditional forms of healthcare.	
Agency Description & Address	40910 Fremont Blvd, Fremont http://www.bach.health Bay Area Community Health (BACH) is a nonprofit, Federally Qualified Health Center providing high-quality comprehensive health services in southern Alameda County and Santa Clara County (SCC). BACH provides primary medical, dental, vision, and behavioral health services for the entire family through 27 clinic sites stretching from Union City to Gilroy, including a dental site, a vision clinic, eight mobile clinics and six school-based clinics. BACH's mission is to deliver exceptional health and social services that improves the quality of life for the individuals, families, and communities we serve.	
Program Delivery Site(s)	Services provided at the following community, neighborhood and senior centers: • Eastside Neighborhood Center • Evergreen Community Center • Mayfair Community Center • Roosevelt Community Center • Southside Senior Center	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Intake and assessments • 20-30-minute medical health appointments • Behavioral health appointments • Travel vouchers and assistance for patients to attend referral appointments Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $100,000	FY23 Recommended: $50,000

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	140	275
	Number of physical and/or behavioral health sessions	1,444	2,888
	An increased/improved overall wellness, positive outlook, sense of connectedness to others and environment.	75%	75%
	An improved knowledge and behaviors around key physical and mental issues such as healthy eating, cognitive development, increased activity, and adequate sleep.	75%	75%
	An understanding of healthy activities and outlets of future lifestyles and directions and social connectivity.	75%	75%

FY23 Healthcare Access & Delivery Application Summary

Cambrian School District – School Nurse Program

Program Title	School Nurse Program	*Recommended Amount:* $125,000
Program Abstract & Goal	To provide one full-time and one part-time RN district nurse, as well as equipment, to the Cambrian School District. These nurses are necessary to maintain the health and well-being of pre-K-8th grade students. Services include vision and hearing screenings, crisis intervention and long-term management of acute and chronic health issues for students. School nurses provide professional development to all staff, families and the Cambrian community at large to support healthy children. Services will be provided on campus before, during and after the school day.	
Agency Description & Address	4115 Jacksol Drive, San Jose http://www.cambriansd.org Cambrian School District, a caring and collaborative community, develops creative and critical thinkers who communicate effectively, value diversity and are ready to excel in a global society. We believe in valuing and teaching the whole child, preparing all Cambrian students to be successful in addressing the challenges of the 21st century as global citizens, honoring and encouraging the strengths of every child, fostering a strong sense of community, and creating a safe, orderly learning environment for all, and academic excellence that is built through collaboration and teamwork.	
Program Delivery Site(s)	Services provided at all Cambrian school locations: • Sartorette Elementary School • Bagby Elementary School • Steindorf STEAM K-8 Magnet School • Farnham Elementary School • Fammatre Elementary School • Ida Price Middle School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Vision and hearing screenings • Crisis intervention (individual sessions when needed) and long-term intervention for health needs such as diabetics, seizures, cardiac care, asthma and allergies • Professional development for district nursing and health clerk staff • Resources for immunizations for families with no insurance • CPR, AED and Epipen training for specific designated district staff • Seizure training for select designated staff Full requested amount funds one 1.5 FTE RN, some health clerk hours, supplies and program support costs.	
FY23 Funding	FY23 Requested: $175,000	FY23 Recommended: $125,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $200,000 FY22 Approved: $125,000 FY22 6-month metrics met: 0%	FY21 Approved: $125,000 FY21 Spent: $125,000 FY21 6-month metrics met: 25% FY21 Annual metrics met: 80%	FY20 Approved: $128,000 FY20 Spent: $128,000 FY20 6-month metrics met: 33% FY20 Annual metrics met: 60%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	1,400	2,959
	Encounters	700	1,400
	Students mandated to be screened for visin/hearing, grades TK, K, 2,5,8	60%	100%
	Staff professional development fo health clerks and designated staff on compliance, preventative measures, CPR, AED and Epipen training	50%	100%
	Students needing immunization compliance	5%	15%

FY23 Healthcare Access & Delivery Application Summary

Campbell Union School District – School Nurse Program

Program Title	School Nurse Program	*Recommended Amount:* $215,000
Program Abstract & Goal	To fund two school nurses and 300 hours of community liaison time to support student health and wellbeing in the Campbell Union School District (CUSD). CUSD schools are known by the community to be "safe places" for families to seek assistance and guidance for a variety of services and health resources. The school nurses and community liaisons connect families with physicians, community resources, and other services they may need, including medical, dental and vision services. School nurses provide health assessments, including vision and hearing screenings, and administer brief classroom interventions aimed at mitigating transmission of viruses along with reducing stress and anxiety in students. School nurses also support teachers with health education videos. Services are provided onsite before, during and after school hours.	
Agency Description & Address	155 N. Third Street, Campbell http://www.campbellusd.org Established in 1921, Campbell Union School District (CUSD) is a PreK-8 school district that includes parts of 6 cities in Santa Clara County. Our teachers educate more than 6,600 students at 10 elementary schools including a Transitional Kindergarten (TK)-8 school, 2 middle schools, a Home School Program, and district-operated preschools.	
Program Delivery Site(s)	School sites in the Campbell Union School District: • Blackford Elementary • Campbell Middle • Capri Elementary • Castlemont Elementary • Forest Hill Elementary • Lynhaven Elementary • Marshall Lane Elementary • Monroe Middle • Rolling Hills Middle • Rosemary Elementary • Sherman Oaks Elementary • Village Elementary	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Direct nursing services to students • Vision and hearing screenings; follow-ups and referrals as needed • Emergency Health Care Plans for students with severe health concerns • Train school teachers and staff about student health needs and emergency procedures • COVID -19 vaccination promotion • Health education videos • Health promotion information for students and parents/caregivers, such as dental, vision, and insurance resources Full requested amount funds salaries for two RNs and the partial salary for a community liaison.	
FY23 Funding	FY23 Requested: $231,000	FY23 Recommended: $215,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $215,000 FY22 Approved: $215,000 FY22 6-month metrics met: 100%	FY21 Approved: $215,000 FY21 Spent: $215,000 FY21 6-month metrics met: 83% FY21 Annual metrics met: 100%	FY20 Approved: $215,000 FY20 Spent: $215,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 60%

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Campbell Union School District – School Nurse Program

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	2,000	3,850
	Classrooms (2 total) with a high percentage of free reduced lunch students participating in GoNoodle (movement and mindfulness activities) at least once a week, for 10 week sessions.	1	2
	Teachers and front office staff who receive Epi-Pen trainings.	50%	75%
	Transitional Kindergarten/Kindergarten classrooms participating in handwashing videos and teeth brushing videos among two Title 1 elementary schools.	35%	50%
	Students with a failed health screening who saw a healthcare provider.	0%	40%

County of Santa Clara Health System

Program Title	Better Health Pharmacy	*Recommended Amount:* $75,000
Program Abstract & Goal	To increase medication access for the uninsured and under-insured residents of Santa Clara County. Better Health Pharmacy is the first and largest no-cost County pharmacy in California. The grant allows the pharmacy to supplement inventory of most commonly needed medications. Pharmacy is open Tuesday-Saturday and is located near downtown San Jose. The pharmacy is staffed with pharmacists and pharmacy technicians, and recently restarted onboarding volunteers in 2022 after the volunteer program was closed due to COVID-19 in March 2020.	
Agency Description & Address	777 Turner Drive, Suite 220, San Jose http://www.betterhealthrx.org 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. Please see organizational chart here:	
Program Delivery Site(s)	Services will be provided at the Better Health Pharmacy	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Maintain a constant supply of low cost medications most commonly needed by patients for chronic conditions such as hypertension, hyperlipidemia, diabetes, asthma, etc. Full requested amount funds purchase of medications only (no personnel or other program expenses)	
FY23 Funding	FY23 Requested: $75,000	FY23 Recommended: $75,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $75,000 FY22 Approved: $75,000 FY22 6-month metrics met: 80%	FY21 Approved: $50,000 FY21 Spent: $50,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $50,000 FY20 Spent: $50,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 1000%

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	2,100	3,200
	Prescriptions dispensed	17,000	31,000
	Patients who answered very satisfied to the quality of service	97%	97%
	Patients who answered very satisfied with the time waited for services	97%	97%
	Patients who answered very satisfied with the time waited for information	97%	97%

FY23 Healthcare Access & Delivery Application Summary

Cupertino Union School District – School Nurse Program

Program Title	School Nurse Program	*Recommended Amount:* $100,000
Program Abstract & Goal	This program aims to support the Student Health Services program in the Cupertino School Union 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. All services are provided on school sites during the school day during the school year.	
Agency Description & Address	1309 S. Mary Avenue, Sunnyvale http://www.cusdk8.org 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)	Services will be provided at18 elementary and middle schools in the Cupertino Union School District and as-needed by referral in the school district. • Abraham Lincoln Elementary • Arthur Hyde Middle • Blue Hills Elementary • Christa McAuliffe Elementary • Eaton Elementary • D.J. Sedgewick Elementary • Dwight Eisenhower Elementary • Garden Gate Elementary • Joaquin Miller Middle • John F Kennedy Middle • John Muir Elementary • L.P. Collins Elementary • Manuel DeVargas Elementary • Murdock Portal Elementary • Nelson Dilworth Elementary • Sam H. Lawson Middle • Stevens Creek Elementary • William Faria Elementary	

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FY23 Healthcare Access & Delivery Application Summary

Cupertino Union School District – School Nurse Program

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<table>
<tr><td>Services Funded By Grant/How Funds Will Be Spent</td><td colspan="4">Services include:
Day to day nursing assessment, care, and documentation of illness and injury
Ongoing recording and monitoring of students with special medical needs at school
Collaboration with primary and specialty care providers to determine specialized needs
Ongoing administration of medications and procedures for students requiring them at school (i.e. insulin, urinary catheterization)
Screening/follow-up for undiagnosed vision and hearing Impairments
Oral health screenings/follow-ups
Identification of non-compliant TB testing, required immunizations and physical exams
Annual and ongoing confirmation of physical health assessments for all first grade students
Individual health assessment for student evaluated for Special Education
Identification of students with medical conditions and creation of Individualized Student Healthcare Plans (ISHP) to meet their unique needs at school
Development/implementation of health and safety protocols and trainings for a variety of situations and settings, including COVID-19
Supervision of COVID-19 isolation areas and assistance with contact tracing
Training of unlicensed personnel to perform scope-appropriate medical care
Full requested amount funds partial staff salaries and some program expenses.</td></tr>
<tr><td>FY23 Funding</td><td colspan="4">FY23 Requested: $120,367   FY23 Recommended: $100,000</td></tr>
<tr><td rowspan="2">Funding History & Metric Performance</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $294,792
FY22 Approved: $100,000
FY22 6-month metrics met: 100%</td><td>FY21 Approved: $90,000
FY21 Spent: $90,000
FY21 6-month metrics met: 75%
FY21 Annual metrics met: 100%</td><td colspan="2">FY20 Approved: $81,921
FY20 Spent: $81,921
FY20 6-month metrics met: 100%
FY20 Annual metrics met: 50%</td></tr>
<tr><td>FY23 Dual Funding</td><td colspan="4">FY23 Requested: $120,367   FY23 Recommended: $100,000</td></tr>
<tr><td rowspan="2">Dual Funding History & Metric Performance</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $280,743
FY22 Approved: $100,000
FY22 6-month metrics met: 100%</td><td>FY21 Approved: $100,00
FY21 Spent: $100,000
FY21 6-month metrics met: 80%
FY21 Annual metrics met: 100%</td><td colspan="2">FY20 Approved: $81,921
FY20 Spent: $81,921
FY20 6-month metrics met: 100%
FY20 Annual metrics met: 100%</td></tr>
<tr><td rowspan="6">FY23 Proposed Metrics</td><td colspan="2">Metrics</td><td>6-month Target</td><td>Annual Target</td></tr>
<tr><td colspan="2">Individuals served</td><td>5,231</td><td>10,462</td></tr>
<tr><td colspan="2">Hearing & Vision Screenings Performed</td><td>1,150</td><td>9,062</td></tr>
<tr><td colspan="2">Students who saw an eye care provider after failing a vision screening at school as a result of the nurse's referral.</td><td>55%</td><td>85%</td></tr>
<tr><td colspan="2">Students who receive a flu vaccine as a result of SHS community education and advice to get flu shot.</td><td>35%</td><td>43%</td></tr>
<tr><td colspan="2">Staff members who received training on food allergies and administration of life-saving Epi-Pen.</td><td>20%</td><td>25%</td></tr>
</table>

FY23 Healthcare Access & Delivery Application Summary

Health Mobile

Program Title	Mobile Dental Clinic for Low-income and Homeless Community Members	*Recommended Amount:* $75,000
Program Abstract & Goal	To provide free dental care services to low-income children, adults, seniors and homeless individuals in San Jose and Santa Clara. Dental treatments include dental exams, x-rays, fillings, dental cleaning, oral hygiene education, oral cancer screening, root canals, and extractions. Dental services are provided by licensed bilingual and bicultural dentists and dental assistants. Services will be provided at homeless facilities, schools and senior centers. Services are based on industry standards.	
Agency Description & Address	1659 Scott Boulevard, #4, Santa Clara http://www.healthmobile.org Health Mobile is a non-profit organization providing onsite dental care since 1999. In 2008, the agency added primary medical care to the services. In 2015, the agency obtained two new mobile clinics with financial support of a HRSA grant. Health Mobile currently owns and operates seven mobile clinics and one fixed-site clinic.	
Program Delivery Site(s)	Services will be provided at schools in the San Jose and Santa Clara Unified School Districts as well as at community sites such as homeless shelters and senior centers.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Dental Exam • Full mouth X-ray • Dental Cleaning • Oral Cancer Screening • Oral hygiene education • Smoking cessation education • Fillings • Root Canals • Extractions Full requested amount funds staff salaries and program expenses.	
FY23 Funding	FY23 Requested: $150,000	FY23 Recommended: $75,000

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

FY23 Dual Funding	FY23 Requested: $150,000	FY23 Recommended: DNF

	FY22	FY21	FY20
Dual Funding History & Metric Performance	DNF in FY22	FY21 Approved: $75,000 FY21 Spent: $75,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 100%	FY20 Approved: $150,000 FY20 Spent: $150,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 50%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	150	400
	Dental procedures proivided	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

Healthier Kids Foundation

Program Title	My HealthFirst, DentalFirst, and HearingFirst Screenings	*Recommended Amount:* $60,000
Program Abstract & Goal	To provide hearing, dental, and mental health screenings on school sites and provide referrals for follow up care as needed. Screenings provide the first step in preventative care for children. Screening results are shared with school administrators and parents. Case Managers assist parents with referrals- accessing mental health, dental and hearing care with dentists, pediatricians, behavioral health providers, and audiologists near the child's home. Case managers also follow up with parents about appointment reminders and to check that care has been received. Screeners and case managers are provided by agency. Program benefits children by providing preventive care and helping them get the follow up treatment they need. Preventive care screenings are a well-accepted best practice.	
Agency Description & Address	4040 Moorpark Avenue, Suite 100, San Jose http://www.hkidsf.org Healthier Kids Foundation's vision is that all Silicon Valley youth achieve good health, educational equity, and success in life as productive community members. Their mission is to remove health barriers impacting the health, learning, and life success of Silicon Valley youth. To achieve their mission, they focus on three key strategies: improving health care access and utilization, changing health behavior through education, and advocating for health policy and systems change. Healthier Kids Foundation currently operate four preventive wellness screening/case management programs (vision/dental/hearing/mental health), two educational programs (10 Steps to a Healthier You! for parents and preschoolers), a foster care appointment program, and Medi-Cal enrollment for families.	
Program Delivery Site(s)	Services will be provided in the following school districts: • Alum Rock School District • Franklin McKinley School District • Luther Burbank School District	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Screenings for hearing, dental, and mental health on school campuses • Case management to assist parents in finding dentists, pediatricians, mental health providers, and/or audiologists, as needed Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $60,000	FY23 Recommended: $60,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $30,000 FY22 Approved: $30,000 FY22 6-month metrics met: 75%	FY21 Approved: $30,000 FY21 Spent: $30,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 100%	FY20 Approved: $30,000 FY20 Spent: $30,000 FY20 6-month metrics met: 75% FY20 Annual metrics met: 100%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	410	820
	Encounters	410	820
	Children who will have a dental referral	34%	34%
	Children who will have a hearing referral	5%	5%
	Children who will receive a My HealthFirst Wellness referral	40%	40%

FY23 Healthcare Access & Delivery Application Summary

Mt. Pleasant School Disitrct – School Nurse Program

Program Title	School Nurse Program	*Recommended Amount:*$122,000
Program Abstract & Goal	To fund a school nurse in the Mt. Pleasant School District, one of the most economically disadvantaged school districts in Santa Clara County. Nursing services will provide direct support to students, develop individual health plans, educate staff, support students missing immunizations, including COVID, and link families to resources and preventive care. The entire Mt. Pleasant community will benefit from the services, especially students with health conditions resulting in high absenteeism and families impacted by financial insecurity and lacking resources. School nurse programs have been shown to improve both long and short-term health and eduational outcomes in students.	
Agency Description & Address	3434 Marten Avenue, San Jose http://www.mpesd.org Mt. Pleasant School District(MPESD), pre-K-8, in east San Jose, serves a very diverse population, 78% of our students are economically disadvantaged, 45% are English Language Learners, 18% of our students live in a home with more than one family due to economic hardship. Our community in the zip code of 95127, is one of the most underserved areas in Santa Clara County, with one of the highest infection rates for COVID. The District strives to bring in resources to meet students' basic needs, including health, so that each student can attend school, learn and thrive.	
Program Delivery Site(s)	Schools within Mt. Pleasant School District (MPESD) located in San Jose: • Mt. Pleasant Elementary School • Valle Vista Elementary School • Robert Sanders Elementary School • August Boeger Middle School • Ida Jew Academy	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Health screenings including: vision, hearing, dental and scoliosis • Follow up with individual families on failed screenings and make referrals as needed • Crisis intervention and long-term support for students with identified health conditions • Professional development for staff in the areas of epi-pens, AEDs, diabetes management and seizure disorders • Follow up on students missing required immunizations, CHDP, or COVID vaccinations • Parent outreach and education on healthy foods and preventing type 2 diabetes • Student education on asthma management, and illness prevention • Communication and follow up for students who are chronically absent from school Full requested amount fully funds one school nurse and some program expenses.	
FY23 Funding	FY23 Requested: $124,000	FY23 Recommended: $122,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $122,000 FY22 Approved: $122,000 FY22 6-month metrics met: 60%	FY21 Approved: $125,000 FY21 Spent: $104,333 FY21 6-month metrics met: 80% FY21 Annual metrics met: 100%	FY20 Approved: $125,000 FY20 Spent: $97,983 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

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Mt. Pleasant School Distirct – School Nurse Program

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	600	2,100
	Encounters	800	3,200
	Reduce the percentage of students chronically absent due to a health reason	2%	3%
	Reduce the percentage of students missing school due to missing immunizations	60%	75%
	Increase percentage of students receiving follow up medical care after a failed screening	40%	70%

FY23 Healthcare Access & Delivery Application Summary

Tower Foundation of San Jose State University

Program Title	Project iura	*Recommended Amount:* DNF
Program Abstract & Goal	The aim is to make reproductive healthcare universally more inclusive, equitable, and accessible for all individuals in need through a social technology platform. This pilot program represents the rights of all individuals to access care that is inclusive of their specific needs and values. Services are provided by a social technology app that brings together patients and providers who have similar values- patients benefit from positive delivery of care experiences when their values align with their provider's values. Patients benefit from program include those whose with values that are underserved, underrepresented, or fall within the minority for the geographical area. The project makes use of common industry practices from human-centered design (HCD), human factors and ergonomics (HFE), and user-experience design (UX).	
Agency Description & Address	One Washington Square, San Jose http://www.sjsu.edu/towerfoundation/ San Jose State University (SJSU) is a comprehensive public university serving more than 35,000 students annually. SJSU's mission is to enrich the lives of its students, to transmit knowledge to its students along with the necessary skills for applying it in the service of our society, and to expand the base of knowledge through research and scholarship. The Tower Foundation of SJSU is the entity responsible for stewarding philanthropic gifts for university-led efforts such as the proposed Healthy Development Community Clinic (HDCC) activities. Involving a cross-disciplinary team, the HDCC is coordinated through SJSU's Connie L. Lurie College of Education. The College of Education includes undergraduate, graduate, and credential programs that prepare the next generation of practitioners and educators through community-engaged training.	
Program Delivery Site(s)	Services will be provided via each patient's or provider's mobile device.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Patient and provider participants will receive free, unlimited access to the app, allowing them to contribute to and benefit from the iura community database as it grows and evolves Full requested amount funds staff salaries and program expenses.	
FY23 Funding	FY23 Requested: $49,000	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	35	100
	Services provided	105	300
	Patients who report at least a one point increase in perceived ease of finding an OB-GYN who is right for them after using the iura app.	75%	75%
	Patients reporting a one or more point increase in feeling more confident working with a provider whom they found using iura's system.	75%	75%
	Clients who score 68 or higher on the Systems Usability Scale (SUS	75%	75%

FY23 Healthcare Access & Delivery Application Summary

Vista Center for the Blind and Visually Impaired

Program Title	Vision Loss Rehabilitation	*Recommended Amount:* $40,000
Program Abstract & Goal	To support and teach the necessary skills to an individual who is losing or has lost their vision in order to maintain or regain their independence. Services include psychosocial assessment, daily living skills training, orientation and mobility training, assistive technology training, low vision examination, support groups, information and referral and case management. Services are provided by credentialed or Master's level rehabilitation specialists, social workers/case workers, and board certified low vision optometrists. Services are provided in the client's home, workplace, community site, or agency site. Low vision services are offered at agency's clinics. Adults who have lost or are losing their vision benefit because they can remain independent using the skills taught in the program, preventing isolation and depression. Service impact is rated on evidence-based statistics.	
Agency Description & Address	2500 El Camino Real, Suite 100, Palo Alto http://www.vistacenter.org 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 FY 21, 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 will be provided at agency sites, community sites, client's homes and workplaces	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Initial assessments • Individual and/or group counseling • Weekly rehabilitation classes • Low vision exams Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $83,138	FY23 Recommended: $40,000

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

FY23 Dual Funding	FY23 Requested: $48,057	FY23 Recommended: DNF

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

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FY23 Healthcare Access & Delivery Application Summary

Vista Center for the Blind and Visually Impaired

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	40	82
	Services provided	275	515
	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

ACT for Mental Health

Program Title	Behavioral Health Services for Court-Referred Low-Income Clients	*Recommended Amount:* $40,000
Program Abstract & Goal	To provide bilingual/bicultural behavioral health services to court-referred low-income residents in the process of divorcing/separating and for whom the primary focus is custody issues. Referrals primarily come from SCC Family Court for divorce/custody counseling services. To successfully work through this difficul, often contentious time, participants will benefit from family and individual counseling services provided by professionals with the expertise and willingness to handle these complex and often conflict-laden cases. Children in these situations benefit when their parents learn skills like coping, anger management, and co-parenting, thus lessening the traumatic effects of Court-involvement.	
Agency Description & Address	441 Park Avenue, San Jose http://www.actmentalhealth.org ACT is a long-standing nonprofit, outpatient mental health agency in downtown San Jose providing counseling services to all ages, primarily low-income/disadvantaged for whom other resources might be unavailable. ACT's caseload includes a high number of Latinx and Vietnamese clients. One specialty service is supported by ongoing funding from Santa Clara County Board of Supervisors: counseling for Court-referrals for whom service options are sparse. Staff include a licensed psychologist and others who are licensed in CA, as well as staff with multicultural and multilingual capacity. ACT also provides psycho-education classes for Anger Management, Stress Reduction, Parenting and Co-Parenting.	
Program Delivery Site(s)	Services will be provided through agency site	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual and family counseling • Referral to partner agency for additional services as needed, including case management, education and coordination of care Full requested amount funds partial staff salaries, including counselors, and some program expenses.	
FY23 Funding	FY23 Requested: $50,000	FY23 Recommended: $40,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $62,355 FY22 Approved: $60,000 FY22 6-month metrics met: 100%	New in FY22	New in FY22

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	16	32
	Services provided	390	780
	Participants who rate Satisfied or Very satisfied on the Post-Counseling Satisfaction/Progress Questionnaire.	90%	90%
	Statistically Significant Improvement from pre-to-post evaluation times on Perceived Stress Scale (PSS).	60%	60%

FY23 Behavioral Health Application Summary

Adolescent Counseling Services (ACS)

Program Title	Mental Health Access for Youth Initiative	*Recommended Amount:* $25,000
Program Abstract & Goal	To provide a variety of mental health services to at-risk, low-income students who lack access to these services. The demand for mental health services increased through the pandemic, so this program will expand services and allow more young people to benefit from evidence-based therapies provided by Adolescent Counseling Services (ACS). ACS clients include a high proportion of BIPOC/Latinx, LGBTQ+ and low-income community members. Services are offered both in-person and remotely, thus reaching a larger target population. Program seeks to fill the gap between supply and demand for therapists and mental health services.	
Agency Description & Address	643 Bair Island Road, Suite 402, Redwood City http://www.acs-teens.org ACS' mission is to empower youth in our community to find their way through social-emotional support and by building safe, accepting communities. ACS operates five programs: the On-Campus Counseling (OCC) Program, providing multilingual individual counseling, crisis intervention, mental health education, and support at no cost to students/families attending local middle and high schools; the Adolescent Substance Abuse Treatment (ASAT) Program, an outpatient facility providing treatment to youth and families; the Community Counseling Program, providing outpatient mental health assessment, treatment and education; Outlet, serving LGBTQIA+ youth and allies with support groups, counseling, leadership training, and education in both Spanish and English; and the Institute of Psychotherapy and Training, offering clinical training to a full spectrum of mental health trainees.	
Program Delivery Site(s)	Services are provided through agency site and onsite at local middle and high school campuses, with plans including the Los Gatos Saratoga Union High School District	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Assessments • Individual and group mental health therapy • Substance use treatment • Education, consults, and outreach • Support groups for youth and caregivers Full requested amount funds partial staff salaries.	
FY23 Funding	FY23 Requested: $30,000	FY23 Recommended: $25,000

	FY22	FY21	FY20
Funding History & Metric Performance	New in FY23	New in FY23	New in FY23

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	150	300
	Services provided	210	420
	Parents/guardians will report a thorough understanding of substance use/abuse, its consequences, and will understand the treatment recommendation of the ASAT team	N/A	90%
	Clients seen 5 or more times will improve their level of functioning	N/A	70%
	Youth will report that since joining Outlet, they feel more connected to the LGBTQIA+ community	75%	75%

FY23 Behavioral Health Application Summary

Almaden Valley Counseling Service

Program Title	Counseling for Children and Youth	*Recommended Amount:* $36,000
Program Abstract & Goal	To provide mental and emotional health counseling to high-risk students whose emotional states require individual and/or group therapy, and crisis intervention. Students who are referred to these services receive evidence-based, trauma-informed behavioral health therapies specific to their individual needs. Program offers more intensive on-campus therapies than typical school counseling services as needed. Students benefit by receiving the level of care and support they need on campus. Additionally, crisis intervention may involve the child being placed under a psychiatric hold. Wherever possible, a safety plan will be developed that addresses the crisis without hospitalization.	
Agency Description & Address	6529 Crown Boulevard, Suite D, San Jose http://www.avcounseling.org AVCS offers a range of mental health counseling services, supporting personal growth, positive family relationships and emotional wellbeing. AVCS serves children, teens, adults, families, couples who reside in 42 of the County's 57 zip codes with 44% of clients paying at the lowest fee ($35). AVCS currently provides telehealth and school-based counseling services, crisis intervention, assessments, and referrals at 32 area schools. AVCS focuses on prevention and intervention, helping parents work proactively towards improving their relationships with their children by providing Positive Parenting and Co-Parenting classes, and serving victims of domestic violence, substance abuse and clients at risk for suicide. AVCS provides programs for Victim Witness, Valley Medical, Departments. of Social Services, Family and Children 's Services, and Mental Health.	
Program Delivery Site(s)	Services will be provided at 30 high-needs schools identified in the following school districts, and via telehealth, as needed: • Oak Grove School District • San Jose Unified School District	
Services Funded By Grant/How Funds Will Be Spent	Bilingual services include: • Individual and group counseling • Crisis intervention Full requested amount funds partial staff salaries, including therapists and clinical supervisor, and intern stipends, as well as some program expenses.	
FY23 Funding	FY23 Requested: $80,000	FY23 Recommended: $36,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $80,000 FY22 Approved: $70,000 FY22 6-month metrics met: 0%	FY21 Approved: $70,000 FY21 Spent: $70,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 75%	FY20 Approved: $60,000 FY20 Spent: $60,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 0%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	135	360
	Services (Counseling Encounters)	700	2,300
	Students who stay at the same score or improve on the 40-point Strengths and Difficulties Questionnaire Impact assessment, based on self-report or therapist report for students ages 11-17.	N/A	50%
	Students who stay at the same score or improve on the 40-point Strengths and Difficulties Questionnaire. Impact assessment based on parent/guardian assessment for students ages 10 and under.	N/A	50%
	Students requiring one-time Crisis Intervention are placed properly in follow-up services.	N/A	50%

FY23 Behavioral Health Application Summary

Alzheimer's Disease and Related Disorders Association

Program Title	Latino Family Connections - Dementia Initiative	*Recommended Amount:* DNF
Program Abstract & Goal	To deliver bilingual, culturally competent information and services to Latino family and community caregivers for patients with Alzheimer's disease (AD) and other related dementias. The prevalence of AD is rapidly increasing in the Latino community. By providing information, education, referrals, and family care consultations, program seeks to increase the reach of care and support services for the Latino community. Services are evidence-based and have been determined as effective support for family caregivers. Everyone benefits from this program- family caregivers are better able to support their patient, and these patients benefit from receiving better care.	
Agency Description & Address	2290 N. 1st Street, Suite 101, San Jose, CA 95131 http://alz.org/norcal The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. Our vision is a world without Alzheimer's. Five strategic objectives guide our work: increasing concern and awareness, advancing public policy, enhancing care and support, accelerating research and growing revenue to meet mission goals. These initiatives drive the Association's efforts to eliminate Alzheimer's and offer help and hope to all those affected by this devastating disease.	
Program Delivery Site(s)	Services will be provided virtually, by phone and at various community sites including senior centers, housing sites, community centers and churches.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Information and referral services • Family caregiver care consultations • Educational and training sessions Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $70,000	FY23 Recommended: DNF

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $70,000 FY22 Approved: $70,000 FY22 6-month metrics met: 50%	FY21 Approved: $65,000 FY21 Spent: $65,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 80%	FY20 Approved: $70,000 FY20 Spent: $70,000 FY20 6-month metrics met: 50% FY20 Annual metrics met: 80%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	125	250
	Total Services Provided	319	700
	Information and Referral Services clients who agree or strongly agree that they are able to find resources to utilize	N/A	95%
	Clients surveyed using Care Consultation services who agree or strongly agree that they were satisfied with the services they received	N/A	95%
	Care Consultation participants who agree or strongly agree they are better informed of necessary steps to address identified needs	N/A	90%

FY23 Behavioral Health Application Summary

Bill Wilson Center

Program Title	Child Abuse Therapy Program (CHAT)	*Recommended Amount:* $25,000
Program Abstract & Goal	To provide comprehensive treatment and psychotherapy clinical services to Santa Clara County children and youth (0-17 Years) who are victims of all forms of abuse, neglect, and parental substance abuse. Emphasis is placed on dependents of the court; children in the child welfare systems, those emancipating out of the system or their family, and other under-served children. These evidence-based services are provided by Licensed Marriage Family Therapists, and/or supervised post-graduate, and/or interns at the Bill Wilson Center as well as at three other school sites. Services are provided in-person following public health safety guidelines, remote counseling is still available for clients who prefer this mode of counseling. With these interventions, clients can increase their functioning in their environments that had been impacted by their trauma experience	
Agency Description & Address	3490 The Alameda, Santa Clara http://www.billwilsoncenter.org The agency's mission is to support and strengthen the community by serving youth and families through counseling, housing, education and advocacy. We now directly serve about 4,000 clients annually through 30 programs, still focused on the needs of youth and young parent families. We are the only agency in Santa Clara County to provide a continuum of services (shelter, meals, access to basic health services and more), particularly to the often overlooked young adult population, ages 16-25. Our Core Programs include outpatient counseling and mental health services for youth and families; Drop-In Center for at-risk and homeless youth (ages 12-25); emergency shelters for homeless youth (11-17 years) and young adults; youth development and short, medium and long term housing programs for young adults and families.	
Program Delivery Site(s)	At agency site as well as the following schools, and virtually and by phone, as needed: • Piedmont Hills High School • Santa Teresa High School • Merritt Trace Elementary School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Psychotherapy treatment services • Information packets and referrals for victim/witness compensation services • Assistance in understanding and helping the child to understand and prepare for participation in court proceedings Full requested amount funds partial staff salaries for Program Manager, Systems Administrator and Hotline Call Specialist as well as some program expenses.	
FY23 Funding	FY23 Requested: $25,000	FY23 Recommended: $25,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $25,000 FY22 Approved: $25,000 FY22 6-month metrics met: 67%	FY21 Approved: $25,000 FY21 Spent: $25,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $25,000 FY20 Spent: $25,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

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FY23 Behavioral Health Application Summary

Bill Wilson Center

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	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	6	12
	Individual therapy sessions annually	60	120
	Clients who complete the satisfaction survey at end of treatment will report a high score for service impact	80%	90%
	Clients completing the program will report that they have learned one new healthy coping mechanism as measured by Outpatient Post Survey	80%	90%
	Clients will demonstrate improvement in their coping skills as measured by the Outpatient Post Survey	80%	90%

FY23 Behavioral Health Application Summary

Behavioral Health (Including Domestic Violence Trauma)

Cambrian School District – Mental Health Program

Program Title	Mental Health Services	*Recommended Amount:* DNF
Program Abstract & Goal	To provide social-emotional learning (SEL) for middle school students and SEL training for school staff. Both small group and individual services will be provided on campus in the natural social environment. Licensed marriage and family therapists will lead these groups and trainings. Evidence-based curricula brings together universal classroom-based (SEL) with coping skills to support students with their anxiety within the educational setting. Since the need for mental health services has increased due to the pandemic, more students can now benefit from a school-based integrated approach to providing care and education.	
Agency Description & Address	4115 Jacksol Drive, San Jose http://www.cambriansd.org Cambrian School District, a caring and collaborative community, develops creative and critical thinkers who communicate effectively, value diversity and are ready to excel in a global society. We believe in valuing and teaching the whole child, preparing all Cambrian students to be successful in addressing the challenges of the 21st century as global citizens, honoring and encouraging the strengths of every child, fostering a strong sense of community, and creating a safe, orderly learning environment for all, and academic excellence that is built through collaboration and teamwork.	
Program Delivery Site(s)	Services will be provided at the following Cambrian School District schools: • Price Middle School • Steindorf STEAM School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual and group counseling • Mindfulness strategies taught in the classroom • Counseling for parents with children struggling with mental health Full requested amount funds 1.0 FTE MFT, one part-time MFT and two laptops.	
FY23 Funding	FY23 Requested: $150,000	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	65	135
	6-week social skills group	10	30
	Student with 2 or less ODF per month	80%	85%
	Student ages 11-14 reduce score on SDQ by 2 or more points	50%	65%

FY23 Behavioral Health Application Summary

Cancer CAREpoint

Program Title	Counseling for Cancer Patients, Survivors, Family Members, and Caregivers	*Recommended Amount:* $30,000
Program Abstract & Goal	To support individualized counseling for cancer patients and their families. Counseling services are provided by licensed social work and therapy professionals. Personalized counseling will help families and cancer patients reduce psychological distress from a cancer diagnosis and can lead to an improved quality of life, and impact treatment decisions and compliance. Services are currently offered virtually but will shift to a hybrid model once conditions are safe to do so.	
Agency Description & Address	2505 Samaritan Drive, Suite 402, San Jose http://www.cancercarepoint.org Cancer CAREpoint provides free non-medical support services to anyone in Silicon Valley impacted by cancer no matter their type of cancer or where they are receiving treatment. Our services are offered to patients and family members throughout their cancer experience from initial diagnosis to post-treatment. We have also developed a Family CARE program for parents with cancer and their minor children and our Survivorship Workshop for patients who have completed active treatment. All our programs are designed to improve the health-related quality of life of cancer patients and their families. We are currently offering all programs online.	
Program Delivery Site(s)	Services are currently offered virtually but will switch to a hybrid model once public health guidelines allow	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual and group counseling sessions Full requested amount funds partial salaries for counselors.	
FY23 Funding	FY23 Requested: $36,000	FY23 Recommended: $30,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $30,240 FY22 Approved: $30,000 FY22 6-month metrics met: 100%	FY21 Approved: $22,000 FY21 Spent: $22,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $21,600 FY20 Spent: $21,600 FY20 6-month metrics met: 10% FY20 Annual metrics met: 100%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	100	210
	Counseling sessions provided	375	750
	Clients who agree or strongly agree they experienced reduced levels of anxiety about issues related to a cancer diagnosis.	80%	80%
	Clients will agree or strongly agree that they experienced reduced levels of isolation after the counseling session.	90%	90%
	Clients will agree or strongly agree that they received helpful tools or resources.	90%	90%

FY23 Behavioral Health Application Summary

Child Advocates of Silicon Valley

Program Title	Advocacy Program for School-Aged Foster Youth	*Recommended Amount:* $40,000
Program Abstract & Goal	To provide consistent advocacy and support for school-aged foster children, particularly if mental or behavioral health intervention is indicated. Court Appointed Special Advocates (CASAs) are volunteers who provide a consistence presence in a foster child's life, and support foster children in the key areas of behavioral and physical healthcare, education, housing and other basic needs. Foster youth benefit from this stability because CASAs are often the only person with the comprehensive knowledge of a youth's health background, which is necessary to ensure proper services are received. Services are provided weekly at a youth's placement or in a public setting. The framework that guides the services of CASAs offers evidence-based strategies to help counteract the negative effects of toxic stress.	
Agency Description & Address	509 Valley Way, Milpitas http://www.BeMyAdvocate.org Child Advocates' mission is to be there for every foster child in Santa Clara County who has experienced abuse, neglect and/or abandonment. We accomplish this by operating the county's Court Appointed Special Advocates (CASA) program. CASAs are trained community volunteers who are appointed by a judge's order to advocate for the best interests of foster children. CASAs serve foster youth in three distinct ways: 1) Mentor: CASAs build a one-to-one trusted relationship with their foster child and plan weekly in-person visits and activities. 2) Advocate: CASAs ensure youth receive the services and resources they're entitled to and would benefit from. 3) Voice: CASAs attend court hearings and submit written reports directly to the Court to ensure the child's voice is heard in court.	
Program Delivery Site(s)	Services provided at agency site, at court, in other community locations, at foster placement sites and virtually, as needed	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Weekly meetings with youth, their family, and caregivers • Follow up and referrals to other agencies as needed • Assisting their child in accessing needed resources • Advocacy Plan Development • Assessing home environment for youth safety and wellbeing Full requested funding would support the partial salary of a Court Appointed Special Advocate (CASA) specialist.	
FY23 Funding	FY23 Requested: $40,000	FY23 Recommended: $40,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $40,000 FY22 Approved: $40,000 FY22 6-month metrics met: 100%	FY21 Approved: $30,000 FY21 Spent: $30,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $30,000 FY20 Spent: $30,000 FY20 6-month metrics met: 0% FY20 Annual metrics met: 100%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	40	80
	CASA workshops focused on 6-17 year old youth, health, behavioral health and/or education	4	8
	High school seniors who will graduate high school with a CASA supporting them through the transition	N/A	85%
	CASAs who will report feeling they have made a positive difference in their child's life.	N/A	85%
	CASAs who will report providing educational support to their child	N/A	70%

FY23 Behavioral Health Application Summary

Community Health Partnership

Program Title	Acknowledging the Past for a Healthier Future: Increasing Access to Trauma Screening and Behavioral Health Services	*Recommended Amount:* DNF
Program Abstract & Goal	To increase provider capacity and sensitivity for trauma screening. Trainings for providers in consortium health centers will focus on using evidence-based trauma screening practices (ACEs, PEARLS, etc.). Health center staff may have faced similar life experiences as their patients; consequently, the trainings will help avoid the future retraumatization of both staff and patients during the screening and education process. Patients will also receive multilingual education materials on trauma screening. Trainings will be provided by organization's workforce development staff and additional bilingual program coordinators.	
Agency Description & Address	408 N Capitol Avenue, San Jose http://www.chpscc.org Community Health Partnership (CHP) is a nonprofit consortium of ten community health centers (CHCs) in Santa Clara and San Mateo Counties. Founded in 1993, its mission is to advocate for affordable and accessible health services for low-income, medically underserved, diverse communities. CHP provides its CHC members with resources and expertise to deliver high quality, affordable care by focusing on four priority areas: health care policy, workforce readiness, health care access, and population health. CHP gives its members a collective voice to educate policy makers, funders, and community leaders to support local health centers' efforts to shape health policy, secure funds, and strengthen the health care safety-net. CHP's staff offers support and technical assistance that allows members to stay focused on patient care and community health.	
Program Delivery Site(s)	Services will be provided at agency site	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Trauma-informed care training sessions • Multilingual patient education flyers on pediatric trauma screening and destigmatizing mental health services (English, Spanish, Vietnamese) • Multilingual patient education flyers on adult trauma screening and destigmatizing mental health services (English, Spanish, Vietnamese) Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $50,000	FY23 Recommended: DNF

Funding History & Metric Performance	FY22	FY21	FY20
	Senior Access to Telehealth & Care for Chronic Conditions FY22 Requested: $50,000 FY22 Approved: $40,000 FY22 6-month metrics met: 100%	*Patient Attribution and Engagement Project* FY21 Approved: $61,000 FY21 Spent: $61,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 67%	*Patient Attribution and Engagement Project* FY20 Approved: $50,000 FY20 Spent: $50,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 67%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	20	50
	Training encounters	30	75
	Increase of clinic providers who attest to completing ACEs training on DHCS website by June 30, 2023	2%	4%
	Training participants who report at least a 3-point increase in their confidence with implementing trauma screening based on a Likert scale	60%	60%

Cupertino Union School District

Program Title	Mental Health Counseling Program	*Recommended Amount:* $120,000
Program Abstract & Goal	To continue and expand the mental health counseling program to meet the rising mental health challenges of students at Cupertino Union School District (CUSD) schools. 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 http://www.cusdk8.org 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)	Services will be provided at Cupertino Union School District schools	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Weekly counseling sessions (individual, group, and family). • Social-emotional skill building groups for elementary and middle school students referred by teachers/staff • Risk assessment for suicidality, self-harm, aggressive externalizing behaviors, and other high risk/impulsive behaviors, as needed. • Crisis intervention, as needed. • Weekly case management • Collaboration and consultation with school staff • Weekly social and emotional learning lessons, as caseload allows. Full requested amount funds partial staff salaries and full program expenses.	

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FY23 Behavioral Health Application Summary

Behavioral Health (Including Domestic Violence Trauma)

Cupertino Union School District

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<table>
<tr><td>*FY23 Funding*</td><td colspan="2">FY23 Requested: $137,000</td><td colspan="2">FY23 Recommended: $120,000</td></tr>
<tr><td rowspan="2">*Funding History & Metric Performance*</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $135,000
FY22 Approved: $120,000
FY22 6-month metrics met: 100%</td><td>FY21 Approved: $120,000
FY21 Spent: $120,000
FY21 6-month metrics met: 100%
FY21 Annual metrics met: 100%</td><td colspan="2">FY20 Approved: $140,000
FY20 Spent: $140,000
FY20 6-month metrics met: 100%
FY20 Annual metrics met: 40%</td></tr>
<tr><td>*FY23 Dual Funding*</td><td colspan="2">FY23 Requested: $93,000</td><td colspan="2">FY23 Recommended: $93,00</td></tr>
<tr><td rowspan="2">*Dual Funding History & Metric Performance*</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $92,500
FY22 Approved: $90,000
FY22 6-month metrics met: 33%</td><td>FY21 Approved: $90,000
FY21 Spent: $90,000
FY21 6-month metrics met: 100%
FY21 Annual metrics met: 100%</td><td colspan="2">New in FY21</td></tr>
<tr><td rowspan="6">*FY23 Proposed Metrics*</td><td colspan="2">*Metrics*</td><td>*6-month Target*</td><td>*Annual Target*</td></tr>
<tr><td colspan="2">Individuals served</td><td>90</td><td>210</td></tr>
<tr><td colspan="2">Service hours provided</td><td>930</td><td>2,110</td></tr>
<tr><td colspan="2">Students who improve on treatment plan goals</td><td>60%</td><td>80%</td></tr>
<tr><td colspan="2">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)</td><td>0%</td><td>50%</td></tr>
<tr><td colspan="2">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)</td><td>0%</td><td>50%</td></tr>
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FY23 Behavioral Health Application Summary

Eating Disorders Resource Center

Program Title	Support Towards Recovery and Getting Connected		*Recommended Amount:* DNF
Program Abstract & Goal	To increase the number of providers to address the rise in patients with disordered eating behaviors. Program activities aid in the prevention, proper diagnosis, early intervention, and recovery from eating disorders through support groups, case management and educational outreach. These services benefit individuals suffering from eating disorders and their family/friends by giving them information and support to understand and treat eating disorders. Services are provided onsite and/or through phone and email. Tailored educational programs are also provided for health care professionals, community members, and school staff. The comprehensive online resource directory is the only listing of local treatment professionals, helpful links, insurance information, and educational articles for reference.		
Agency Description & Address	3131 S. Bascom Avenue, Suite 140, Campbell, CA 95008 http://www.edrcsv.org 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 at agency site as well as by phone and email		
Services Funded By Grant/How Funds Will Be Spent	Services include: • Weekly support groups • Ongoing phone and email support • Ongoing case management • Educational outreach programs Full requested amount funds partial staff salary.		
FY23 Funding	FY23 Requested: $22,500	FY23 Recommended: DNF	
Funding History & Metric Performance	FY22	FY21	FY20
	New in FY23	New in FY23	New in FY23
FY23 Dual Funding	FY23 Requested: $22,500	FY23 Recommended: $22,500	
Dual Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $25,000 FY22 Approved: $25,000 FY22 6-month metrics met: 100%	FY21 Approved: $22,500 FY21 Spent: $22,500 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $20,000 FY20 Spent: $20,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%
FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	85	170
	Encounters	85	170
	Support Group Rating Excellent/Good	90%	95%

FY23 Behavioral Health Application Summary

Fremont Union High School District

Program Title	School Site Wellness Rooms	*Recommended Amount:* DNF
Program Abstract & Goal	To create and support School Site Wellness Rooms on the five campuses in the Fremont Union High School District. Wellness rooms provide a social space and respite from the school, allowing students to connect with each other, meditate, play games, etc. Wellness rooms may also be the initial entry point for students to access mental health services because the rooms will be staffed by behavoiral health trainees. Data gathered when students check in/out will assist with ongoing program coordination that reflects student needs. Evidence-based SEL framework will be supported through the structure and staffing of each wellness room. Wellness rooms are available to any student who wishes to use them.	
Agency Description & Address	589 W Fremont Ave, Sunnyvale http://www.fuhsd.org The Fremont Union High School District is home to five comprehensive sites, Educational Options and an Adult School. We pride ourselves on the holistic focus of our programs providing students with a variety of opportunities for academic achievement, elective courses, extracurricular activities and athletics. Student progress and wellness are augmented by 22 counselors and 12.4 psychologists and 16.1 licensed therapists or social workers who form mental health teams for each site.	
Program Delivery Site(s)	Services will be provided at Fremont Union High School District schools: • Cupertino High School • Fremont High School • Homestead High School • Lynbrook High School • Monta Vista High School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Staffing school site wellness rooms • Referrals as needed Full requested amount funds partial staff salary and program expenses.	
FY23 Funding	FY23 Requested: $155,000	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	500	1,000
	Wellness Room visit (check-in and check-out combined)	1,500	3,000
	Students who report a 2 point increase in their social and emotional wellbeing after visiting the wellness room.	25%	50%
	Visits to the wellness center that support an area of the CASEL SEL Framework (self-awareness, self-management, social awareness, relationship skills, responsible decision-making)	25%	50%

FY23 Behavioral Health Application Summary

Jewish Family Services of Silicon Valley

Program Title	Project Connect@Home	*Recommended Amount:* $75,000
Program Abstract & Goal	To provide essential care management and behavioral health support services to extremely vulnerable older adults enabling them to safely age in place. Isolated seniors, including those with cognitive and physical impairments, will benefit, especially because the pandemic caused a staggering increase in reported loneliness and social isolation, particularly among older adults. Services support psychosocial wellbeing through case management, counseling, non-faith based spiritual support, enrichment programs and newsletters. Services are provided by masters level and licensed social workers with expertise in gerontology. Certified chaplain and trained volunteers engage isolated home-bound older adults in non-faith based spiritual support. Services will be provided primarily in the clients' homes and when appropriate, at the agency site at times convenient for clients. Agency will use a combination of evidenced-based and industry best practices.	
Agency Description & Address	14855 Oka Road, Suite 202, Los Gatos http://www.jfssv.org Jewish Family Services of Silicon Valley (JFS SV) transforms lives and restores hope. JFS SV serves a multi-ethnic community with social, senior, behavioral health, refugee, and volunteer services. Our ethnically diverse staff speak eleven languages. JFS SV Aging with Dignity Senior Services for 2,000 elders at a variety of life stages focuses on promoting healthy living and empowering older adults to remain at home. Our 700 volunteers of all ages participate in a broad range of meaningful activities helping people have better lives.	
Program Delivery Site(s)	Services will be provided at client homes and at agency site	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual case management sessions • Chaplain spiritual support sessions • Individual and group counseling and wellness sessions • Enrichment support services • Referrals to long-term services and support service providers Full requested amount funds partial staff salaries, including a care manager and coordinator.	
FY23 Funding	FY23 Requested: $95,000	FY23 Recommended: $75,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $85,000 FY22 Approved: $82,000 FY22 6-month metrics met: 50%	FY21 Approved: $80,000 FY21 Spent: $80,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $80,000 FY20 Spent: $80,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 75%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	90	120
	Encounters	700	1,400
	Clients demonstrate a 5-point score reduction on the PHQ-9	20%	40%
	Clients who need assistance with at least 2 Activities of Daily Living or 3 Instrumental Activities of Daily Living can continue living in his/her own home.	90%	90%
	Clients who report at least two of the following after participation in group counseling, spiritual support, or enrichment program: decreased loneliness, increased sense of connection, improved mood and increased brain stimulation and alertness.	80%	80%

FY23 Behavioral Health Application Summary

LGS (Los Gatos Saratoga) Recreation

Program Title	55 Plus Program	*Recommended Amount:* $15,000
Program Abstract & Goal	To use recreation and leisure activities to improve the behavioral wellbeing of seniors who are at an increased risk for social isolation. Older adults' participation in recreation programs and services will increase connectedness and improve physical, cognitive, and psychological health. A variety of clubs, access to services, and evidence-based programs will be provided to participating seniors, including exercise programs and music and art therapy workshops. All activities will be provided onsite at the senior center by senior center staff.	
Agency Description & Address	208 E. Main Street, Los Gatos http://www.lgsrecreation.org/ The LGS Recreation 55 Plus Program is dedicated to ensuring free or low-cost access to recreation, education, socialization, and wellness opportunities for older adults throughout Los Gatos and surrounding areas. Our goal is to create a sense of belonging by providing opportunities to make connections in the community and participate in meaningful recreation programs that address social, psychological, physical, and cognitive needs of older adults. We strive to increase social connectedness, decrease social isolation, and combat mental health distress through leisure and recreation activities. Our Senior Center also acts as a hub of information to connect older adults or caregivers with services and resources.	
Program Delivery Site(s)	Services and programs are provided through agency site	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Variety of exercise programs, including traditional exercise, water-based exercise, and chair yoga • Art workshops • Music workshops • Individual counseling • Targeted support groups • Social discussion groups • Annual themed events Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $31,790	FY23 Recommended: $15,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $58,530 FY22 Approved: $20,000 FY22 6-month metrics met: 67%	FY21 Approved: $20,000 FY21 Spent: $20,000 FY21 6-month metrics met: 67% FY21 Annual metrics met: 67%	FY20 Approved: $20,000 FY20 Spent: $20,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 0%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	400	450
	Encounters Provided	40	160
	Increased participation in activities that will reduce loneliness as measured on UCLA Loneliness Scale	65%	75%
	Participants who answer 3 or higher: My experience has been positive as a result of joining 55+ programs and I would recommend it to others	65%	75%
	Participants who answer 3 or higher: I feel more connected to people and services as a result of the 55+ Programs	65%	75%

FY23 Behavioral Health Application Summary

LifeMoves

Program Title	Behavioral Health Services for Homeless Individuals and Families	*Recommended Amount:*$50,000
Program Abstract & Goal	To provide behavioral health screenings and therapy to families and individuals experiencing trauma and other behavioral health issues at LifeMoves homeless shelters. Services are provided at three homeless shelters in San Jose serving families, single women, and LGBTQ+ single adults. Behavioral health conditions are sometimes the reason some clients become homeless and good behavioral health is essential for homeless clients to return to stable housing and self-sufficiency. A variety of therapies are provided by therapist interns under the supervision of licensed psychologists. This evidence-based program offers mental health services such as individual psychotherapy, group therapy, milieu therapy, art and expressive play therapy for children, and specialized services for victims of interpersonal violence. Clients are connected to onsite services that address their trauma and behavioral health issues, and are also connected to community-based services for support after program exit.	
Agency Description & Address	181 Constitution Drive, Menlo Park http://www.lifemoves.org 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)	Services provided at agency sites, three homeless shelters in San Jose, and virtually as needed	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Screening adult and child clients for behavioral health needs issues at program entry • Evaluation for clients who are referred or requesting services • Individual and group therapy: weekly sessions for the duration of clients shelter stay • Milieu therapy • Continuing therapy for clients who successfully exit shelter to stable housing, for up to three months • Connection to community-based support programs after program exit Full requested amount funds partial staff salaries, including the Behavioral Health Director and Senior Director of Clinical Services, intern therapist stipends as well as program support costs.	

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FY23 Behavioral Health Application Summary

LifeMoves

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FY23 Funding	FY23 Requested: $60,000	FY23 Recommended: $50,000	
Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $60,000 FY22 Approved: $60,000 FY22 6-month metrics met: 100%	FY21 Approved: $60,000 FY21 Spent: $60,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $50,000 FY20 Spent: $50,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%
FY23 Dual Funding	FY23 Requested: $160,000	FY23 Recommended: $160,000	
Dual Funding History & Metric Performance	FY22	FY21	FY20
	Funds LVN & Behavioral Health Services at Mountain View Shelter FY22 Requested: $160,000 FY22 Approved: $160,000 FY22 6-month metrics met: 100%	New in FY22	New in FY22

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	75	160
	Hours of therapy provided	100	350
	Clients reporting improved mood & function	N/A	85%
	Clients report understanding of BH issues	N/A	75%
	Interns report understanding of BH issues	N/A	85%

FY23 Behavioral Health Application Summary

Los Gatos Union School District – Mental Health Program

Program Title	K-8 Mental Health Counselor	*Recommended Amount:* $110,000
Program Abstract & Goal	To support a K-8 mental health counselor to serve all five schools in the Los Gatos Union School District, including four elementary schools and one middle school. All students in these schools benefit from the services of a K-8 mental health counselor, who has become an integral part of prevention and intervention efforts. The K-8 counselor will continue to oversee and develop age-appropriate programs at the schools, engage parents through expanded parent education opportunities, and offer other services such as leading individual or group therapy sessions. The K-8 counselor will also implement an evidence-based SEL curiculum. Additionally, the K-8 counselor will oversee the development of the Wellness Center, a collaborative effort with Santa Clara County Behavioral Health and the HEARD Alliance. All services and programs will be provided before, during and after school on the school campuses.	
Agency Description & Address	17010 Roberts Road, Los Gatos http://www.lgusd.org The Los Gatos Union School District (LGUSD) serves transitional kindergarten through eighth grade students. Today, approximately 3,000 students are enrolled in four elementary schools (Blossom Hill, Louise Van Meter, Daves Avenue, Lexington,) and one middle school (R.J. Fisher). The district is committed to provide equitable learning opportunities to educate all children to their unique potential by teaching, modeling and supporting the skills, and attitudes that contribute to their development as globally and socially responsible citizens demonstrating stewardship and "service before self".	
Program Delivery Site(s)	At the four elementary schools and one middle school in the Los Gatos Union School District: • Blossom Hill Elementary School • Louise Van Meter Elementary School • Daves Avenue Elementary School • Lexington Elementary School • R.J. Fisher Middle School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Staff a Wellness Center for grades 3-5 and 6-8 students • Social Emotional Learning (SEL) curriculum and Interventions for K-8 • Preventative classes or workshops for students • Individual counseling for behavioral and discipline issues • Individual or group therapy sessions on topics such as grief counseling, substance abuse, bullying, anger management, relationships, self-image, LGBTQ issues, self-harm • Parent Education seminars, six or more per year Full requested amount funds partial salary of K-8 counselor.	
FY23 Funding	FY23 Requested: $110,000	FY23 Recommended: $110,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $177,298 FY22 Approved: $110,000 FY22 6-month metrics met: 100%	FY21 Approved: $110,000 FY21 Spent: $110,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 67%	New in FY21

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Los Gatos Union School District – Mental Health Program

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	400	800
	Teacher served	30	75
	Percent of 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	70%	70%
	Parents who participate in Parent Education Seminars and Resources will increase their self-reported readiness to support their student's mental health needs.	80%	80%
	Third through fifth-grade students (aged 8-12), who increased from baseline local survey to end of year wellness and school connectedness survey.	N/A	60%

Momentum for Health

Program Title	La Selva Community Clinic	*Recommended Amount:*$40,000
Program Abstract & Goal	To provide behavioral health services for clients with financial barriers to accessing treatment. Services include psychiatry assessment, medication management, case management, short-term counseling, crisis counseling, and discharge planning. These evidence-based practices are provided by psychiatrists, clinicians, and administrative staff. Vulnerable populations without insurance or financial resources benefit from quick access to treatment and supportive services. This is especially critical because many clients have underlying case management needs such as housing, food, and other basic needs, creating further complexity. Services are provided at Momentum for Health service site in Palo Alto in person or via telehealth.	
Agency Description & Address	438 N. White Road, San Jose http://www.momentumformentalhealth.org 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. During fiscal year 2020-21 a total of 4,074 individuals were served across Momentum's 10 service locations and 12 supportive housing sites throughout Santa Clara County.	
Program Delivery Site(s)	Services provided at agency site and virtually as needed	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Psychiatry assessment • Treatment and medication management • Case management • Iindividual and family counseling • Crisis counseling Full requested amount funds partial staff salaries, including a psychiatrist, and some program expenses.	

FY23 Funding	FY23 Requested: $46,000	FY23 Recommended: $40,000	
Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $51,127 FY22 Approved: $46,000 FY22 6-month metrics met: 100%	FY21 Approved: $51,000 FY21 Spent: $51,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $50,000 FY20 Spent: $50,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%
FY23 Dual Funding	FY23 Requested: $290,000	FY23 Recommended: $290,000	
Dual Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $286,640 FY22 Approved: $290,000 FY22 6-month metrics met: 80%	FY21 Approved: $160,000 FY21 Spent: $160,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 40%	FY20 Approved: $268,140 FY20 Spent: $268,140 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

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Momentum for Health

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	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	17	24
	Services	220	334
	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

Next Door Solutions to Domestic Violence

Program Title	Comprehensive Services for Victims of Domestic Violence	*Recommended Amount:* $90,000
Program Abstract & Goal	To provide adults with continuum of comprehensive intervention and support services addressing needs arising from impacts and trauma due to domestic violence and intimate partner violence. Services include community and systems advocacy, self-sufficiency-focused case management, bilngual support groups, therapeutic counseling, and parenting after violence healing workshops. Services are provided by trained and certified Domestic Violence Peer Counselors, many of whom are bi-lingual. Program staff are further trained in best practice methodologies for supporting clients, including trauma informed care, client-centered case management and motivational interviewing.	
Agency Description & Address	234 E. Gish Road, Suite 200, San Jose http://www.nextdoor.org Next Door Solutions to Domestic Violence (NDS), an autonomous nonprofit based in San Jose, is the largest and oldest provider of services addressing the impact of domestic violence at the individual and community level. Its mission is "to end domestic violence in the moment and for all time" – creating paths for survivors through crisis to safety, stability, and self-sufficiency. Core programs: 24/7 Hotline, Shelter and Housing Services, Community & Systems Advocacy, Support Services, and Community Partnerships.	
Program Delivery Site(s)	Services are currently provided remotely. Future services will be provided via a hybrid "on-site/virtual" model	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Risk assessment, safety planning, and crisis counseling • Community & systems advocacy services • Support groups • Self-sufficiency case management Full requested amount funds partial staff salaries, including Crisis Support and Self-Sufficiency Advocates and Support Group Facilitator, as well as some program expenses.	
FY23 Funding	FY23 Requested: $95,000	FY23 Recommended: $90,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $95,000 FY22 Approved: $90,000 FY22 6-month metrics met: 100%	FY21 Approved: $95,000 FY21 Spent: $95,000 FY21 6-month metrics met: 75% FY21 Annual metrics met: 75%	FY20 Approved: $75,000 FY20 Spent: $75,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 75%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	56	112
	Encounters provided	294	588
	C&SA clients completing the Evaluation of Advocacy Appointment survey will respond that they have gained at least one way to increase their, and their children's, safety.	90%	90%
	Support Groups clients completing the Support Group Evaluation Survey will respond that they can better manage stress when it occurs.	80%	80%
	Self-Sufficiency Case Management clients will indicate through the SS Matrix that they have maintained or increased they level of Wellness.	68%	68%

FY23 Behavioral Health Application Summary

Peninsula Healthcare Connection

Program Title	Psychiatric Services-Medication Management	*Recommended Amount:*$90,000
Program Abstract & Goal	To provide affordable comprehensive health and mental health care services regardless of financial status to a racially and ethnically diverse, economically disadvantaged, and underserved population. Clients have other factors impacting their health, including with complex medical, behavioral health and social needs. The primary goal is to provide clients with individualized, high-quality services and the support necessary to return to lives of stability, independence and overall well-being, thereby improving the health and safety of the community as a whole. Quality, consistent behavioral health services is a crucial component to stability and empowerment of unhoused individuals, and a vital piece to ending homelessness.	
Agency Description & Address	Opportunity Center, 33 Encina Avenue, #103, Palo Alto http://www.peninsulahcc.org 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 will be provided at agency site	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Psychiatric services • Comprehensive psychiatric care, including assessment, care planning and medication management • Referral to intensive case management services and therapy as needed • Screening for depression and referral to psychiatry services if indicated • Recurring and pop-up Outreach and education events. Full requested amount funds partial salaries of a psychiatrist, a licensed vocational nurse and some supplies.	
FY23 Funding	FY23 Requested: $100,000	FY23 Recommended: $90,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $90,000 FY22 Approved: $90,000 FY22 6-month metrics met: 83%	FY21 Approved: $90,000 FY21 Spent: $90,000 FY21 6-month metrics met: 83% FY21 Annual metrics met: 100%	FY20 Approved: $90,000 FY20 Spent: $90,000 FY20 6-month metrics met: 80% FY20 Annual metrics met: 60%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	100	200
	Services provided (psychiatry, therapy and case management)	300	600
	Patients not hospitalized in a 12 month program.	85%	90%
	Patients that attend scheduled follow up appointments.	60%	75%
	Patients screened for depression that attend scheduled follow up appointments with Psychiatrist.	45%	55%

FY23 Behavioral Health Application Summary

South Bay Kidpower Teenpower Fullpower

Program Title	From Trauma to Thriving	*Recommended Amount:* DNF
Program Abstract & Goal	To build resilience in at-risk and vulnerable populations to mitigate the mental and beahvioral health impacts of the pandemic. Program trainers will conduct a series of tailored, interactive, multilingual on-line workshops and coaching sessions, based on participants' needs. Agency utilizes an evidence-based success- and skills-building model. Participants will regain a sense of control over their lives and improve their mental and behavioral health, safety and well-being. Kidpower's Positive Practice Teaching Method™ gives people the chance to be successful in PRACTICING skills in a context specific to their abilities and life situations, which reduces anxiety and builds competence.	
Agency Description & Address	51 E. Campbell Ave #129-1152, Campbell http://www.kidpower.org Kidpower Teenpower Fullpower ('Kidpower') builds the voice and power of underserved people of all ages, abilities and walks of lif, especially youth and families impacted by racial, gender, and economic inequities and health disparities. With prevention and restorative intervention tools and skills to stay safe, act wisely and believe in themselves; protect their social-emotional, mental and behavioral health & well-being; and develop individual and community leadership for its successful implementation.	
Program Delivery Site(s)	Services will be provided virtually, until safe to resume in person.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Workshops and coaching sessions • Parent education sessions and joint parent-child trainings • Professional development for teachers and school staff Full requested amount funds partial staff salaries for Senior Trainer, Senior Instructor, Instructor and Program Coordinator as well as some program expenses.	
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	250	600
	Services provided	30	75
	Children and youth trained will demonstrate increased APPLICATION of mental and behavioral safety, health and wellness skills as measured by 7 performance indicators.	85%	85%
	Families trained will report increased knowledge and skills related to reinforcing mental and behavioral safety, health and wellness skills with the kids in their care as measured by 7 performance indicators.	90%	90%
	Teachers/program staff will report increased knowledge and skills on how to teach and reinforce mental and behavioral safety, health and wellness skills with the kids in their care on their own as measured by 7 performance indicators.	80%	80%

FY23 Behavioral Health Application Summary

Tower Foundation of San Jose State University

Program Title	Healthy Development Community Clinic	*Recommended Amount:* $25,000
Program Abstract & Goal	To maximize wellness and prevent adverse outcomes for children, youth, and families. Health equity and positive health outcomes are achieved through screenings, short-term interventions, outreach and education, and targeted referrals. Program offers families easy access to evidence-based care to promote health equity by removing access barriers. Services are provided onsite by San José State University (SJSU) faculty experts, including licensed clinicians, and teams of student clinicians. This program addresses adverse childhood experiences as well as barriers to accessing mental health services.	
Agency Description & Address	One Washington Square, San Jose http://www.sjsu.edu/towerfoundation/ San Jose State University (SJSU) is a comprehensive public university serving more than 35,000 students annually. SJSU's mission is to enrich the lives of its students, to transmit knowledge to its students along with the necessary skills for applying it in the service of our society, and to expand the base of knowledge through research and scholarship. The Tower Foundation of SJSU is the entity responsible for stewarding philanthropic gifts for university-led efforts such as the proposed Healthy Development Community Clinic (HDCC) activities. Involving a cross-disciplinary team, the HDCC is coordinated through SJSU's Connie L. Lurie College of Education. The College of Education includes undergraduate, graduate, and credential programs that prepare the next generation of practitioners and educators through community-engaged training.	
Program Delivery Site(s)	Services will be provided at Oak Grove High School campus	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Sensory function screenings (hearing and vision function screenings, questionnaires) • Speech and Language Screenings • Behavioral health screenings • Behavioral health workshops Full requested amount funds partial staff salaries, including a psychologist and a speech/language/hearing specialist, and some program expenses.	
FY23 Funding	FY23 Requested: $50,000	FY23 Recommended: $25,000

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	30	60
	Services provided	60	120
	Participants who complete a screening (i.e., sensory, speech and language, or behavioral health) will indicate a high likelihood of following up on the referral within 4 weeks.	60%	60%
	Youth who attend a minimum of three Behavioral Health Workshops will identify at least one new coping strategy that they can use to manage stress and mental health challenges.	60%	60%
	Participants who complete a screening or attend a workshop will indicate that they were satisfied with the services received.	60%	60%

FY23 Behavioral Health Application Summary

Union School District

Program Title	Wellness Support	*Recommended Amount:* DNF
Program Abstract & Goal	Program supports the complex mental, behavioral and physical health needs of students and families. Program will be implemented by mental health therapists, behaviorists, nurses and licensed clinical social workers. An array of evidence-based therapies covering counseling, intervention and health education services will be provided. All students will benefit from whole class SEL lessons/training and students with, or at risk of, adverse mental and behavioral conditions will be able to access a tiered model of support based on need and severity. The majority of services will occur during the school day at school and in some cases before and after school in the students home.	
Agency Description & Address	5175 Union Ave, San Jose http://unionsd.org Union School District is a PK-8th grade school district in San Jose CA. We have 6 elementary schools and 2 middles schools serving close to 5800 students. We have a full continuum of special education programs and serve a diverse community of students and families. We have 2 Title 1 elementary schools in our district (Lietz Elementary and Noddin Elementary) that feed into one of our Middle schools (Dartmouth Middle School). Title one status is based on having over 40% of students at the site considered socioeconomically disadvantaged. We receive LCFF funding (we are not a basic aide school) and are one of the lowest funded districts in Santa Clara County and California.	
Program Delivery Site(s)	• Alta Vista Elementary School • Carlton Elementary School • Guadalupe Elementary School • Lietz Elementary School • Noddin Elementary School • Oster Elementary School • Dartmouth Middle School • Union Middle School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual and group therapy • Family therapy • Parent Training • Diabetic monitoring and education • Individual and group behavior intervention • Intensive support and monitoring of students returning from hospitalizations • Explicit Student Education in Mindfulness/SEL/Coping stratgies Full requested amount funds full salary of LVN and partial salaries of mental health therapists, licensed clinical social workers, behaviorists and BCBA.	
FY23 Funding	FY23 Requested: $380,000	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	350	950
	Services provided	4,900	8,918
	Students who report a 5 point decrease on the MFQ	25%	80%
	Students will meet their individual treatment goals	25%	85%
	Students participating in Health and Wellness education	30%	95%

FY23 Behavioral Health Application Summary

Uplift Family Services at Campbell Union High School District

Program Title	Addiction Prevention Services	*Recommended Amount:*$210,000
Program Abstract & Goal	To provide counseling support for mental health and substance use prevention in the six high schools of the Campbell Union High School District. Services are delivered by skilled counselors and include a variety of evidence-based practices to assist with mental health and substance use issues. Students benefit from this program with improved outcomes in preventing dangerous behavior in at risk youth. . The goal is to decrease the use of all substances, and increase youths' physical, mental, academic, and social functioning, as well as support parents and teachers as they are challenged with youth behavior issues.	
Agency Description & Address	251 Llewellyn Avenue, Campbell http://www.upliftfs.org Uplift Family Services is a statewide non-profit organization. We are proud to be one of California's leading providers of social services that help children with severe emotional, social, and behavioral needs, and their family members. The agency's mission is to do whatever it takes to strengthen and advocate for children, families, adults, and communities to realize their hopes for behavioral health and well-being. Annually, the agency provides services to over 30,000 children from birth to 21 years of age, and their families throughout more than 30 counties in California. Our goal is to help children and families access healing and hope towards a brighter future.	
Program Delivery Site(s)	• Westmont High School • Prospect High School • Leigh High School	• Branham High School • Del Mar High School • Boynton High School
Services Funded By Grant/How Funds Will Be Spent	Services include: • Assessments / screenings, intake and risk management • Classroom workshops for students • Workshops for caregivers • Targeted prevention or intervention groups • Individual counseling • Year-round access to services for local youth who are Medi-Cal eligible (as needed) • Teacher/staff trainings, workshops, and or collaboration • Caregiver and/or school personnel collateral sessions regarding adolescent needs • Targeted family case management • Brief Intervention • Unplanned Risk Assessments to access for risk or manage crisis Full requested amount funds partial for two onsite counselors and some program expenses.	
FY23 Funding	FY23 Requested: $230,000	FY23 Recommended: $210,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $230,000 FY22 Approved: $210,000 FY22 6-month metrics met: 100%	FY21 Approved: $230,000 FY21 Spent: $230,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 83%	FY20 Approved: $230,000 FY20 Spent: $230,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 67%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	500	1,000
	Prevention/Intervention	535	1,070
	Increase attendance	N/A	20%
	Improved behavior	N/A	60%
	Suicide prevention and improved coping skills	N/A	80%

African American Community Service Agency

Program Title	Family Health Services	*Recommended Amount:* $43,000
Program Abstract & Goal	To continue support of the Family Health Services (FHS) program to benefit the health of low-income, disenfranchised, ethnically diverse children and parents who reside primarily in San Jose. Through child and family outreach, participants will receive screenings, fitness opportuities, maternal health support, nutrition workshops and resources, and Family Resource Center (FRC) parent workshops. Services are provided by program staff members and by professionals for specialized services as needed. Participants are low-income, disenfranchised, diverse families, and will benefit from receiving health services to which they otherwise would not have had access. By bringing health screenings and system navigation to Black and Latinx families at its multiple events, AACSA makes entry to health care systems more trusted and friendly through the Strengthening Families model, an evidence-based framework. Services will be provided at agency site and community events using COVID-19 safety. FHS is based on industry best practices and evidence-based practices in the fields of early childhood development and family support.	
Agency Description & Address	304 N. 6th Street, San Jose http://www.sjaacsa.org Founded in 1978, the African-American Community Services Agency (AACSA) serves and advocates for communities of color in downtown San Jose, including Latinos and other non-English speaking populations, while focusing on the often-overlooked African American population. For these groups, who have the highest rates of poverty and unemployment, AACSA provides a safe space where all are welcome. Its programs for youth and families have sought to reverse the pervasive impacts of racism by providing educational, cultural, social, and recreational programs and services to ethnically diverse low-income children, families and seniors. In 2018, AACSA became a FIRST 5 Family Resource Center (FRC), serving as a neighborhood hub that will ensure children are kindergarten-ready, with strong family relationships, and connections to schools and community.	
Program Delivery Site(s)	Services provided at agency site, community events and client homes as COVID-19 protocols allow.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual, behavioral and child development screening sessions/intake • Coordination of partner-provided eye, dental, physical health screenings at events • Family referrals to appropriate community services and programs • Workshop series on healthy living • Nutritious Soul Food Cooking Classes • Exercise classes Full requested amount would support partial salaries of staff, including two community workers and class instructors, and some program support costs.	
FY23 Funding	FY23 Requested: $60,398	FY23 Recommended: $43,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $28,364 FY22 Approved: $28,000 FY22 6-month metrics met: 100%	FY21 Approved: $25,000 FY21 Spent: $25,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $20,000 FY20 Spent: $20,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 50%

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African American Community Service Agency

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	500	1,488
	Services provided (workshops/classes/screenings/referrals)	650	1,650
	Parents who took FRC classes understand how to support their child's healthy development	N/A	65%
	Participants in exercise classes discovered a fitness modality that would support a healthy lifestyle.	N/A	65%
	Healthy cooking class attendees will report that they learned how to cook in a healthier way.	N/A	65%

FY23 Diabetes & Obesity Application Summary

American Diabetes Association

Program Title	Project Power	*Recommended Amount:* $25,000
Program Abstract & Goal	To slow the rise of obesity and type 2 diabetes. Agency partners with community organizations to strengthen capacity and engage their community members. Trained agency volunteers deliver this program at the partnering organization's site(s) at times that are convenient for community members. Program utilizes an evidence-based curriculum that instills the importance of physical activity and nutrition for the entire family. The entire family benefits but the program focus is on children aged 5-12 years, who will benefit from knowing ways to identify, practice and adopt healthy eating and physical activity habits to reduce the incidence of diabetes.	
Agency Description & Address	1537 Sixth Avenue, Belmont http://diabetes.org American Diabetes Association's mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The ADA is the authoritative voice in the diabetes community, providing research, information and public awareness, and advocacy. For over 80 years, we have been working on the frontlines and within multiple areas to educate at-risk populations, protect the rights of people with diabetes in their daily lives, and pioneer clinical and research breakthroughs by fostering a pipeline of the best and brightest scientists and by educating healthcare professionals on standards of care in diabetes.	
Program Delivery Site(s)	Services will be provided at two community centers in San Jose, as well as 17 schools in San Jose, Santa Clara, Sunnyvale and Gilroy	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Group lessons • Nutrition workshops • Physical activities and games • Family engagement • Cooking demonstrations • SMART goal setting Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $50,000	FY23 Recommended: $25,000

	FY22	FY21	FY20
Funding History & Metric Performance	New in FY23	New in FY23	New in FY23

[Continued on next page]

American Diabetes Association

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	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	800	1,000
	Families members reached	1,600	2,000
	Youth survey respondents knowledgeable about the amount of physical activity to do in a day as assessed by pre/post survey	N/A	68%
	Youth respondents who are confident in their ability to choose fruit as a snack as assessed by pre/post survey. Youth respondents who are confident in their ability to achieve energy balance with the food they eat and the physical activity they do as assessed by pre/post survey	N/A	75%
	Youth respondents who meet the recommended amount of physical activity in a week (5 days or more) as assessed by pre/post survey. Youth respondents who eat vegetables 4 or more times in the past week as assessed by pre/post survey	N/A	55%

FY23 Diabetes & Obesity Application Summary

Bay Area Women's Sports Initiative

Program Title	BAWSI Girls in Campbell Union School District	*Recommended Amount:* $15,000
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. Young girl participants benefit because physical fitness shows immediate and long-term positive impacts on physical and mental health outcomes. Program is delivered afterschool by program coaches.	
Agency Description & Address	1922 The Alameda, Suite 420, San Jose http://www.bawsi.org 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)	Services will be provided at Rosemary Elementary School	
Services Funded By Grant/How Funds Will Be Spent	Services include: • One school assembly at the start of each semester • Weekly afterschool session of fitness activities • Weekly 15-minute leadership development session for 5th Grade junior coaches • One Game Day event attending a women's sporting event on a college campus Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $60,000	FY23 Recommended: $15,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $24,500 FY22 Approved: $15,000 FY22 6-month metrics met: 67%	FY21 Approved: $15,000 FY21 Spent: $15,000 FY21 6-month metrics met: 33% FY21 Annual metrics met: 33%	FY20 Approved: $16,500 FY20 Spent: $16,500 FY20 6-month metrics met: 67% FY20 Annual metrics met: 67%
FY23 Dual Funding	FY23 Requested: $60,000	FY23 Recommended: $26,000	

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

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	60	120
	Encounters	17	35
	Average weekly attendance percentage	80%	80%
	Percentage of participants who respond positively (4's and 5's) to the statement, "I like to exercise".	60%	60%
	Percentage of parents who respond positively (4's and 5's) to the question, "Does your child want to do more physical activity since joining BAWSI?"	70%	70%

FY23 Diabetes & Obesity Application Summary

Chinese Health Initiative

Program Title	Chinese Health Initiative (CHI)	*Recommended Amount:*$20,000
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, M/S WIL204, Mountain View http://https://www.elcaminohospital.org/services/chinese-health-initiative 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: • Educational workshops and webinars on diabetes and hypertension adapted to reflect Chinese cultural and language preferences, with an emphasis on lifestyle changes • Screenings and health consultations with a dietitian or physician and resource support through the call center or from event outreach • Specific hypertension and diabetes prevention and management programs conducted in Mandarin • Maintain other media outreach, including bilingual website, quarterly bilingual eNewsletters, and COVID-19 updates • Monthly Qigong exercise classes presented in Chinese and English • 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 • Annual Health Fair, including health screenings, workshops, dietitian and physician consultations Full requested amount funds partial staff salaries and some program expenses.	

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FY23 Diabetes & Obesity Application Summary

Chinese Health Initiative

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

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	115	255
	Services provided	277	554
	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

El Camino Health

Program Title	El Camino Health Food Pharmacy	*Recommended Amount:* $148,500
Program Abstract & Goal	To establish an El Camino Health Food Pharmacy intervension program with local community partner Fresh Approach. Hospitalization and re-hospitalization among vulnerable patients will be reduced through access to healthy food, nutrition education, and personalized guidance for healthy, nutritionally balanced eating. ECH patients suffering from malnutrition and/or diabetes/pre-diabetes as well as food insecurity, identified through screening, will be referred to the Food Pharmacy. The program will provide four months of food that support the production of nutritious meals to patients and their household members, consultation sessions with an ECH Nutrition Services dietician and Fresh Approach's four-month VeggieRx nutrition education program. Boxes of nutritious food supplies and recipes will be delivered weekly to patients and their families/household members.	
Agency Description & Address	2500 Grant Road, Mountain View http://elcaminohealth.org El Camino Health provides a personalized healthcare experience at two nonprofit acute care hospitals in Los Gatos and Mountain View, and at primary care, multi-specialty care and urgent care locations across Santa Clara County. For sixty years, the organization has grown to meet the needs of the individuals and communities it serves. Bringing together the best in new technology and advanced medicine, the network of nationally recognized physicians and care teams deliver high quality, compassionate care. Key medical specialties include cancer, heart and vascular, mental health and addiction services, mother-baby health and lifestyle medicine. Affiliated partners include El Camino Health Foundation, El Camino Health Medical Network and Concern.	
Program Delivery Site(s)	Services will be provided directly to patients homes, at community locations such as ECH campuses and community services agencies, as well as via phone and virtually.	
Services Funded By Grant/How Funds Will Be Spent	Services of the four-month intervention program include: • Weekly food delivery with recipe guidance to provide 10 nutrious meals per week for four months for patients and household members • Nutrition guidance and monthly follow up consultation sessions with ECH dietician • Four-month Nutrition education class series, VeggieRx, in English and Spanish Full requested amount funds partial salaries for staff, food and program expenses.	
FY23 Funding	FY23 Requested: $148,591	FY23 Recommended: $148,500

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	60	150
	Services provided	560	1,400
	Improvement in BMI (body mass index) over the course of program	30%	30%
	Increased consumptions of fruits and vegetables over the course of program	80%	80%
	Participants report an increase in their ability to care for themselves through good nutrition	75%	75%

FY23 Diabetes & Obesity Application Summary

Gardner Family Health Network

Program Title	Down with Diabetes	*Recommended Amount:* $254,500
Program Abstract & Goal	To support increased access in diabetes disease management in underserved Latinx communities in San Jose. Services are delivered at health centers in San Jose and include assistance with medication adherence, no-cost glucose monitors and annual supply of strips, case management, blood tests, fresh produce vouchers, diet and exercise guidance, and referrals to fitness programs. Program addresses access to care barriers and benefits teens and adults who are prediabetic and diabetic. The program provides evidenced-based treatment practices delivered by bilingual professional clinical staff and wellness coaches.	
Agency Description & Address	160 E. Virginia Street, Suite 100, San Jose, CA 95112 http://www.gardnerfamilyhealth.org Gardner Health Services has 8 clinics, 2 specialty service sites, and 2 mobile clinics in Santa Clara and San Mateo counties dedicated to improving the health of hardworking communities of color who seek our medical and mental healthcare services. Economic and food insecurities top the health concerns among our patient population. 90.3% of Gardner Health Services' patients/clients live below 200% of the federal poverty threshold, 1,782 are homeless, many undocumented and 29% are not covered through any insurance program. 72% of our patients are Hispanic and 51% whose primary language is not English. In 2021 Gardner Health Services provided care to 42,032 unduplicated individuals. The organization is steadfast in its commitment to assist anyone struggling to afford and access healthcare in the region.	
Program Delivery Site(s)	Services will be provided at agency sites in San Jose: • Gardner Health Center • St. James Health Center • Comprecare Health Center	
Services Funded By Grant/How Funds Will Be Spent	Bilingual services include: • Assessments • Nutrition and exercise prescriptive treatment plans • Blood tests to monitor HbA1c levels • Case management • Provision of food vouchers, glucose monitors and annual supply of strips, and diabetes educational materials and resources • Nutrition education workshops Full requested amount funds staff salaries and most program expenses.	
FY23 Funding	FY23 Requested: $271,469	FY23 Recommended: $254,500

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $242,369 FY22 Approved: $230,000 FY22 6-month metrics met: 100%	FY21 Approved: $225,000 FY21 Spent: $225,000 FY21 6-month metrics met: 75% FY21 Annual metrics met: 75%	FY20 Approved: $220,000 FY20 Spent: $220,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 75%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	900	1,550
	Total services/encounters provided, including patient visits with a PCP, Registered Dietitian and/or MA-Health Coach	1,900	3,500
	Patients demonstrating a reduction in body weight	40%	40%
	Adult patients who experience weight loss of at least 5%	4%	4%
	Enrolled patients demonstrating a reduction of at least 0.1%HbA1c	40%	40%

GoNoodle

Program Title	GoNoodle Movement and Mindfulness Videos and Games	*Recommended Amount:* $40,000
Program Abstract & Goal	To continue providing GoNoodle physical activity and mindfulness breaks to schools and homes in ECH service areas and partner with ECH on outreach to promote positive health messages. Educators and family users will receive access to GoNoodle content and resources. These academically, high activity and mindfulness-focused movement games are core subjects aligned to inspire more student minutes of movement and expand the currently active GoNoodle user base in ECH schools and homes. GoNoodle is available in schools and at home where teachers and parents can access the physical activity and mindfulness breaks to help elementary school children re engage, refocus, stay on task, and transition from one topic or standard to the next. Go Noodle is based on research that shows that short bursts of physical activity positively impact academic achievement, cognitive skills, behavior, as well as overall health.	
Agency Description & Address	209 10th Avenue South, Suite 517, Nashville http://www.gonoodle.com GoNoodle gets kids moving to be their smartest, strongest, bravest, silliest, best selves. Short, interactive movement videos make it awesomely simple and fun to incorporate movement into every part of the day with dancing, stretching, running and mindfulness activities. At school, teachers use GoNoodle to keep students energized, engaged, and active inside the classroom. At home, GoNoodle turns screen time into active time, so families can have fun and get moving together. In 2021, GoNoodle reached 95% of US Public elementary schools. Fall 2021 was GoNoodle's best back to school season ever, with 827K active teachers in September alone, an increase of 11% from 2020. GoNoodle has reached 25.5M unique classroom students with both families and students achieving 5.3 billion activity minutes this past year!	
Program Delivery Site(s)	School sites and homes in El Camino Health service area	

Services Funded By Grant/How Funds Will Be Spent	Services include:
	• GoNoodle content for educators and parents/students in ECH sponsored area
	• Placement of ECH name and logo on the GoNoodle site and on materials sent to teachers and parents
	• Email campaigns, social media activity and ads designed to promote positive health messages:
	    o Collaboration on community wellness initiatives, such as about diabetes and obesity prevention opportunities, nutrition education and mental health
	    o Coordinated messages to other ECH-funded school-based programs
	    o Reaching nearly 10,000 local school teachers and families
	    o 15 second media ads on GoNoodle for families to view that allow ECH to communicate community initiatives to parents and children
	    o Promoting ECH outreach strategies (e.g., a Community Partnerships e-newsletter) to increase reach in the community
	Full requested funding would support access to GoNoodle in schools, community organizations and homes in the ECH service area and broad access to reach educators and parents with positive health messages and information.	

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GoNoodle

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FY23 Funding	FY23 Requested: $114,000		FY23 Recommended: $40,000	
Funding History & Metric Performance	FY22	FY21	FY20	
	FY22 Requested: $114,000 FY22 Approved: $113,000 FY22 6-month metrics met: 100%	FY21 Approved: $113,000 FY21 Spent: $113,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 60%	FY20 Approved: $113,000 FY20 Spent: $113,000 FY20 6-month metrics met: 67% FY20 Annual metrics met: 100%	
FY23 Proposed Metrics	*Metrics*		*6-month Target*	*Annual Target*
	Individuals served		87,115	193,040
	Local schools served		362	384
	Teacher's who report GoNoodle has had a positive impact on their students' focus and attention in the classroom.		75%	75%
	Teacher's who report GoNoodle has had a positive impact on their students' academic success in the classroom.		75%	75%
	Teacher's who report GoNoodle has had a positive impact on their students' physical health.		75%	75%

FY23 Diabetes & Obesity Application Summary

Indian Health Center of Santa Clara Valley

Program Title	Healthy Futures: Youth Diabetes Prevention Program	*Recommended Amount:* $111,500
Program Abstract & Goal	To decrease the number of Indian Health Center pediatric patients (ages 0-17) who are overweight or obese and to decrease the A1c of patients with pre-diabetes or diabetes. Program utilizes a best practices approach to address the health needs by providing holistic, wrap around services served in a team-based approach that includes parents, pediatric patients, primary care physicians, Registered Dietitians, registered nurses, health educators, peer educators, and fitness instructors. Services include body image classes, nutrition services and various fitness services. In addition to better health outcomes, participants will benefit from ongoing access to registered dietitians, personal training, fitness classes, and to agnecy's fitness center. Other family members are also included in program activities to help support the success of the pediatric patients. All services are provided free of charge.	
Agency Description & Address	1211 Meridian Avenue, San Jose, CA 95125 http://indianhealthcenter.org The Indian Health Center (IHC) began operation in 1977. In 1993, IHC obtained Federally Qualified Health Center (FQHC) status to provide services to anyone in need of care. IHC offers medical, counseling, nutrition, WIC, dental and wellness services. In 2002, IHC started a wellness program to promote healthy living and IHC now operates a Wellness Center in downtown San Jose that houses a fitness center, nutrition counseling, diabetes case management, health education and cultural activities. IHC has four medical sites, two dental sites, three WIC sites, and a wellness center with counseling and substance abuse services.	
Program Delivery Site(s)	Services will be provided at agency sites, including wellness center and medical sites, local parks and virtually, as needed	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual medical nutrition therapy • Tailored personal training sessions with the Fitness Coordinator, with parental consent • Youth exercise groups • Access to Fitness Center • Healthy Adventures Summer Program during school break which includes lunch, nutrition education and outdoor physical activity • Classes on nutrition, body image and fitness • Periodic check-in with Patient Navigators Full requested amount fully funds partial staff salaries, including RN, Registered Dietician and Patient Navigator, and program expenses.	
FY23 Funding	FY23 Requested: $125,000	FY23 Recommended: $111,500

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $87,000 FY22 Approved: $87,000 FY22 6-month metrics met: 100%	FY21 Approved: $80,000 FY21 Spent: $80,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $74,000 FY20 Spent: $73,528 FY20 6-month metrics met: 100% FY20 Annual metrics met: 50%

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	200	400
	Services provided	500	900
	Participant that decrease BMI Percentile	30%	33%
	Participants that demonstrate retention of key health material through assessment	60%	80%
	Pre-diabetic and diabetic patients in the Healthy Futures Program that are engaged in care coordination	40%	70%

FY23 Diabetes & Obesity Application Summary

Palo Alto Medical Foundation

Program Title	5210 Program-Numbers to Live By!	*Recommended Amount:* DNF
Program Abstract & Goal	To offer nutrition lessons and wellness education to prevent chronic diseases such as diabetes and obesity. School-aged children, parents, school staff, and administrators will benefit from the services provided to promote ongoing health and wellness messages. Services are provided by health educators and include 5th and 3rd grade nutrition lessons, physical activity contests, lunch tastings of fruits and vegetables, after school programming, and parenting classes. Additional educational presentations are provided to staff and administrators throughout the school year. Services are provided to 18 schools in the El Camino Hospital service area during the school year and take place both during and after the school day. Program utilizes evidence-based methods.	
Agency Description & Address	2300 River Plaza Dr., Sacramento http://www.pamf.org The Palo Alto Medical Foundation for Health Care, Research and Education (PAMF) is a not-for-profit health care organization dedicated to enhancing the health of people in our communities. PAMF serves more than 100 communities in Northern California. The purpose of the 5210 program is to increase nutritional awareness and competency among youth within our service area and to create environments that make healthy choices easier for families to practice. We engage students with healthy eating lessons and physical activity to promote a healthy lifestyle.	
Program Delivery Site(s)	Services will be provided at 18 schools in three school districts: Campbell Union School District: • Blackford Elementary, San Jose • Campbell School of Innovation, Campbell • Capri Elementary, Campbell • Castlemont Elementary, Campbell • Forest Hill Elementary, San Jose • Lynhaven Elementary, San Jose • Marshall Lane Elementary, Saratoga • Monroe Middle School, San Jose • Rolling Hills Middle School, Los Gatos • Rosemary Elementary, Campbell • Sherman Oaks Elementary, San Jose Cupertino Union School District: • De Vargas Elementary, San Jose • Eisenhower Elementary, Santa Clara • Sedgwick Elementary, Cupertino San Jose Unified School District: • Almaden Elementary, San Jose • Canoas Elementary, San Jose • Grant Elementary, San Jose • Horace Mann Elementary, San Jose	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Nutrition and fitness lessons • Parent classes • Educational presentations to school staff Full requested amount funds staff salaries and program expenses.	

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Palo Alto Medical Foundation

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FY23 Funding	FY23 Requested: $25,000	FY23 Recommended: DNF		
Funding History & Metric Performance	FY22	FY21	FY20	
	FY22 Requested: $25,000 FY22 Approved: $20,000 FY22 6-month metrics met: 0%	FY21 Approved: $25,000 FY21 Spent: $12,100 FY21 6-month metrics met: 0% FY21 Annual metrics met: 0%	FY20 Approved: $20,000 FY20 Spent: $20,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 67%	
FY23 Dual Funding	FY23 Requested: $30,000	FY23 Recommended: DNF		
Dual Funding History & Metric Performance	FY22	FY21	FY20	
	FY22 Requested: $ 30,000 FY22 Approved: $ 25,000 FY22 6-month metrics met: 0%	FY21 Approved: $ 30,000 FY21 Spent: $ 14,885 FY21 6-month metrics met: 0% FY21 Annual metrics met: 0%	FY20 Approved: $ 25,000 FY20 Spent: $ 22,942 FY20 6-month metrics met: 100% FY20 Annual metrics met: 0%	
FY23 Proposed Metrics	*Metrics*		*6-month Target*	*Annual Target*
	Individuals served		1,200	2,400
	Total Students Served		140	280
	Students who report being active one or more hours per day after 5210 programming		N/A	58%
	Students who report knowledge to limit sugary beverages to zero drinks per day after 5210 programming		N/A	75%
	Students who report knowledge that a healthy diet has at least 5 servings of fruits and vegetables per day after 5210 programming		N/A	80%

FY23 Diabetes & Obesity Application Summary

Playworks

Program Title	Playworks Campbell Union School District — Recommended Amount: $40,000
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 http://www.playworks.org 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)	Services will be provided at the following Campbell Union School District sites: • Blackford Elementary, San Jose • Lynhaven Elementary, San Jose • Sherman Oaks Elementary, San Jose • Rosemary Elementary, Campbell • Castlemont Elementary, Campbell
Services Funded By Grant/How Funds Will Be Spent	Services include: • Daily implementation of play-based strategies onsite by Playworks professional • Biweekly class for individualized support on conflict resolution strategies and rules of games during regularly scheduled periods • 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 • Training of upper grade students to serve as Junior Coaches during recess to lead games and activities, and manage conflict • Professional development workshops and consultations for educators • Training school staff on specific Playworks strategies • Digital services for educators that include courses on demand, weekly game instruction, and online tools Full requested amount funds partial staff salaries and digital support package for school staff.

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Playworks

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<table>
<tr><td>FY23 Funding</td><td colspan="4">FY23 Requested: $81,000   FY23 Recommended: $40,000</td></tr>
<tr><td rowspan="2">Funding History & Metric Performance</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $86,000
FY22 Approved: $86,000
FY22 6-month metrics met: 0%</td><td>FY21 Approved: $86,000
FY21 Spent: $12,900
FY21 6-month metrics met: N/A
FY21 Annual metrics met: 0%</td><td colspan="2">FY20 Approved: $91,627
FY20 Spent: $91,627
FY20 6-month metrics met: 100%
FY20 Annual metrics met: 80%</td></tr>
<tr><td>FY23 Dual Funding</td><td colspan="4">FY23 Requested: $231,000   FY23 Recommended: $200,000</td></tr>
<tr><td rowspan="2">Dual Funding History & Metric Performance</td><td>FY22</td><td>FY21</td><td colspan="2">FY20</td></tr>
<tr><td>FY22 Requested: $218,000
FY22 Approved: $200,000
FY22 6-month metrics met: 100%</td><td>FY21 Approved: $218,000
FY21 Spent: $191,841
FY21 6-month metrics met: 0%
FY21 Annual metrics met: 80%</td><td colspan="2">FY20 Approved: $216,034
FY20 Spent: $216,034
FY20 6-month metrics met: 100%
FY20 Annual metrics met: 100%</td></tr>
<tr><td rowspan="6">FY23 Proposed Metrics</td><td colspan="2">Metrics</td><td>6-month Target</td><td>Annual Target</td></tr>
<tr><td colspan="2">Individuals served</td><td>2,400</td><td>2,400</td></tr>
<tr><td colspan="2">The program encounter is defined as the number of days a Playworks coach is on campus during the school year.</td><td>85</td><td>175</td></tr>
<tr><td colspan="2">Teacher/administrators reporting that Playworks positively impacts classroom climate</td><td>N/A</td><td>95%</td></tr>
<tr><td colspan="2">Teachers reporting that overall engagement increased attentiveness and participation in class</td><td>N/A</td><td>91%</td></tr>
<tr><td colspan="2">Teacher/administrators who agree that Playworks helps increase physical movement</td><td>N/A</td><td>96%</td></tr>
</table>

FY23 Diabetes & Obesity Application Summary

South Asian Heart Center

Program Title	AIM to Prevent	*Recommended Amount:* $50,000

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 https://www.southasianheartcenter.org 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. The AIM to Prevent™ program's revolutionary approach has helped thousands lower their risk with a comprehensive evaluation, expert lifestyle counseling, and personalized health coaching. The Center's STOP-D™ program helps those with prediabetes to stop diabetes before it starts, and helps those with diabetes to stop the progression and prevent/delay onset of symptoms.
Program Delivery Site(s)	Services will be provided agency site, community events, virtually and by phone
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting health assessments and engaging participants in the AIM to Prevent, STOP-D and SlimFIT programs • Personalized assessment and counseling on nutrition and exercise • Providing outreach, workshops, and seminars on lifestyle topics • 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 Full requested amount funds partial staff salaries and some program expenses.

FY23 Funding	FY23 Requested: $110,000	FY23 Recommended: $50,000

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

FY23 Dual Funding	FY23 Requested: $330,000	FY23 Recommended: $300,000

	FY22	FY21	FY20
Dual Funding History & Metric Performance	FY22 Requested: $300,000 FY22 Approved: $300,000 FY22 6-month metrics met: 100%	FY21 Approved: $210,000 FY21 Spent: $210,001 FY21 6-month metrics met: 100% FY21 Annual metrics met: 67%	FY20 Approved: $140,000 FY20 Spent: $116,669 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

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South Asian Heart Center

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	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	75	165
	Service encounters	380	760
	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

Valley Verde

Program Title	San Jose Gardens for Health	*Recommended Amount:* $60,000
Program Abstract & Goal	To improve the long-term health of low-income San Jose residents by providing fresh organic produce through home gardening. Participants will receive a comprehensive set of culturally relevant services and resources to enable them to successfully grow their own organic produce and prepare healthy meals from fresh vegetables. In addition to building and supporting home gardens, low-income participants (apprentices) will learn to grow commercial-quality seedlings for use in this program. Other services include workshops and lessons on nutrition, healthy cooking, and organic gardening. Services are provided year round by agency staff who are experts in organic urban gardening and who utilize best practices and resources from well-established sources such as the USDA, FDA, and the EPA. Typically services are offered in participants' homes, school sites, and agency's community greenhouse and demonstration garden in downtown San Jose, but for COVID-19 safety, group workshops are currently delivered virtually.	
Agency Description & Address	376 West Virginia Street, San Jose http://www.valleyverde.org/ Valley Verde supports the health of San Jose residents by empowering them with knowledge and skills to grow healthy organic food for themselves and their communities. Since 2012, Valley Verde has helped more than 600 low-income families learn to grow food at home and share that knowledge with others. Our programs teach gardening, nutrition, and healthy cooking; encourage physical activity; foster community; and raise awareness of health and environmental issues. In addition, we provide leadership and entrepreneurship opportunities to revitalize low-income communities. Throughout our work, we uplift the cultural heritage of our participants by growing culturally preferred crops and highlighting traditional growing methods. Families participate for an entire year or more, which gives them a foundation for growing and eating healthy food for the long-term.	
Program Delivery Site(s)	Services provided in participants homes, schools serving low-income students, and at agencies community greenhouse and demonstration garden, as well as virtually, as needed	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Healthy cooking and nutrition education classes • Monthly workshops for first-year participants in program. Topics include nutrition, healthy cooking, and organic urban gardening techniques. • Advanced skills and information workshops for participants who have completed their first year of the program • Building new organic vegetable gardens with infrastructure and supplies for a year of gardening • School garden support • Mentorship visits and monthly check-ins • Training apprentices on how to grow professional-quality vegetable seedlings for use by participants in program Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $60,000	FY23 Recommended: $60,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $60,000 FY22 Approved: $45,000 FY22 6-month metrics met: 25%	FY21 Approved: $45,000 FY21 Spent: $45,000 FY21 6-month metrics met: 50% FY21 Annual metrics met: 100%	FY20 Approved: $45,000 FY20 Spent: $45,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 75%

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Valley Verde

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	114	227
	Services provided	150	300
	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%	80%
	Participants report increased consumption of vegetables by at least one unit of measurement for themselves and their families since they became involved in the program, as measured by pre- and post-program surveys.	85%	85%
	Participants report an increase by at least one unit of measurement in their knowledge of nutrition and healthy cooking, as measured by pre- and post-program surveys.	70%	70%

FY23 Diabetes & Obesity Application Summary

West Valley Community Services

Program Title	Community Access to Resources and Education CARE	*Recommended Amount*:$184,500
Program Abstract & Goal	To help low-income households move out of poverty towards self-sufficiency and better health outcomes. Services include case management, food assistance, and wrap-around services. Food insecurity is addressed through an onsite food pantry with a broad selection of fresh produce, dairy, and meat items as well as staples such as rice, beans, canned, and dried goods. Money saved on food can be used for rent, childcare, or transportation, effectively stretching a client's household budget. Additionally, clients have access to a wealth of wrap-around services that support household stability and self-sufficiency. Program benefits clients by preventing homelessness in low-income households, creating economic stability, and supporting better health outcomes. Services are provided by program staff.	
Agency Description & Address	10104 Vista Drive, Cupertino http://wvcommunityservices West Valley Community Services is a nonprofit organization that has been providing safety net services to low-income and homeless individuals and families in the west valley region of Santa Clara County for more than 48 years. West Valley Community Services offers a range of services, including a food pantry, affordable housing, emergency financial assistance, a mobile food pantry, financial coaching, access to public benefits, case management, and referral services. The mission of West Valley Community Services is to unite the community to fight hunger and homelessness.	
Program Delivery Site(s)	Services provided at agency site and virtually	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Access to healthy food, including a mobile food pantry • Health screening and referrals • Workshops and educational opportuities • Multiplingual diabetes prevention classes • Virtual healthy cooking demonstrations as well as Q&A meetings with a nutritionist • Assistance navigating and accessing government benefits • Assistance navigating and accessing emergency financial assistance • Employment readiness program and financial coaching Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $275,000	FY23 Recommended: $184,500

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $213,650 FY22 Approved: $160,000 FY22 6-month metrics met: 100%	FY21 Approved: $153,000 FY21 Spent: $153,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $153,000 FY20 Spent: $153,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	175	350
	Households that receive intensive Case Management services	25	50
	Case managed clients who increase in 3 of 18 domains in the SSM	N/A	90%
	Program participants who will improve on the health domain through supportive services using the health risk assessment	N/A	80%
	Clients will remain stably housed after 3 months of receiving EFA	N/A	95%

FY23 Chronic Conditions Application Summary

American Heart Association

Program Title	Healthy Hearts Initiative - San Jose	***Recommended Amount:***$60,000	
Program Abstract & Goal	To improve hypertension in under-resourced community members in East San Jose. The American Heart Association-El Camino Health Healthy Hearts Initiative utilizes an evidence-based chronic disease management program as part of a four-month treatment and self-monitoring program, Check.Change.Control. Program includes screenings, referrals and education about managing and preventing high blood pressure. Services will be delivered at the SOMOS Mayfair community based organization. Clients benefit from adopting healthy lifestyles and gaining the skills to self-manage high blood pressure.		
Agency Description & Address	1111 Broadway, Suite 1360, Oakland http://www.heart.org The American Heart Association (AHA) is one of the largest and most trusted voluntary health organizations in the world. To fulfill our 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. Our 2024 Impact Goal states that as champions for health equity, the AHA will advance cardiovascular health for all, including identifying and removing barriers to health care access and quality. As such, the AHA established and now champions 10 commitments designed to break down barriers to health equity. One of those commitments recognizes the crucial role of high blood pressure in cardiovascular health disparities.		
Program Delivery Site(s)	Services will be provided at SOMOS Mayfair Family Resource Center		
Services Funded By Grant/How Funds Will Be Spent	Services include: • Screening and referral for hypertension • Education on hypertension management and prevention • Workshops on healthy lifestyles Full requested amount funds full salaries of program staff, RNs for screening, hypertension workshop costs and other program expenses.		
FY23 Funding	FY23 Requested: $60,000	FY23 Recommended: $60,000	
Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $80,000 FY22 Approved: $50,000 FY22 6-month metrics met: 100%	FY21 Approved: $50,000 FY21 Spent: $49,210 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	New Program in FY21
FY23 Dual Funding	FY23 Requested: $110,000	FY23 Recommended: $100,000	
Dual Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $116,500 FY22 Approved: $110,000 FY22 6-month metrics met: 80%	FY21 Approved: $110,000 FY21 Spent: $101,113 FY21 6-month metrics met: 40% FY21 Annual metrics met: 50%	FY20 Approved: $110,000 FY20 Spent: $94,825 FY20 6-month metrics met: 67% FY20 Annual metrics met: 50%

FY23 Proposed Metrics

Metrics	***6-month Target***	***Annual Target***
Individuals served	95	190
Check.Change.Control. Intervention Workshop participants (unduplicated)	90	180
CCC Participants will improve BP by 7mm	35%	35%
CCC Participants will measure 8 BP readings within 4 months	55%	55%
CCC Participants will adopt health behaviors to improve BP by self-reporting increased fruit and vegetable consumption	35%	35%

FY23 Chronic Conditions Application Summary

Breathe California

Program Title	Children's Asthma Services		*Recommended Amount:*$40,000
Program Abstract & Goal	To provide culturally competent, best-practice asthma management education and support services for target populations of diverse, under-served, low-socioeconomic status (SES) children and their parents/families and care providers. Clients benefit from increased access to appropriate care or treatment and to improve management of their chronic condition of asthma. These services will be provided by program staff and volunteers of highly qualified, experienced professionals of Health Educators, Respiratory Therapists, Physicians, and other Health Professionals. Program follows evidence-based guidelines and will be offered virtually until it is safe to meet in person.		
Agency Description & Address	1469 Park Avenue, San Jose http://www.breathebayarea.org Breathe California of the Bay Area (BCBA) is a 111-year-old grassroots, community-based, voluntary 501(c) 3 non-profit that is committed to achieving clean air and healthy lungs. Our Mission: 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. Goals: tobacco-free communities, healthy air quality, reduced lung diseases. Prior to COVID, we served over 40,000 individuals per year with programs in health education, health policy and research, focusing on populations with health disparities. COVID, a respiratory disease that affects seniors most seriously, and the greater recognition of the importance of building health equity make Seniors Breathe Easy vital to the health of the ECHD community of seniors.		
Program Delivery Site(s)	Services are currently provided virtually.		
Services Funded By Grant/How Funds Will Be Spent	Services include: • Asthma management educational sessions • Training and technical assistance • Asthma home visits and environmental assessments • Information/referral to additional resources Full requested amount funds partial salary for four staff and some program costs.		
FY23 Funding	FY23 Requested: $40,000		FY23 Recommended: $40,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $40,000 FY22 Approved: $40,000 FY22 6-month metrics met: 100%	FY21 Approved: $40,000 FY21 Spent: $40,000 FY21 6-month metrics met: 0% FY21 Annual metrics met: 67%	FY20 Approved: $50,000 FY20 Spent: $36,681 FY20 6-month metrics met: 100% FY20 Annual metrics met: 67%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	130	400
	Encounters	100	300
	Children with asthma who receive multi-session asthma education who have an increase in knowledge/skills	50%	50%
	Parents, teachers, and childcare providers trained who have an increase knowledge/skills/confidence handling of asthma management, environmental triggers for asthma, environmental remediation steps, and confidence in managing asthma.	60%	60%
	Home, school, and childcare centers served that reduce environmental hazards/triggers for asthma, as measured by comparison of assessments and re-assessments of respiratory hazards using the EPA's best-practice environmental checklist.	50%	50%

FY23 Chronic Conditions Application Summary

Latinas Contra Cancer

Program Title	The Cancer Prevention and Early Detection in the Latino Community Program (CPED)	*Recommended Amount:* $40,000
Program Abstract & Goal	To decrease cancer-related health disparities among the Hispanic population in Santa Clara County and mitigate the impact of disparities through culturally and linguistically responsive community health outreach, education, screening, and navigation services. Health Educator and Patient Navigators will provide services, with assistance from Promotores – Latina community health workers who have cultural and linguistic proficiency in serving the target population. Services are offered where clients frequent – spaces in medical clinics, hospital systems, schools, non-profits, government entities, and churches. Services take place at times convenient to the target population. Program benefits low- and very low-income Latina/os by removing access to healthcare barriers. The promotora model is evidence-based and shown to be effective in decreasing cancer morbidity and mortality.	
Agency Description & Address	255 N. Market Street, Suite 175, San Jose http://www.latinascontracancer.org Founded in 2003, Latinas Contra Cancer's (LCC) mission is to create an inclusive health care system for Latinx residents in Santa Clara County (SCC). LCC clients, primarily low-income, undocumented and/or monolingual Spanish speakers, face obstacles to health care caused by cultural, linguistic, socioeconomic, and institutional inequities. A Latina-founded and Latina-led organization, LCC provides health education, patient navigation, survivorship support, research, and advocacy to address the needs of underserved Latinx community members in SCC across the cancer continum, from prevention, diagnosis, treatment, patient support, survivorship, to end of life.	
Program Delivery Site(s)	Services will be delivered at various community sites, including clinics, hospitals, schools, non-profits, and churches.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Health Education Bingo game and outreach events • Health screenings • Follow-up phone calls • Patient Navigation service sessions • Health and medical appointment accompaniment (if allowable) • Referrals to agency and other safety net services Full requested amount funds partial staff salaries.	
FY23 Funding	FY23 Requested: $75,000	FY23 Recommended: $40,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $35,000 FY22 Approved: $35,000 FY22 6-month metrics met: 100%	FY21 Approved: $25,000 FY21 Spent: $25,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	New in FY21

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	345	690
	Services provided	1,045	2,090
	Clients showing an increased understanding of key cancer prevention and health messages.	70%	70%
	Navigation clients showing a better understanding of their health status, options, and care plan.	90%	90%
	Health navigation participants reporting overall satisfaction with those services.	85%	85%

FY23 Chronic Conditions Application Summary

Pink Ribbon Girls

Program Title	Simply Fight/No Age No Stage	*Recommended Amount:* $25,000
Program Abstract & Goal	To address the basic needs of patients with breast or gynecological cancers. Program provides healthy meals, rides to treatment, housecleaning, education, and peer support to breast and gynecological cancer patients. Patients benefit from improved health outcomes and treatment compliance. This evidence-based program is delivered by nurse navigators and oncology social workers, SunBasket (nutritious meals), and UberHealth (safe, HIPAA-compliant rides to treatement). Services are provided as needed by the patients, at times that are convenient for them.	
Agency Description & Address	32 E Main St., Tipp City http://https://www.pinkribbongirls.org/ PRG is a 501(c)(3) nonprofit founded by breast cancer survivors that provides healthy meals, rides to treatment, and peer support (held virtually currently) to individuals with breast or gynecological cancers free of charge. We strive to balance the fear and uncertainty that these cancers bring to individuals, enabling our clients to focus on healing and family. Our services are essential to our immunocompromised clients, especially given the additional challenges presented by COVID-19 to which they are most vulnerable. Pink Ribbon Girls provides critical services to cancer patients at their time of greatest need. This is independent of age, stage, or socio-economic considerations - because cancer doesn't discriminate.	
Program Delivery Site(s)	Services will be provided to patients in their homes and clinics, as well as virtually.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Onboarding call to determine when and which services the client needs to support them during treatment • 3 healthy meals per week, if needed • Rides to/from treatment, if needed • One housecleaning kit (non-toxic cleaning supplies and a light-weight vacuum), if needed • Virtual peer support and education Full requested amount funds partial program expenses for healthy meals, rides for treatment, home services, education and peer support.	
FY23 Funding	FY23 Requested: $25,000	FY23 Recommended: $25,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $25,000 FY22 Approved: $25.000 FY22 6-month metrics met: 100%	New in FY22	New in FY22

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	50	120
	Services provided	720	1,920
	Patients who report feeling stronger and well-nourished through treatment,	40%	60%
	Social workers who report that treatment compliance (i.e. fewer missed appointments) has increased by 20% as assessed in bi-annual follow-up calls.	50%	85%
	Clients that report a 50% decrease in feelings of loneliness and isolation as assessed by post survey.	35%	50%

FY23 Economic Stability Application Summary

Catholic Charities of Santa Clara County

Program Title	Parish Engagement Program	*Recommended Amount:* $30,000
Program Abstract & Goal	The Parish Engagement Program (PEP) will train and develop the capacity of local parishioners throughout the Diocese of San Jose to support and empower each other, helping those in need to achieve self-sufficiency and avoid re-traumatization. PEP offers outreach and community mapping, care and accompaniment, as well as stability and self-agency follow-up/accountablility checks, and The Community Market, a once-a-week pop-up market where clients access vital social services, a hot meal, and fresh groceries, legal advice, physical and mental health care, and social service navigation in a setting that destigmatizes poverty and celebrates community. PEP staff train accompaniment volunteers, who serve as peer support systems in the parishes, providing individual consultations, peer counseling, food distribution, community events, resources, information, linkages, and referrals. PEP implements a model of neighbors helping neighbors, building community strength and resiliency in new and lasting ways. PEP serves extremely low- to low-income families where many are forced to choose between medical care, rent, or eating. PEP implements trauma-informed, client-centered practices, and is informed by the framework of "Encuentro" (to find), a Latinx-specific conversational process that yields learning about those in need and has been successfully applied by the Peace Corps in developing nations.	
Agency Description & Address	2625 Zanker Road, San Jose http://www.catholiccharitiesscc.org Catholic Charities of Santa Clara County (CCSCC) serves and advocates for individuals and families in need, especially those living in poverty. Rooted in gospel values, the agency works to create a more just and compassionate community in which people of all cultures and beliefs can participate and prosper. CCSCC typically serves more than 40,000 people each year, providing critical support in the areas of food, health, housing, education, economic stability, and safety net services to help break the cycle of poverty in our community. Since the onset of COVID-19, CCSCC has served over 80,000 people annually to help Santa Clara County residents overcome the health and economic impacts of the pandemic.	
Program Delivery Site(s)	Services are delivered at various sites in the community, in the following parishes: • Our Lady of Refuge, San Jose • Christ the King, San Jose • St. Leo Parish, San Jose • St. Athanasius, Mountain View	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Intake and assessments • Individual peer counseling and check-ins • Referrals Full requested amount funds partial staff salaries and some program expenses.	
FY23 Funding	FY23 Requested: $50,000	FY23 Recommended: $30,000

	FY22	FY21	FY20
Funding History & Metric Performance	New in FY23	New in FY23	New in FY23

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Catholic Charities of Santa Clara County

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	Metrics	6-month Target	Annual Target
FY23 Proposed Metrics	Individuals served	216	432
	Number of duplicate sessions provided	1,080	2,160
	Increased understanding of how to navigate the social services system	70%	70%
	Increased client confidence in ability to achieve goals toward self-sufficiency and stability.	70%	70%
	Increase in Self-Sufficiency Matrix Score	70%	70%

Downtown Streets Team

Program Title	Downtown Streets Team - Continued Support of San Jose Program	*Recommended Amount:*$30,000
Program Abstract & Goal	To help individuals who are 18 years or older recover from homelessness. Targetted population includes clients who are actively experiencing homelessness, at-risk of homelessness, and/or low-income. Program utilizes an assets-based, best practices model that encourages clients to engage in volunteer work, which rebuilds positive habits, expands their skillset and readies them to re-enter the workforce. In exchange for their volunteerism, participants benefit from case management and employment services, and receive stipends for basic needs. Program staff engage with clients at agency site as per COVID-19 guidelines, and wherever clients are located in the community, including parks, encampments, libraries, etc.	
Agency Description & Address	1671 The Alameda #306, San Jose https://www.streetsteam.org/ Downtown Streets Team (DST) is building Teams that restore dignity, inspire hope, and provide a pathway to recover from homelessness by engaging people experiencing homelessness in a volunteer work experience model to beautify communities. Through creating an inclusive and supportive community, Team Members (clients) overcome barriers to success and exit homelessness. Our model encourages individuals to volunteer their time on Street Beautification Teams in the community while working on job-readiness and self-sufficiency. In exchange for their volunteerism, we offer our Team Members case management and employment services, as well as basic needs stipends for food, shelter, and more. By beautifying the community, not only are our Team Members building positive habits, they are regaining self-sufficiency and achieving a higher quality of life.	
Program Delivery Site(s)	Services provided at locations in the community where staff can engage with homeless individuals, includes parks, encampments, libraries and at agency site.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual case management and assessments • Courses related to employment, housing, healthy habits, and life skills that will prepare clients for a seamless transition into self-sufficiency • Referrals as necessary Full requested amount funds partial salary of Case Manager.	
FY23 Funding	FY23 Requested: $30,000	FY23 Recommended: $30,000

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $30,000 FY22 Approved: $30,000 FY22 6-month metrics met: 100%	New in FY22	New in FY22

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	10	20
	Encounters	60	120
	Participants who report a 4 point increase of self-supporting on our 5 point wellness meter scale in one or more categories.	50%	75%
	Participants who report improved their self-esteem, motivation, and/or hope since joining the program.	50%	75%
	Participants who report decreased quantity or improved the quality of interactions with law enforcement/the court system.	20%	40%

FY23 Economic Stability Application Summary

El Camino Health

Program Title	ECH DEI & Economic Opportunity Program	*Recommended Amount:*$35,000
Program Abstract & Goal	To establish an internship and mentorship program to provide professional opportunities in healthcare to local young adults with economically challenged backgrounds. Program will provide career development opportunities to diverse, local high school, community college, college, and graduate students by placing them in internships at one of the El Camino Health campuses. Internship activities will include 'Lunch and Learn' with ECH leadership and service line leaders, trainings in different areas of hospital operations and mentorship with a designated ECH employee for six months upon completion of internship. Participants (interns) access training and career opportunities. This program aims to help build a diverse, local healthcare workforce as we as promote economic opportunity.	
Agency Description & Address	2500 Grant Road, Mountain View http://elcaminohealth.org El Camino Health provides a personalized healthcare experience at two nonprofit acute care hospitals in Los Gatos and Mountain View, and at primary care, multi-specialty care and urgent care locations across Santa Clara County. For sixty years, the organization has grown to meet the needs of the individuals and communities it serves. Bringing together the best in new technology and advanced medicine, the network of nationally recognized physicians and care teams deliver high quality, compassionate care. Key medical specialties include cancer, heart and vascular, mental health and addiction services, mother-baby health and lifestyle medicine. Affiliated partners include El Camino Health Foundation, El Camino Health Medical Network and Concern.	
Program Delivery Site(s)	Services will be provided at (internships conducted at) El Camino Health campuses in Mountain View and/or Los Gatos and virtually as needed.	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Internship within an ECH department • Lunch and Learn meetings with ECH executives and service line leaders • Hospital operations trainings • Mentorship with ECH employee via Zoom or phone Full requested amount funds internships stipends and a contract with Health Career Connections for recruiting interns.	
FY23 Funding	FY23 Requested: $37,000	FY23 Recommended: $35,000

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	2	6
	Encounters	20	60
	Participants strongly agree with the statement, " I have at least two new healthcare professions contacts they feel comfortable remaining in touch with to help advance their desired career path.	80%	80%
	Participants strongly agree with the statement, "I gained knowledge or ideas for my career path from the internship and/or mentor relationship."	80%	80%

FY23 Economic Stability Application Summary

First Community Housing

Program Title	Healthy and Equitable Communities	*Recommended Amount:* DNF
Program Abstract & Goal	To improve health literacy and promote healthy behavior changes in low-income individuals and families. Program provides ongoing access to healthy fresh food and health education by managing community gardens for fresh produce and implementing workshops on health, nutrition, exercise and reducing toxins in the home. Program will also conduct outreach and sign residents up for Santa Clara County healthcare, in particular COVID-related preventive care. Services will be provided by First Community Housing (FCH) resident services program staff in the community spaces (indoor and outdoor) at FCH apartments, and will be provided at various times, depending on the residents' needs. Program utilizes evidence-based and industry best practices for engaging residents and providing health education services. FCH residents benefit from equitable access to healthy food and information, leading to improved health outcomes.	
Agency Description & Address	75 E Santa Clara Street Suite 1300, San Jose http://www.firsthousing.org First Community Housing is a nonprofit 501c3 corporation created to develop, construct, and manage affordable housing for San Jose and the greater SF Bay Area. FCH's mission is to build high-quality affordable housing that responds to the needs of diverse communities and embraces environmental sustainability. Their vision is that all populations are housed in affordable, healthy, thriving, environmentally sustainable communities. Since 1986, FCH has developed housing for 1,700+ households, serving 4,500 people at 22 properties, with another 1,800 units in development. They serve low-income populations including individuals, families, senior citizens, and those with special needs like chronic and mental illness and developmental disabilities. FCH apartments' affordability levels range from 20-60% of area median income with 90% of FCH residents at 50% or below the median.	
Program Delivery Site(s)	Services will be delivered at multiple agency sites	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Health education classes • Dissemination of information on community resources • Community garden workshop • Assisting residents in signing up for SCC health care programs Full requested amount fully funds program staff and all program expenses.	
FY23 Funding	FY23 Requested: $90,000	FY23 Recommended: DNF

	FY22	FY21	FY20
Funding History & Metric Performance	FY22 Requested: $30,000 FY22 Approved: $30,000 FY22 6-month metrics met: 100%	New in FY22	New in FY22

	Metrics	*6-month Target*	*Annual Target*
FY23 Proposed Metrics	Individuals served	250	500
	Services provded (Classes, workshops, physical activity, resources)	400	700
	Residents report committing to eating more fruits & veggies	60%	70%
	Residents report committing to performing more physical activity	60%	70%
	Residents report committing to reducing toxins in their home	60%	70%

FY23 Economic Stability Application Summary

Rebuilding Together Silicon Valley

Program Title	Safe and Healthy Homes for Older Adults		*Recommended Amount:*$30,000
Program Abstract & Goal	To provide critical home safety repairs and accessibility modifications that enable low-income homeowners to age-in-place. Repairs and accessibility modifications meet the specific needs of the homeowner, and include a variety of tasks that make the home safer, including installation of grab bars, hand railings, bath seats, raised toilets, modified and progressive stairs, wheelchair ramps and lifts, improved lighting, smoke/CO detectors, plumbing, and electrical repairs. The benefit to the homeowner is that they and their family, which often include older adults or people with disabilities, can continue to live safely and independently in their own home and can age-in-place successfully. Services are completed by agency's skilled professionals and volunteers (if safe and feasible) at the homeowner's residence. Program effectiveness is measured through various evidence-based practices and tools.		
Agency Description & Address	1701 S. 7th Street, #10, San Jose https://rebuildingtogethersv.org/ Our mission is repairing homes, revitalizing communities, rebuilding lives, and our vision is safe homes and communities for everyone. We provide home repairs and accessibility modifications for low-income residents in Santa Clara County, including older adults, individuals living with disabilities, and veterans. These services are provided at no cost to the people we help and are tailored to the needs of each homeowner. We also provide facility maintenance and repairs for nonprofit organizations so they can dedicate their time and resources to helping those in need in our community. Since our founding in 1991, Rebuilding Together Silicon Valley has mobilized nearly 40,000 local volunteers who have repaired and transformed over 4,500 homes and community facilities.		
Program Delivery Site(s)	Services will be provided at homeowner's residences		
Services Funded By Grant/How Funds Will Be Spent	Services include: • Home safety repairs and accessibility improvements Full requested amount funds multiple partial staff salaries and program expenses such as labor, materials, supplies, etc.		
FY23 Funding	FY23 Requested: $30,000		FY23 Recommended: $30,000

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

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	5	24
	Individual homes repaired/modified	3	10
	Older adult service recipients who report their overall health has improved somewhat or a lot since completed repairs/modifications.	75%	75%
	Older adult service recipients who report a low or no chance of falling due to completed repairs/modifications.	65%	65%
	Older adults who report a 1 point increase in their ability to move around their home.	65%	65%

FY23 Economic Stability Application Summary

Sacred Heart Community Service

Program Title	La Mesa Verde: Growing Strong Communities	*Recommended Amount:* DNF
Program Abstract & Goal	To build urban gardens to promote economic stability and alleviate food insecuirty among low- and extremely low-income residents in San Jose. Residents benefit from access to healthy fresh produce, which minimizes the health-related impacts of food insecurity. Program staff and volunteers deliver garden beds (with all necessary components), seedlings and seeds to each resident's home, or to a community gardening space for families without space at their primary residence. Workshops on gardening and food justice are also offered by program staff. Services are delivered year-round, maximizing both the spring and fall growing seasons. Program is founded upon the principles of agroecology, which is an industry best practice.	
Agency Description & Address	1381 S. First Street, San Jose http://https://sacredheartcs.org/ Sacred Heart Community Service (SHCS) is an anti-poverty and anti-racist organization founded in 1964 as a grassroots movement to address homelessness and hunger in San Jose, CA. As a State designated Community Action Agency, we are the largest provider of essential services and self-sufficiency programming in Santa Clara County, CA. We offer 10 community programs, touching the lives of 47,000 individuals each year, and working towards addressing the root causes and consequences of poverty.	
Program Delivery Site(s)	Services will be provided in clients homes and at agency community gardens	
Services Funded By Grant/How Funds Will Be Spent	Services include: • Community-building events • Bilingual (English & Spanish) workshops on organic gardening skills and agroecology education • Bilingual (English & Spanish) workshops on food justice and political systems education • Monthly evening meetings • Gardening supplies Full requested amount funds partial staff salaries of Organizing Manager and Organizing Coordinator and some overhead expenses.	
FY23 Funding	FY23 Requested: $20,000	FY23 Recommended: DNF

Funding History & Metric Performance	FY22	FY21	FY20
	DNF in FY22	FY21 Approved: $20,000 FY21 Spent: $20,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	New in FY21

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	14	43
	Encounters	24	96
	Participants will save between $30-80/week during peak harvest season	N/A	55%
	Participants will feel a stronger sense of belonging in the community since they started gardening	N/A	80%
	Participants will feel prepared to implement skills learned at educational workshops in their gardens	N/A	75%

FY23 Economic Stability Application Summary

School of Arts and Culture at MHP

<table>
<tr><td>Program Title</td><td colspan="3">Los Mercaditos Hunger Relief Program</td><td colspan="2">Recommended Amount: DNF</td></tr>
<tr><td>Program Abstract & Goal</td><td colspan="5">To alleviate food insecurity in East San Jose by giving residents 50 pounds of subsidized food. Program (Mercaditos) utilizes a farmers market model, where participants choose the food items they want. There will also be resource booths each time the Mercadito meets, connecting community members to essential services. Low income, food insecure residents of East San Jose will benefit from the availability of healthy, nutritious food and easy access to essential services and resources. Agency staff will organize the Mercaditos and Second Harvest of Silicon Valley will supply the nutritious food. Mercaditos will be held twice per month for 2 hours. The farmers market model has been shown to successfully support access to healthy foods in communities that experience food insecurity.</td></tr>
<tr><td>Agency Description & Address</td><td colspan="5">1700 Alum Rock Avenue, San Jose
http://schoolofartsandculture.org
The mission of the School of Arts and Culture at MHP (SOAC) is to catalyze creativity and empower community. To fulfill its mission, SOAC engages the primarily low-income, working class Latinx and Asian children, youth, and families of Mayfair/East San José in arts, cultural, and community events that connect them to each other, their families, and their heritage. These families also benefit from our basic needs and resources services, which has been especially vital during the pandemic. As a cultural anchor institution deeply embedded in this community, SOAC supports and advocates on behalf of residents through a mission-driven arts and cultural lens.</td></tr>
<tr><td>Program Delivery Site(s)</td><td colspan="5">Services will be provided at the Mexican Heritage Plaza (“La Plaza”)</td></tr>
<tr><td>Services Funded By Grant/How Funds Will Be Spent</td><td colspan="5">Services include:
• Bi-monthly Mercaditos for the provision and distribution of 50-pounds of nutritious, healthy food per household.
Full requested amount funds partial staff salaries of Community Hub Events Manager and Community Engagement Program Manager as well as marketing and professional fees.</td></tr>
<tr><td>FY23 Funding</td><td colspan="2">FY23 Requested: $30,427</td><td colspan="3">FY23 Recommended: DNF</td></tr>
<tr><td rowspan="2">Funding History & Metric Performance</td><td>FY22</td><td>FY21</td><td colspan="3">FY20</td></tr>
<tr><td>New in FY23</td><td>New in FY23</td><td colspan="3">New in FY23</td></tr>
<tr><td rowspan="5">FY23 Proposed Metrics</td><td colspan="2">Metrics</td><td colspan="2">6-month Target</td><td>Annual Target</td></tr>
<tr><td colspan="2">Individuals served</td><td colspan="2">116</td><td>116</td></tr>
<tr><td colspan="2">Duplicate number of individuals served</td><td colspan="2">1,392</td><td>2,784</td></tr>
<tr><td colspan="2">Mercadito attendees surveyed will express increased food security as a result of the Mercaditos.</td><td colspan="2">65%</td><td>65%</td></tr>
<tr><td colspan="2">Mercadito attendees surveyed will express they have access to foods they want to eat.</td><td colspan="2">65%</td><td>65%</td></tr>
</table>

FY23 Economic Stability Application Summary

Teen Success

Program Title	San Jose Teen Success Program			*Recommended Amount:* DNF
Program Abstract & Goal	To empower teen mothers to achieve their full potential in school and as parents. Program partners with teen mothers and provides them with the support necessary to complete high school and persist through post-secondary education. Program utilizes successful, evidence-based models. Young mothers receive comprehensive services through one-on-one coaching, peer learning groups and community workshops. Teen mothers and their children in this program are able to thrive and prosper when they complete their post-secondary degree and start earning a living wage. Services are delivered wherever convenient for young mothers- schools, community centers, their homes, coffee shops, etc. Due to COVID restrictions, peer learning groups are operating virtually.			
Agency Description & Address	Sobrato Center for Nonprofits, 508 Valley Way, Milpitas http://www.teensuccess.org Teen Success builds pathways to prosperity for two generations—young mothers and their children. We believe that education is the key factor in breaking the intergenerational cycle of poverty faced by young families. Our mission is to create opportunities for economic mobility for two generations, by helping California's young mothers advance their education, build life and career skills, and nurture their child's positive development. Teen Success, Inc.'s two-generation approach involves partnering with young mothers to help them achieve the following goals of completing high school and post-secondary education, and develop the knowledge and skills to nurture their child's positive development.			
Program Delivery Site(s)	Services will be provided at participants homes, community sites such as schools, coffee shops, libraries, community centers, etc., as well as virtually			
Services Funded By Grant/How Funds Will Be Spent	Services include: • One-on-one coaching • Peer learning groups • Community workshops Full requested amount funds partial staff salary for San Jose Advocate (.3FTE) and some administrative costs.			
FY23 Funding	FY23 Requested: $25,000		FY23 Recommended: DNF	
Funding History & Metric Performance	FY22	FY21	FY20	
	DNF in FY22	FY21 Approved: $20,000 FY21 Spent: $20,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $20,000 FY20 Spent: $20,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 67%	
FY23 Proposed Metrics	*Metrics*		*6-month Target*	*Annual Target*
	Individuals served		10	10
	Hours of one-on-one coaching for 10 young mothers		130	260
	Participants will complete high school, or its equivalent, or will be on track to graduation at program completion.		75%	85%
	Of those participants who have graduated from high school will persist through completion of a post-secondary degree or certificate.		70%	75%
	Participants who will demonstrate a decrease in parenting stress from beginning of the program to program completion as measured by the PSI-4 (Parenting Stress Index)		75%	75%

FY23 Economic Stability Application Summary

West Valley Community Services

Program Title	Senior Community Access to Resources & Education (CARE)	*Recommended Amount:*$45,000

Program Abstract & Goal	To help at-risk seniors become independent by improving access to services, meeting their basic needs, and promoting a connection to the community. Program brings services and resources closer to the target population, coordinates assistance internally and externally, and helps navigate the hospital, social services, and legal systems. Some of the services offered include emergency rental and utility assistanc; access to food (mobile pantry and doorstep drop-off); case management information and referrals; and curb-to-curb transportation. These services stabilize at-risk, low-income seniors and builds self-sufficiency.
Agency Description & Address	10104 Vista Drive, Cupertino http://wvcommunityservices West Valley Community Services is a nonprofit organization that has been providing safety net services to low-income and homeless individuals and families in the west valley region of Santa Clara County for more than 48 years. Founded in 1973 by three public health nurses, West Valley Community Services offers a range of services, including a food pantry, affordable housing, emergency financial assistance, a mobile food pantry, financial coaching, access to public benefits, case management, and referral services. The mission of West Valley Community Services is to unite the community to fight hunger and homelessness.
Program Delivery Site(s)	Service will be provided at agency site and virtually
Services Funded By Grant/How Funds Will Be Spent	Services include: • Access to healthy food, including a mobile food pantry • Health screening and referrals • Workshops and educational opportuities • Multiplingual diabetes prevention classes • Virtual healthy cooking demonstrations • Virtual Q&A meetings with a nutritionist • Assitance navigating and accessing government benefits • Assistance navigating and accessing emergency financial assistance Full requested amount funds partial staff salaries and some program expenses.
FY23 Funding	FY23 Requested: $45,000 FY23 Recommended: $45,000

Funding History & Metric Performance	FY22	FY21	FY20
	FY22 Requested: $45,000 FY22 Approved: $45,000 FY22 6-month metrics met: 100%	FY21 Approved: $45,000 FY21 Spent: $45,000 FY21 6-month metrics met: 100% FY21 Annual metrics met: 100%	FY20 Approved: $45,000 FY20 Spent: $45,000 FY20 6-month metrics met: 100% FY20 Annual metrics met: 100%

FY23 Proposed Metrics	*Metrics*	*6-month Target*	*Annual Target*
	Individuals served	30	60
	Services provided	160	320
	Case managed clients who increased in 3 of the 18 domains measured by the self-sufficiency matrix	N/A	91%
	Clients will remain stably housed after 3 months of receiving emergency financial assistance	N/A	91%
	Program participants who will improve on the health domain through healthy options and supportive services using the health risk assessment	N/A	80%

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

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

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Finance Committee
From: Jon Cowan, Senior Director, Government Relations & Community Partnerships
Date: May 26, 2022
Subject: 2022 El Camino Health Community Health Needs Assessment

Recommendation:

To approve the 2022 El Camino Health Community Health Needs Assessment

Summary:

1. Situation: Conducted every three years, the Community Health Needs Assessment (CHNA) is conducted in compliance with California State Senate Bill 697 and IRS requirements per the Affordable Care Act of 2010.

2. Authority: The triennial CHNA is the framework for the annual Implementation Strategy Report and Community Benefit Plan (Plan) which is presented to the Finance Committee for approval.

3. Background:
Per the Affordable Care Act, El Camino Hospital conducted a community health needs assessment from January 2021 through March 2022. Four nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties, 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.

The CHNA highlights five priority focus areas for the El Camino Health service area.

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

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: The 2022 CHNA will represent the framework of the Plans for Fiscal Years 2023 through 2025. After approval by the Finance Committee, the written CHNA will be go the Hospital Board for approval.

7. List of Attachments:

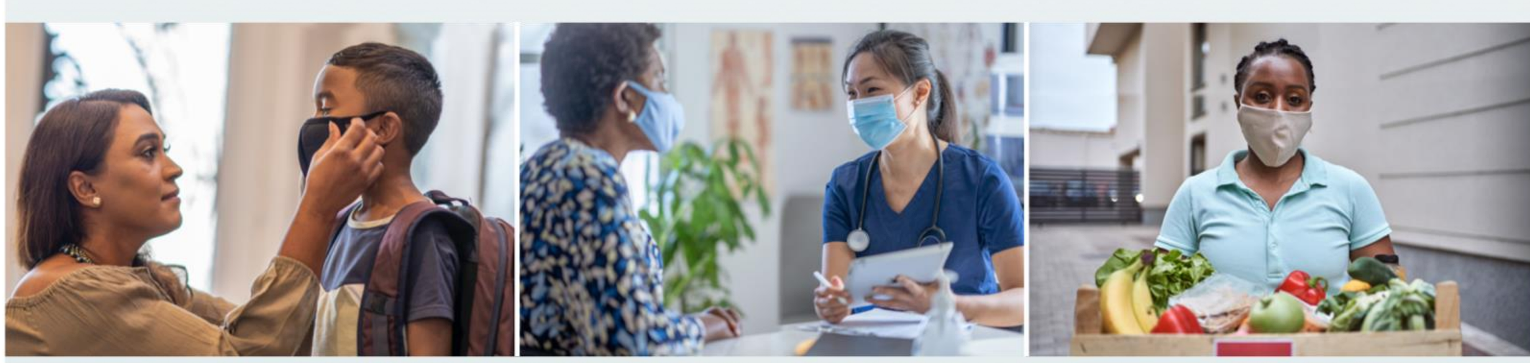
1. 2022 Community Health Needs Assessment

Suggested Committee Discussion Questions:

N/A

2022 Community Health Needs Assessment

June 2022



ACKNOWLEDGEMENTS

El Camino Health[1] would like to recognize the following organizations and individuals for their contributions to this report:

- El Camino Health
  Jon Cowan, Senior Director, Government Relations & Community Partnerships
  Barbara Avery, Director (retired), Community Benefit
  Sharan Johal, Senior Community Benefit Specialist

- Lucile Packard Children's Hospital Stanford
  Joey Vaughan, Manager of Community Partnerships
  Melissa Burke, MPH, Director of Community Relations
  Emily Gudaitis, MPH, Community Relations Specialist

- Stanford Health Care
  Colleen Haesloop Johnson, Director, Community Health & Partnerships
  Alpa Vyas, Vice President & Chief Patient Experience Officer
  Jaclyn Liu, MS, Community Health Program Manager, Community Health & Partnerships

- Sutter Health Mills-Peninsula Medical Center and Menlo Park Surgical Hospital
  Bindi Gandhi, Community Health Director, Bay Area
  Lisa Hom, Community Health Manager, South Bay
  Kayla Gupta, Community Health Coordinator, South Bay

- Sutter Health Palo Alto Medical Foundation
  Lisa Hom, Community Benefit Manager - Bay Medical Foundations, External Affairs

EL CAMINO HOSPITAL CEO AND BOARD OF DIRECTORS

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- Don Watters
- John L. Zoglin

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

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

- Melanie Espino, Co-Founder and Principal
- Jennifer van Stelle, PhD, Co-Founder and Principal

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1. EXECUTIVE SUMMARY

BACKGROUND

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

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

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

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

PROCESS AND METHODS

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

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

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

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

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

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

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

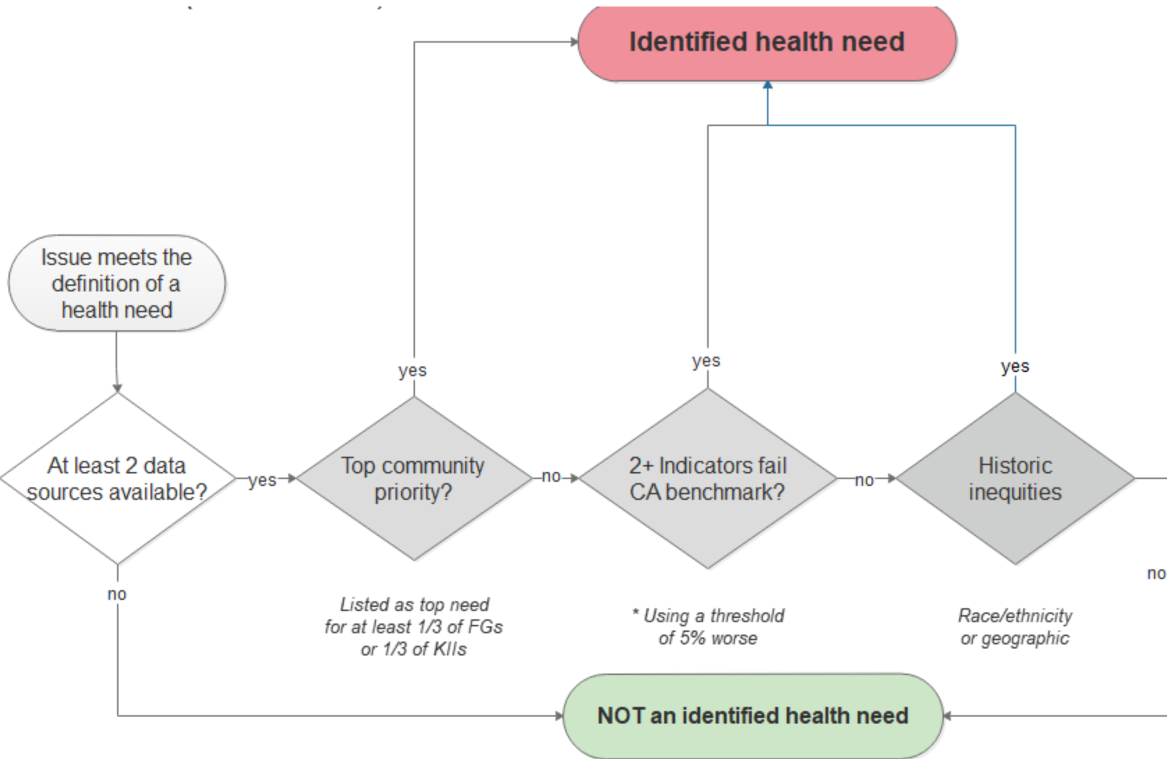
Health needs described in this report are either a poor health outcome and its health driver(s), or a health driver associated with a poor health outcome. El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which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

1. Must fit the definition of a “health need.” *(See Definitions box, opposite.)*
   and
2. Is suggested or confirmed by at least two sources (i.e. more than one source of secondary and/or primary data).
   and
3. Must be prioritized by at least one-third of focus groups or key informants,
   or
4. Two or more direct indicators must fail the benchmark by 5 percent or more,
   or
5. Two or more direct indicators must exhibit documented inequities by race.

DEFINITIONS

Health condition: A disease, impairment, or other state of physical or mental health that contributes to a poor health outcome.
Health driver: A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes. May be a social determinant of health.
Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.
Health need: A poor health outcome and its health driver, or a health driver associated with a poor health outcome.
Health outcome: The measurable impact — morbidity (quality of life) and mortality (death) — of a disease within a community.

Health Needs Identification Criteria



HEALTH NEEDS

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

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

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

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

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

Health Need	Justification
	significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4). ○ In East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%). ● Racial/ethnic disparities and inequities: ○ Smaller proportions of Santa Clara County Black (45%), Pacific Islander (38%), and Latinx (46%) 11th-graders met or exceeded grade-level English-language arts standards compared to California 11th-graders overall (57%). ○ Much smaller proportions of the county's Black (32%), Pacific Islander (34%), and Latinx (38%) high school graduates completed college-preparatory courses compared to high school graduates statewide (47%).
Behavioral Health (including mental health, trauma, and substance use)	● Behavioral health ranked high as a health need, being prioritized by all focus groups and more than half of key informants. ● Many experts spoke of depression, anxiety, trauma, and grief among all populations as an effect of the pandemic and reported an increased demand for services; however, children and adolescents were of particular concern. ● Students in Santa Clara County have lower access to psychologists at school (1,199:1) compared to students statewide (1,041:1, a 15% difference). ● The county's youth self-harm injury hospitalization rate (32.7 per 100,000 age 0-17) is significantly higher than the state's rate (22.4 per 100,000). ● Experts noted the lack of mental health providers (348.0 per 100,000 people in the county vs. 352.3 per 100,000 at the state level) and addiction services overall, especially in non-English languages. ● Key informants and focus group attendees described youth isolation and lack of interaction with peers due to the pandemic as preventing normal adolescent development. ● CHNA participants suggested that many students were anxious about returning to school, in part because of the chance of infection. ● Experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that

<table>
<tr><th>Health Need</th><th>Justification</th></tr>
<tr><td></td><td>seemed to occur beginning about three months into the pandemic.

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected.
Experts said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.
Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment.
Some noted that many hospitals no longer provide mental health services and there are very few inpatient psychiatric beds for acute/high needs.
It was stated that services for people without health insurance can be expensive and difficult to access.
Racial/ethnic disparities and inequities:

Drug overdose deaths among Santa Clara County's Black population occur at nearly twice the rate (25.0 per 100,000 people) as for all Californians (14.0 per 100,000).
Self-harm injury hospitalizations are much higher for the county's white youth (66.3 per 100,000 age 0-17) and Latinx youth (31.9 per 100,000) than for all California youth (22.4 per 100,000).
The county's white suicide rate for all ages (13 per 100,000 people) remains persistently higher than the state rate (11 per 100,000 people).
Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) were substantially higher for Black (23.0 per 1,000) and Latinx (9.3 per 1,000) Santa Clara County youth than for California youth overall (4.1 per 1,000).
African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic.

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<tr><td>Housing & Homelessness</td><td>More than half of focus groups and one key informant identified housing and homelessness as a top community priority.</td></tr>
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Health Need	Justification

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

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

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

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

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

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

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percentage of individuals enrolled in Medicaid or other public health insurance (42%) compared to the state average (38%).
In Sunnyvale (zip code 94085), another area of concentrated health disparities, a much lower proportion of individuals are enrolled in Medicaid/public health insurance (21%), but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).
In Sunnyvale (zip code 94085) more than one in seven (14%), and in the East San José area more than two in ten (22%) residents speak limited English.

Racial/ethnic disparities and inequities:
Preventable hospital stays (4,942 per 100,000 Black Medicare enrollees [adults aged 65 and over and persons with disabilities] and 3,969 per 100,000 Latinx Medicare enrollees in the county versus 3,358 per 100,000 Medicare enrollees statewide) may be a sign of inequitable access to high-quality care.

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<tr><td>Diabetes & Obesity</td><td>

Approximately one-third of key informants and focus groups identified diabetes and obesity as a top health need.
Two experts in Santa Clara County specifically called out diabetes as trending up in the community (from 6.8 per 100,000 in 2018 to 8.4 per 100,000 in 2019), while the trend for adult obesity remains flat.
Key informants and focus group participants identified the need for nutrition education, particularly from a young age, and some key informants further noted the cost of healthy food as a barrier to good nutrition.
The lack of physical activity was cited as a driver of obesity by multiple key informants, mostly in the context of the pandemic’s interference with regular activities.
The county’s walkability index (9.9) is worse than the state’s (11.2).
Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools.
Among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in Santa Clara County (22.2 per 1,000 people) compared to the state rate (48.1 per 1,000).

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Health Need	Justification

	• A smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (31%) compared to children statewide (35%).
	• Multiple residents made the connection between unhealthy eating and mental health—what's going on "in their head and their heart."
	• Geographic disparities and inequities:
	    ○ SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%).
	    ○ The walkability index for East San José (0.8) and the 94040 zip code of Mountain View (1.5), another area of concentrated health disparities, are substantially worse than the state's (11.2).
	• Racial/ethnic disparities and inequities:
	    ○ The county's Pacific Islander and Latinx middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide; Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards.

Cancer	• Although cancer mortality rates are not as high in Santa Clara County as they are statewide, cancer is still one of the top three causes of death in the county.
	• The breast cancer incidence rate is slightly higher among Santa Clara County women (121.2 per 100,000) compared to California women overall (120.9 per 100,000).
	• The rate of cancer incidence among children ages 0-19 is slightly higher in the county (19.0 per 100,000) than the state (18.2 per 100,000).
	• Racial/ethnic disparities:
	    ○ There are persistent disparities in cancer incidence rates and other cancer statistics.
	    ○ Mammography screening levels, an early cancer detection measure, are lower for the county's Black women (33%), Latinas (29%), and Native American women (33%) than California women overall (36%).
	    ○ The rate of cancer incidence among children ages 0-19 is highest among the county's white children (21.2) and Asian/Pacific Islander children (20.2); both rates are higher than the state (18.2).

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<tr><td>Maternal & Infant Health</td><td>

Maternal and infant health statistics (for all races/ethnicities together) in Santa Clara County are better than state benchmarks. However, the percentage of low birth-weight infants has been rising, which is a concerning trend.
Racial/ethnic disparities and inequities:

Teen births are significantly higher among the county's young Latinas (23.0 per 1,000 females age 15-19) than all females ages 15-19 statewide, (17.0 per 1,000), although the trend is improving.
A maternal and child health expert suggested that cultural norms and access issues may play into differences in teen birth statistics.
Low infant birth weight is a more frequent issue among Asian (8%) and Black (9%) babies born in the county compared to all babies statewide (7%).
Infant mortality is higher among Black babies.
A smaller proportion of Black (79%) and Latinx (78%) mothers in Santa Clara County receive early prenatal care than all Californian mothers (84%).
A maternal and child health expert indicated that inequities in maternal and infant health may also be traced back not only to healthcare access and delivery barriers, but to social determinants of health such as racism.

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<tr><td>Oral/Dental Health</td><td>

Access issues related to oral health arose during the assessment.
Most oral health indicators in Santa Clara County are favorable compared to the state. However, the oral health expert described oral health needs as such:

Lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care.
Few pediatric dentists in the county, still fewer take Denti-Cal due to the low reimbursement rates, leading to a gap in services.
The special needs population as underserved by oral health specialists.
Low-income pregnant women often don't know that they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

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

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

[7] Asthma and Allergy Foundation of American. (2020). Asthma Disparities in America. Retrieved from https://www.aafa.org/asthma-disparities-burden-on-minorities.aspx
[8] American Lung Association. (2020). *Disparities in the Impact of Air Pollution.* Retrieved from https://www.lung.org/clean-air/outdoors/who-is-at-risk/disparities

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

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

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

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

KEY TAKEAWAYS

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

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

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

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

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

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

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

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

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

COVID-19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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/doi/10.1073/pnas.2020685118 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).

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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-experiences-children-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-segregation-and-racial-academic-achievement-gaps

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

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

2. BACKGROUND

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

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

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

CHNA PURPOSE AND ACA REQUIREMENTS

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

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

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

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

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

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

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

BRIEF SUMMARY OF 2019 CHNA

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

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

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

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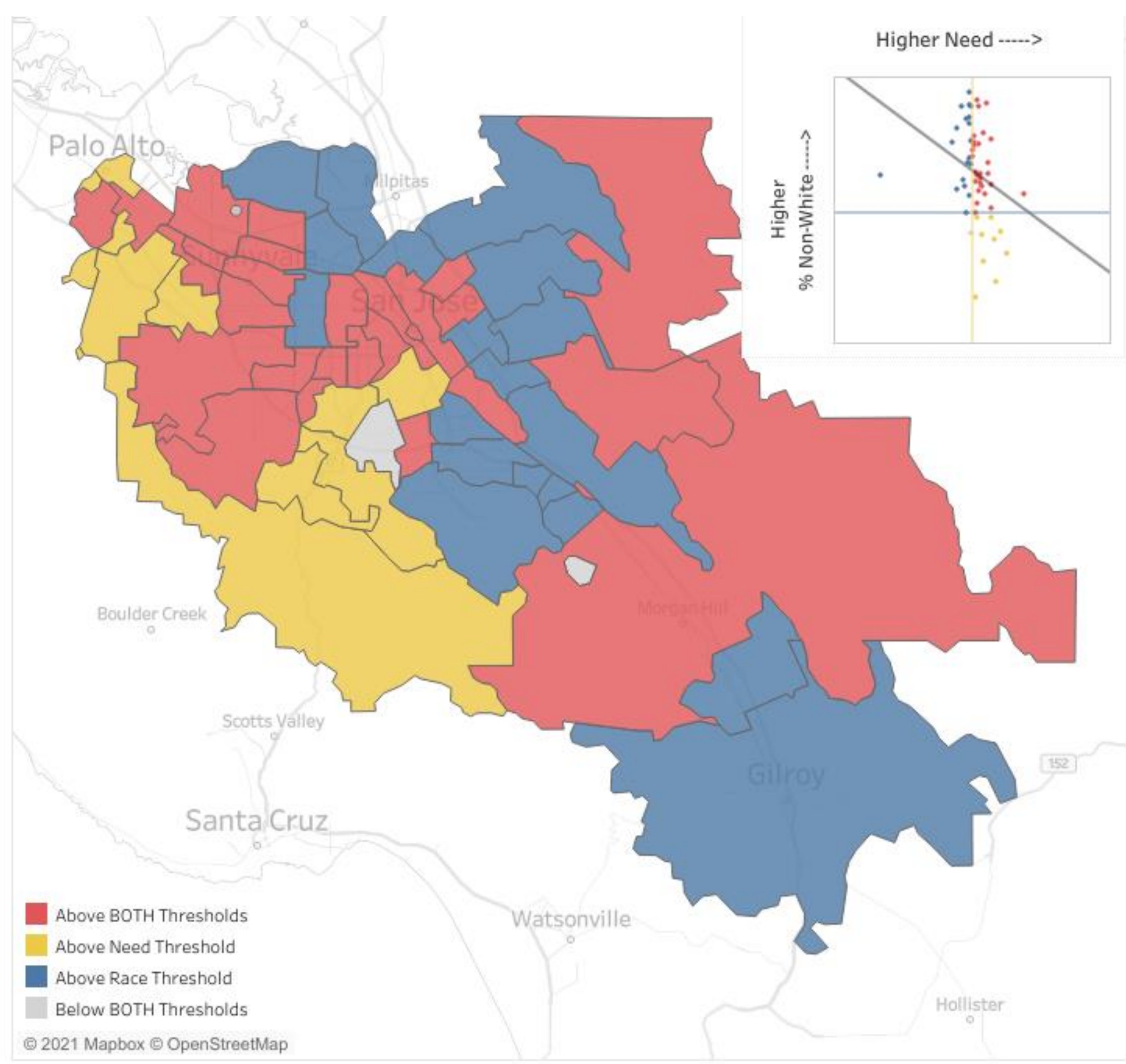
[42] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org

[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.

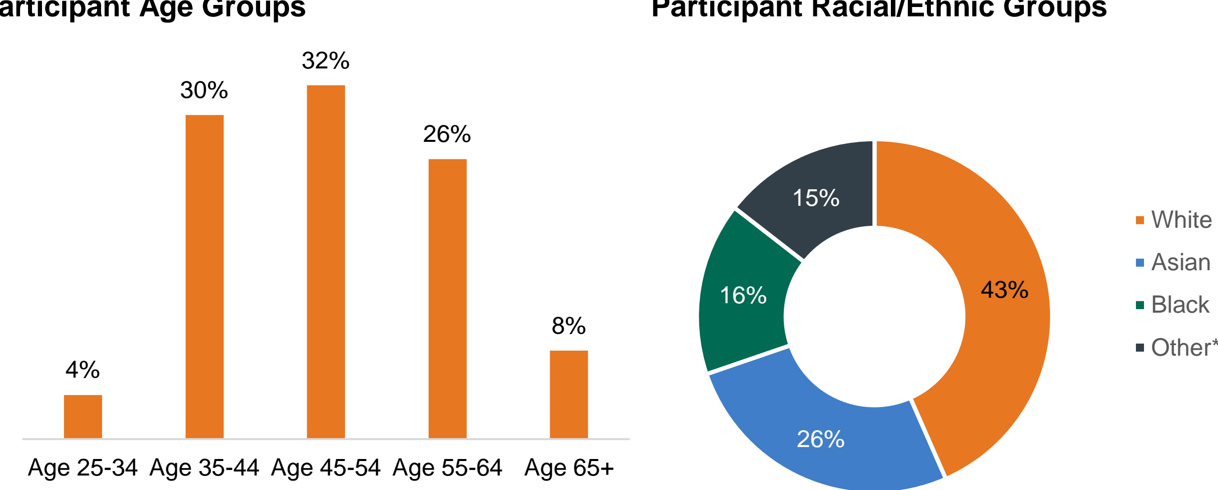
See *Attachment 4: Qualitative Research Protocols* for complete protocols and questions, including pre-surveys. See *Attachment 1: Community Leaders, Representatives, and Members Consulted* for a list of key informants and focus group or interview details.

[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).



* "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

Identified health need

Issue meets the definition of a health need

At least 2 data sources available?

yes

Top community priority?

Listed as top need for at least 1/3 of FGs or 1/3 of KIIs

no

2+ Indicators fail CA benchmark?

* Using a threshold of 5% worse

no

Historic inequities

Race/ethnicity or geographic

yes

yes

yes

no

no

NOT an identified health need

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

PROCESS OF PRIORITIZING THE HEALTH NEEDS

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

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

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

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

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

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

6. PRIORITIZED COMMUNITY HEALTH NEEDS

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

ECONOMIC STABILITY

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

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

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

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

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

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

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

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

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

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

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

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

BEHAVIORAL HEALTH

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

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

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

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

[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

[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).

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

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

MATERNAL & INFANT HEALTH

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

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

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

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

ORAL/DENTAL HEALTH

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

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

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

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

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

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

CLIMATE/NATURAL ENVIRONMENT

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

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

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

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

UNINTENDED INJURIES/ACCIDENTS

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

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

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

COMMUNITY SAFETY

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

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

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

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

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

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

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

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

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

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

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

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

SEXUALLY TRANSMITTED INFECTIONS

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

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

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

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

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

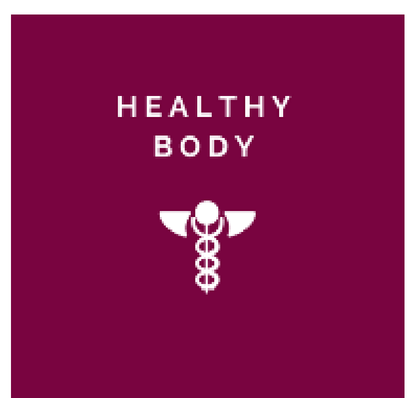
7. EVALUATION OF 2020–2022 IMPLEMENTED STRATEGIES

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

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

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

The health needs fall under three health priority areas:



- Diabetes & Obesity
- Chronic Conditions (other than Diabetes & Obesity)
- Healthcare Access & Delivery
- Oral Health

- Behavioral Health
- Cognitive Decline

- Violence & Injury Prevention
- Economic Stability
- Housing & Homelessness

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

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[75] https://www.elcaminohealth.org/about-us/community-benefit
[76] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf
[77] https://www.elcaminohealth.org/about-us/community-benefit

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

8. CONCLUSION

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

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

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

Next steps for El Camino Health:

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

9. LIST OF ATTACHMENTS

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

ATTACHMENT 1. COMMUNITY LEADERS, REPRESENTATIVES AND MEMBERS CONSULTED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT 2. SECONDARY DATA INDICATORS LIST

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT 3. COMMUNITY ASSETS AND RESOURCES

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

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

GENERAL RESOURCES

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

COMMUNITY HEALTH NEEDS

BEHAVIORAL/MENTAL HEALTH

Assets

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

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

Resources

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

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

CANCER

Assets

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

Resources

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

CLIMATE/NATURAL ENVIRONMENT

Assets

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

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

COMMUNITY SAFETY

Assets

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

Resources

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

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

DIABETES & OBESITY

See Economic Stability for free food resources.

Assets

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

Resources

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

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

ECONOMIC STABILITY

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

Assets

- California Budget & Policy Center
- Silicon Valley Leadership Group

Resources

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

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

Food Resources

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

HEALTH CARE ACCESS AND DELIVERY

Health Care Facilities and Systems

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

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

Community Clinics

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

Mobile Health Services

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

Other Access-Related Assets

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

Other Access-Related Resources

- Avenidas
- City Team Ministries

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

HOUSING & HOMELESSNESS

Assets

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

Resources

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

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

MATERNAL/INFANT HEALTH

Assets

- Healthier Kids Foundation
- March of Dimes

Resources

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

ORAL/DENTAL HEALTH

Assets

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

Resources

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

SEXUALLY TRANSMITTED INFECTIONS

Assets

- Santa Clara County HIV Commission

Resources

- Asian Americans for Community Involvement: HOPE Program

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

UNINTENDED INJURIES/ACCIDENTS

Assets

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

Resources

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

ATTACHMENT 4. QUALITATIVE RESEARCH PROTOCOLS

CHNA KII Protocol - Professionals (60 min.)

PREP

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

INTRODUCTION (5 MIN.)

[Start recording from the beginning of the session.]

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

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

KICK ON ZOOM RECORDING!

HEALTH NEEDS DISCUSSION (35 MIN.)

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

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

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

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

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

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

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

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

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

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

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

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed since COVID began?

ADDITIONAL COMMENTS (TIME PERMITTING)

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

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

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

CLOSING (1 MIN.)

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

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

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

CHNA FG Protocol - Professionals (90 min.)

PREP

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

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

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

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

HEALTH NEEDS DISCUSSION (45 MIN.)

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

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

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

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

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

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

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

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

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

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

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

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

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (TIME PERMITTING)

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

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

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

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

CLOSING (1 MIN.)

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

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

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

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

PREP

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

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

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

[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: • Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance. • May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions. • May *not* exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.		(b)(i) (b)(3) (b)(6)(i)(A)	Section #3
Describes how the community was determined.		(b)(6)(i)(A)	Section #3
Describes demographics and other descriptors of the hospital service area.			Section #3
Health Needs Data Collection			
Describes data and other information used in the assessment:		(b)(6)(ii)	
a. Cites external source material (rather than describe the method of collecting the data).		(b)(6)(F)(ii)	Attachments 1 & 2
b. Describes methods of collecting and analyzing the data and information.		(b)(6)(ii)	Section #5

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

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

Further IRS requirements available:

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

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

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

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

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

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
		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
HEALTHY BODY		Patients demonstrating a reduction in body weight	49%	42%	40%	47%	40%	51%
		Patients demonstrating a reduction in HbA1c levels	44%	41%	40%	51%	40%	40%
	Youth Movement & Mindfulness	Students served	38,250	39,308	38,250	91,181	72,820	135,175
		Schools served	184	197	184	184	204	333
		GoNoodle physical activity breaks played	238,000	218,924	238,000	287,964	7,057,218	8,631,891
		Teachers who believe GoNoodle benefits their students' focus and attention in the classroom	92%	N/A	93%	0%	75%	75%
		Teachers who report GoNoodle has had a positive impact on their students' emotional health	-	-	-	-	75%	75%

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

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

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

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

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

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

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

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

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

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

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

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

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

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Finance Committee
From: Carlos Bohorquez, CFO and Brian Fong, Sr. Director, Revenue Cycle
Date: May 26, 2022
Subject: Revenue Cycle Overview and Update

Purpose:

To update the Finance Committee on billing/revenue cycle topics discussed in prior meetings and provide information on upcoming initiatives.

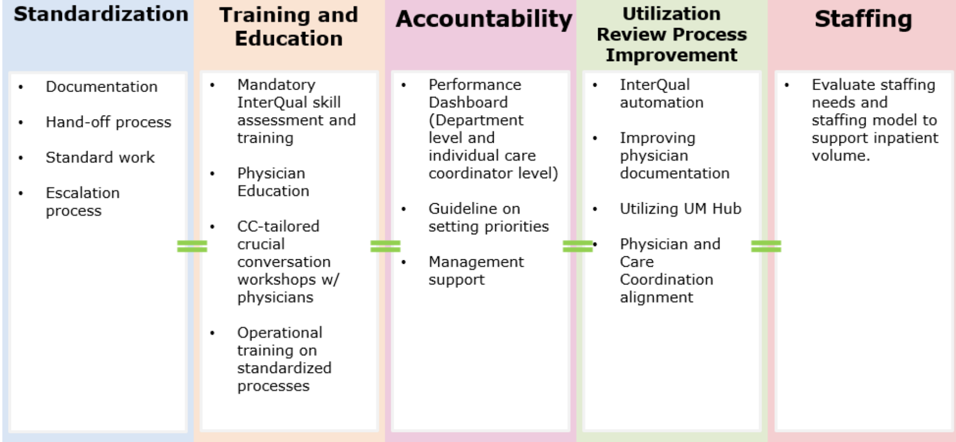
Summary:

With the patient as our top priority, El Camino Health continues to make improvements in its revenue cycle to improve patient satisfaction. During our presentation, we will discuss the following topics:

- **RCM Core Principle: Invest in People, Process, and Technology**:
  By investing in these three areas, we will develop stronger employees and more efficient processes within the Revenue Cycle that will ultimately solidify the foundation for an improved financial experience for our patients:

- **Staff Updates**:
  We will discuss recent staff/management trainings focused on:
  - Service recovery techniques for Patient Access and Customer Service staff who work directly with patients (effective communication, de-escalation, etc.)
  - Leadership development for our management team
  - Technical training for insurance billing/collections teams (best practices and resolution of complex claims)

- **Business Process Updates**:
  We will discuss the following key projects/initiatives for process improvements in the revenue cycle:
  - Care Coordination Performance Improvement Project (Utilization Review/Denials Management)
  - Experian Contract Renegotiation (Cost Savings Update)
  - Small Insurance Balance Vendor Implementation



- **Technology Update**:
  We will provide an update on technology enhancements currently in process:
  - Robotic Process Automation (RPA) in Prior Authorizations Process
  - Epic Payer Platform – Clinical Data Exchange

- **El Camino Health Medicare Network – Revenue Cycle Update**:
  We will present a year-over-year overview of specific Key Performance Indicators related to Accounts Receivable (A/R) and pre-service process metrics for El Camino Health Medical Network.

<u>List of Attachments</u>:

Revenue Cycle Overview and Update – PowerPoint presentation

Revenue Cycle Overview and Update
Finance Committee

Carlos Bohorquez, Chief Financial Officer
Brian Fong, Senior Director, Revenue Cycle

May 26, 2022

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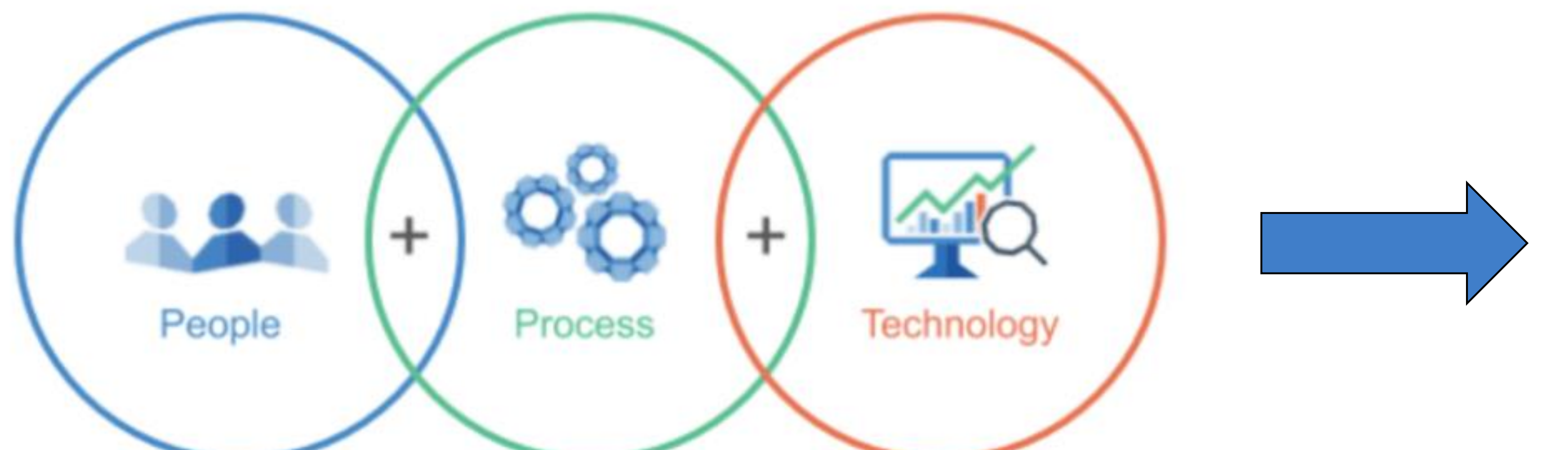
1. Revenue Cycle Management ("RCM") Core Principle – Invest in PPT
2. Staff Updates
3. Business Process Updates
4. Technology Updates
5. El Camino Health Medical Network - Revenue Cycle Update
6. Q&A

RCM Core Principle: Invest in PPT

- **People**: Invest in development of staff, provide continuous training, retain high performing employees, create career ladders, create a culture of teamwork with a focus on continuous improvement
- **Process**: Evaluate workflows and business processes; identify opportunities to implement efficiency
- **Technology**: Implement technology to automate or streamline the performance of repetitive tasks, thereby allowing staff to focus on more complex, high-value activities



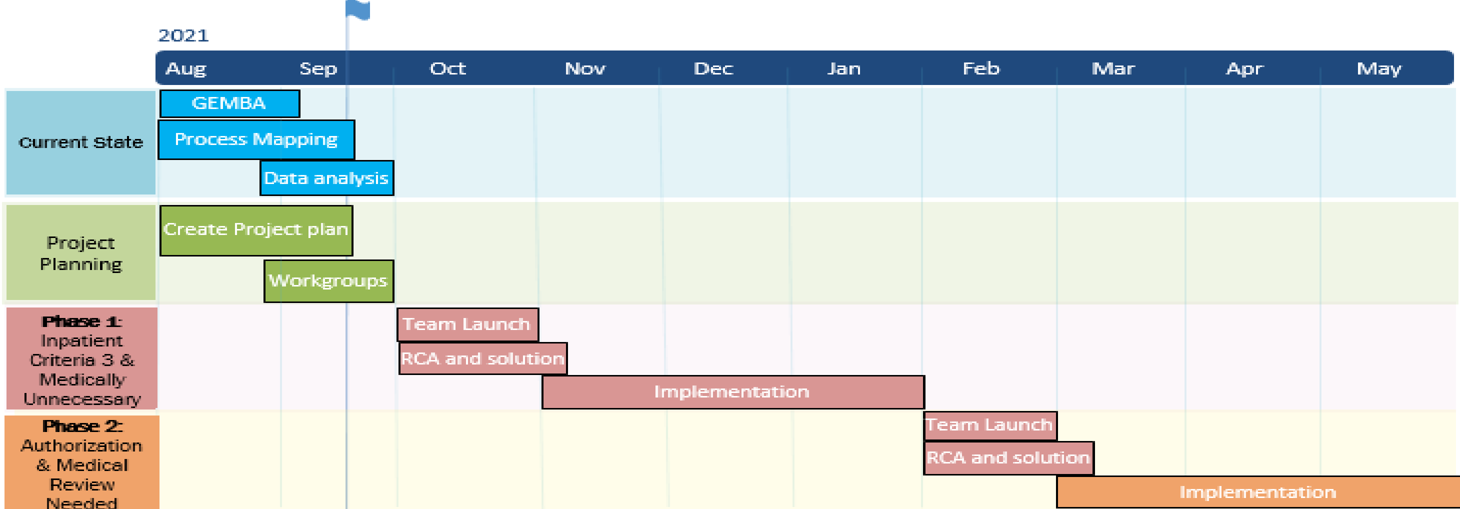
ECH Revenue Cycle Vision:
To support El Camino Health's patient-first ethic and mission by ensuring strong financial performance of the health system's revenue cycle operations.

Staff Updates (People)

- **Leading the ECH Way**: All ECH Directors, Managers, and Supervisors have completed or are currently enrolled in a 12-month management training program (led by Flash Point) that focuses on leadership development, team effectiveness, and coaching.
- **Service Recovery Training**: Staff who interact daily with patients in both the Patient Access (Registration) and Patient Accounts Customer Service Team attended a one-day "Service Recovery" training session led by a certified trainer from the Baird Group. Key themes included:
    - Effective communication techniques
    - De-escalation
    - Understanding the importance of service recovery/linking it to organizational goals
    - Practicing service recovery techniques
- **Follow-Up/Collections Enhancement Training (Commercial Insurance):** An external revenue cycle management vendor provided training to our Follow-Up and Revenue Recovery teams to share best practices on effective insurance follow-up and appeals for complex claims scenarios.
- **Medicare Boot Camp**: Our Medicare team and management attended a refresher training on Medicare billing rules, compliance, and regulations – spanning topics that include Local Coverage Determinations ("LCD") for medical necessity, claim edits, Outpatient Prospective Payment System ("OPPS") payment system logistics, Inpatient Prospective Payment System ("IPPS"), and other topics relevant to daily work.

Business Process Updates - Care Coordination Performance Improvement Project (Utilization Review / Denials Management Focus)

- Revenue Cycle and Care Coordination leadership partnered together with the Performance Improvement Department to conduct a value formal stream project (utilizing Lean principles) to identify and address areas of opportunity in the utilization review process that would lead to a reduction in medical necessity denials. Areas of focus include:
  - The process for utilization review process for patients admitted through the Emergency Department
  - Consistent use of InterQual tool for assessing medical necessity
  - Standardization of processes
  - Communication with physicians
  - Staff training



Business Process Updates: Care Coordination Performance Improvement Project (Utilization Review/Denials Focus) – cont.

Countermeasures:

Standardization	Training and Education	Accountability	Utilization Review Process Improvement	Staffing
• Documentation • Hand-off process • Standard work • Escalation process	• Mandatory InterQual skill assessment and training • Physician Education • CC-tailored crucial conversation workshops w/ physicians • Operational training on standardized processes	• Performance Dashboard (Department level and individual care coordinator level) • Guideline on setting priorities • Management support	• InterQual automation • Improving physician documentation • Utilizing UM Hub • Physician and Care Coordination alignment	• Evaluate staffing needs and staffing model to support inpatient volume.

Business Process Updates: Experian Contract Renegotiation (Cost Savings Update)

ECH renegotiated various service fees with Experian, which became effective February 1, 2021. Adjustments pertained to optimizing various transaction volume thresholds associated with each of the services. See Savings (below):

Renegotiated Fee structure in January 2021

- Effective Date of changes: 2/1/21
- Estimated Savings (FY21): ~$350K
- FY2022 Projected Spending: ~$500 to $550K
- FY2022 Projected Savings: $535K to $585K

Experian

	ECH Fiscal Year (7/1 - 6/30) Annualized		
	FY 2020	FY 2021	FY 2022
Costs	$1,092,987	$ 734,252	$ 508,423
Savings vs. FY2020 Base		$ 358,735	$ 584,564
		32.8%	53.5%

Key Experian Services include:

- Real Time Eligibility
- Patient Identify Verification
- Patient Estimates
- Statement Submission
- Propensity To Pay
- Coverage Discovery
- Payment Safe
- LCD Rule Sets (A&B)
- Precise ID (added in Feb 2022)

Business Process Updates: Small Insurance Balance Vendor

- In November 2021, ECH engaged the services of HFRI to pursue small commercial insurance balances (< $5,000).
- This population represents less than one percent of total dollars in Accounts Receivable (A/R), but is high volume in terms of accounts (making it optimal for vendor support).
- Benefits:
  - Allows internal ECH follow-up/collections staff to prioritize collection efforts on higher-dollar/ yield insurance balances.
  - Results in faster resolution of insurance balances, thereby accelerating timeliness of patient billing cycle (benefit to patient satisfaction).
- Initial one-time placement of aged small balance accounts; ongoing placements established thereafter at day 61 (from date of service).
- Approximately $1M in net collections

Technology Updates: Robotic Process Automation (RPA) in Prior Authorizations Process

- ECH began its journey of evaluating optimal use case scenarios for RPA in the Revenue Cycle in the summer of 2021. After initial research and due diligence, Revenue Cycle leadership identified the prior authorization process as the first use case for implementation of RPA technology.
- RPA technology can streamline the prior authorization process in two key areas:
  - Initial request of insurance prior authorization (applicable to certain hospital departments, such as Radiology and to the ECHMN physician practices) -> single payer portal approach (“one stop shop”)
  - Verification that insurance prior authorization has been secured before patient’s service/procedure (benefits all areas requiring prior authorization, especially surgical procedures verified by Financial Counseling) → uses bots to retrieve authorization status from insurance payer portal; returns authorization status to Epic E.H.R., where staff work queue assignments are optimized based on authorization status.
- Benefits:
  - Alleviates some of the manual work associated with insurance verification today; allows labor resources to be redeployed to other, more complex tasks.
  - May help reduce authorization-related denials through better workflows/processes.
- Experian has been selected as the RPA vendor for prior authorization at ECH; contract review in process; expected completion of contract in June 2022.

Technology Updates: Epic Payer Platform – Clinical Data Exchange

- Epic has created a method to allow automated sharing of clinical data between payers and providers during the utilization review process.
- Epic is gradually establishing agreements with payers and providers for these services. Approximately 60+ health systems have initiated this process with Epic.
- Anthem Blue Cross, United Healthcare, Humana, and a few other insurance carriers from out of area are participating with Epic on its Payer Platform tool.
- Benefits include:
  - A reduction in manual chart requests due to automated exchange of clinical data (less paper)
  - Access to expanded health information, leading to reduced duplicity in orders, tests, and procedures.
  - Consistency and completeness of data to enable more robust patient risk profiles, leading towards faster payments on claims.
  - A reduction of denials where payment is pended for submission of medical records or clinical data.
- ECH has begun its kick-off discussions with United Healthcare for implementation of the Clinical Data Exchange process. Target implementation will be late Summer 2022.
- In 2023, ECH will engage with Anthem Blue Cross on implementation of the Clinical Data Exchange via Epic Payer Platform.

El Camino Health Medical Network – Revenue Cycle Update

	Baseline (Prior Years)		Current		
Key Performance Indicator	ECHMN FY20	ECHMN FY21	ECHMN FY22 (Apr YTD)	Target	Variance (Compared to Target)
Gross A/R Days	49.8	44.5	43.5	45.0	-1.5
Gross A/R Over 90 Days (% of Total A/R)	36.8%	34.9%	37.1%	30.0%	7.1%
POS Collections (% of Net Revenue)	2.6%	2.1%	2.5%	6.0%	-3.5%
Denial Write-offs (% of Net Revenue)	8.3%	4.0%	3.9%	3.0%	0.9%
Uncompensated Care (% of Gross Revenue)	0.8%	0.9%	1.2%	1.0%	0.2%
Bad Debt (% of Gross Revenue)	0.5%	0.7%	1.0%	3.0%	-2.0%
Charity (% of Gross Revenue)	0.3%	0.1%	0.1%	1.0%	-0.9%

- Gross A/R Days (43.5) are favorable to target (45.0) and have improved year over year.
- Gross A/R Over 90 Days (% of Total A/R) remain an area of opportunity. Focused efforts on resolving/escalating systemic insurance payer issues and mitigating denial root causes will drive key improvements to this metric.
- Point of Service ("POS") Collections also present an opportunity for improvement. Strategies to increase POS Collections include reporting POS collections by clinic operations staff and targeted education/training.
- Denial write-offs are slightly higher than target (within 0.9%) but have improved year-over-year. Continued progress will be achieved in this area through existing Denial Workgroup Forum and activities related to root cause analysis/mitigation.
- Uncompensated Care, Bad Debt, and Charity Care all remain strong and favorable to target.

El Camino Health Medical Network – Revenue Cycle Update (cont.)

Pre-Service Process Metrics	FY20 (Baseline)	FY21 (Baseline)	Jul-21	Aug-21	Sep-01	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	FY 22 YTD Avg	Target	FY22 YTD Avg. Variance to Target	FY22 YTD Avg. Variance to FY 21 Baseline
Provider Credentialed Rate - Medicare	90%	98%	97%	87%	88%	91%	95%	95%	98%	96%	95%	98%	94%	**98%**	-4%	-4%
Provider Enrollment Rate - HMO/PPO	74%	88%	89%	81%	81%	79%	78%	78%	80%	80%	83%	87%	81%	**95%**	-14%	-7%
Visit Coverage RTE Usage Rate	80%	86%	92%	92%	92%	93%	93%	93%	93%	92%	92%	93%	92%	**95%**	-3%	6%
Encounter Verification Rate	80%	82%	89%	91%	89%	89%	90%	91%	89%	90%	92%	90%	90%	**90%**	0%	8%
MSPQ Completion Rate	96%	97%	98%	98%	97%	97%	96%	96%	97%	98%	99%	99%	97%	**98%**	-1%	0%
Prior Auth Completion Rate	86%	90%	93%	91%	92%	93%	94%	92%	91%	90%	88%	92%	92%	**95%**	-3%	2%

- April was a solid month overall for Pre-Service Metrics with all but one metric improving from the prior month.
- Provider Credentialed Rate – Medicare improved from 95% (March) to 98% (April) with only 3 providers out of 122 active providers were not fully completed
- Provider Enrollment Rate – HMO/PPO improved from 83% (March) to 87% (April). See completion rate by payer for the list of 122 active providers on the next slide.
- The Visit Coverage Real Time Eligibility ("RTE") Usage Rate has been very stable (b/w 92-93%). This is primarily a measure of "efficiency" for the encounter verification process. There were 1,080 instances (of 14,655) where RTE was not utilized for the Visit Coverage (7.4% of encounters); 844 of those 1,080 (78%) were non-RTE encounters associated with Alignment plans. *Usage Rate for RTE-enabled plans is 98.3% when removing encounters that are not RTE-enabled.*
- Encounter verification rate (including Vaccinations and Lab draws) decreased from 92% (March) to 90% (April) with 13,634 out of 14,891 encounters completely verified (insurance AND demographic = "Complete") by the date of service (DOS). Willow Glen achieved 91.9% in April while McKee achieved 83.7%. There were 456 Lab Draws associated with McKee & Willow Glen. With Lab Draws excluded, Willow Glen was 93.6% and McKee was 96.3%. *See additional slides for details.*
- Medicare Secondary Payer Questions (MSPQ) Completion Rate remained at 99%. Feb through April of 2022 is the best consecutive 3-month period for this metric.
- Prior Authorization Completion Rate improved from 88% (March) to 92% (April). Top opportunities where Prior Authorization Completion Rate < 90% includes the following Payers: Valley Health Plan (87%), Blue Shield (83%), UHC (80%), Cigna (79%), Aetna (79%), Anthem Blue Cross (78%). Additional sampling required.
- The key activities to address Prior Authorization process feedback include the Denial Workgroup forum and other Manager and/or Practice area feedback loops.

Q & A

PRELIMINARY DRAFT

FY2023 COMMITTEE GOALS

Finance Committee

PURPOSE

The purpose of the Finance Committee (the "Committee") is to provide oversight, information sharing, and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital (ECH) Hospital Board of Directors ("Board"). In carrying out its review, advisory, and oversight responsibilities, the Finance Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

STAFF: **Carlos Bohorquez**, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

GOALS	TIMELINE	METRICS
1. Summary of Physician Financial Agreements	Q3	March 2023
2. Review Progress on Opportunities / Risks identified by Management for FY2023 and Managed Care Update	Q2, Q3	Progress on Opportunities / Risks (November 2022), Managed Care update (January 2023)
3. Review strategy, goals, and performance of business affiliates and service lines: 1) Joint Venture – Satellite Healthcare, 2) Orthopedics, 3) Cardiology, 4) Joint Venture – Pathways, 5) ECHMN, 6) CONCERN, 7) Hospital Community Benefits Program, 8) Foundation Performance to Target and 3-5 year strategic plan 9) Urology 10) Oncology	Q1	Service Line Overview: CONCERN (August 2022), Urology (September 2022), ECHMN (September 2022)
	Q2	Service Line Overview: Orthopedics (November 2022), Hospital Community Benefits Program (November 2022), Philanthropy Foundation (November 2022)
	Q3	Service Line Overview: ECHMN (January 2023), Cardiology (January 2023), Hospital Community Benefits Program (March 2023), Oncology (March 2023)
	Q4	ECHMN (May 2023), Joint Venture – Pathways (May 2023)
4. Review and evaluate ongoing customer service/patient experience tactics / metrics and use of AI to improve the process and customer experience for the Revenue Cycle	Q3	Monitor customer service and patient satisfaction metrics (March 2023)

SUBMITTED BY: **Chair**: John Zoglin | **Executive Sponsor**: Carlos Bohorquez, CFO

FY2023 Finance Committee Pacing Plan

FY2023 FC Pacing Plan – Q1

July 2022	August 15, 2022	September 27, 2022
No Scheduled Finance Committee Meeting	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Candidate Interviews and Recommendation to Appoint • Financial Report (FY2022 Periods 11 and 12) **Discussion Items** • Financial Report (Pre-Audit Fiscal Year End 2022 Results) • Service Line / Business Affiliate Review: CONCERN • Medical Staff Development Plan • Report on Board Actions • Other Standing Agenda Items • Executive Session • Post Implementation Review (“PIR”) Per Attached Schedule	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2023 Periods 1 and 2) • Financial Report Fiscal Year End 2022 Results **Discussion Items** • Service Line / Business Affiliate Review: ECHMN Update & Urology • Progress Against FY2023 Committee Goals & Pacing Plan • Project Update: Women’s and Newborn Hospital Project • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session

FY2023 FC Pacing Plan – Q2

October 2022	November 21, 2022	December 2022
No Scheduled Finance Committee Meeting	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2023 Periods 3 and 4) **Discussion Items** • Service Line Review: Orthopedics • Foundation Strategic Plan Update • FY2024 Community Benefit Grant Application Guiding Principles / Process • Review Progress on Opportunities / Risks Identified for FY2023 • Strategic Plan Update • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**

Updated 5/20/22

FY2023 Finance Committee Pacing Plan

FY2023 FC Pacing Plan – Q3		
January 30, 2023	**February 2023**	**March 27, 2023**
5:30pm **Joint Meeting with the Investment Committee:** **Topic: Long Term Financial Forecast** **6:30pm** **Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2023 Periods 5 and 6) **Discussion** • Service Line / Business Affiliate Review: ECHMN Quarterly Financial Update & Cardiology • Managed Care Update • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**	**Approval Items** • Standing Consent Agenda Items • Minutes (motion) • Financial Report (FY2023 Periods 7 and 8) **Discussion Items** • FY2024 Budget Preview: Key Operating Assumptions / Target • FY2024 Community Benefit Grant Program Update • Summary Physician Financial Arrangements (Year-End) • Service Line Report: Oncology • FY2024 Committee Planning: Goals, Pacing Plan and Meeting Dates • Revenue Cycle Update • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session
FY2023 FC Pacing Plan – Q4		
April 24, 2023	**May 22, 2023**	**June 2023**
No Scheduled Finance Committee Meeting	**Approval Items** • Financial Report (FY2023 Period 9 & 10) • Progress Against FY2023 Committee Goals & Pacing • FY2024 Organizational Goals • FY2024 Committee Planning: Goals, Pacing Plan and Meeting Dates • FY2024 El Camino Hospital Community Benefit Grant Program **Discussion Items** • FY2024 Budget: Review Prior to Submission to BOD for Approval • Service Line Report: Pathways JV & ECHMN Quarterly Financial Update • PIR • Report on Board Actions • Other Standing Agenda Items • Executive Session	**No Scheduled Finance Committee Meeting**

Updated 5/20/22

FY2023 Finance Committee Pacing Plan

Last 30 Months Capital Project Approvals

APPROVAL DATE	APPROVING BODY	PROJECT NAME	APPROVED AMOUNT	PROPOSED FC PROJECT UPDATE / POST-IMPLEMENTATION REVIEW DATE
2/13/2019	ECH Board	Women's Hospital Planning	$10M (Total Now $16M)	09/2020
2/13/2019	ECH Board	SVMD Clinic Site Tenant Improvements	$8M	09/2020
2/13/2019	ECH Board	Interventional Equipment Replacement	$13M	09/2020
2/13/2019	ECH Board	Imaging Equipment Replacement	$16.9M	09/2020
2/13/2019	ECH Board	SVMD Asset Acquisition	$1.2M	11/2020 (w/SVMD Financials)
3/13/2019				
3/25/2019	Finance Committee	SVMD Clinic IT Infrastructure	$4.6M	11/2020 (w/SVMD Financials)
5/28/2019	Finance Committee	MV Campus Signage	$1.1M	N/A < $2 M
8/21/2019	ECH Board	Medical Staff Development Plan	$6.1M	01/2021
8/21/2019	ECH Board	ED Remodel	$6.75M	01/2021
10/10/2020	ECH Board	MV Campus Completion (Old Main Demo)	$24.9M	03/2021
1/25/2020*	Finance Committee	Satellite Dialysis*	*No approval on /1/25/2020 presented only	07/2021
7/27/2020	Finance Committee	Sterile Processing Equipment	$1.85M	N/A < $2 M
8/12/2020	ECH Board	Radiation Oncology Replacement Equipment	$10,300,000 (add'l $3.55 M)	01/2022
11/23/2020		None		
1/25/2021	Finance Committee	Real Estate Transaction	$1.875M	09/2021
1/25/2021	Finance Committee	Cardiopulmonary Wellness Center (CPWC) Relocation	$5.0M	04/2022
2/10/2021	ECH Board	Women's Hospital Expansion Project	$149M	Progress Update: 11/2022
3/29/2021		None		
4/26/2021		None		
5/24/2021	Finance Committee	MV Wireless / DAS Network Upgrades	$3.3M	04/2022
8/9/2021	ECH Board	MV Cath. Lab Replacement Project	$19.5M	Progress Update: 01/2023
8/9/2021	ECH Board	Pyxis MedStation Replacement Project	$6.64M	11/2022
8/9/2021	Finance Committee	ECHMN Clinic Relocation	$3.09M	01/2022
10/13/2021	ECH Board	Real Estate Transaction	$14.65M	01/2022
11/22/2021	Finance Committee	LG Interventional radiology Equipment Replacement	$3.86M	01/2023

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11/22/2021	Finance Committee	LG Nuclear Medicine Equipment Replacement & Code Upgrades	$2.4M	01/2023
11/22/2021	Finance Committee	LG Operating Room Sterile Processing Update	$2.386M	03/2023
1/31/2022	Finance Committee	MV Chemistry Line Replacement Project	$2.8M	03/2023

Finance Committee Meetings
Proposed FY2023 Dates

RECOMMENDED FC DATES	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 15, 2022	Wednesday, September xx, 2022
Tuesday, September 27, 2022 **(Sept 26 – Rosh Hashanah)*	Wednesday, November xx, 2022
Monday, November 21, 2022	Wednesday, December xx, 2022
Monday, January 30, 2023 (Plus Joint with IC)	Wednesday, March xx, 2023 **(February xx, 2023 – Retreat)*
Monday, March 27, 2023	Wednesday, April xx, 2023
April (No Meeting Scheduled)	Wednesday, May xx, 2023
Monday, May 22, 2023 (only FC not Joint with Hospital Board) **(May 29 – Memorial Day)*	Wednesday, June xx, 2023