El Camino Health

# AGENDA
## REGULAR MEETING OF THE
## EL CAMINO HOSPITAL BOARD OF DIRECTORS

**Wednesday, June 8, 2022 – 5:30 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:

**1-669-900-9128, MEETING CODE: 995-1251-5092# No participant code. Just press #.**

To watch the meeting Livestream, please visit: https://www.elcaminohealth.org/about-us/leadership/board-meeting-stream
Please note that the Livestream is for **meeting viewing only,** and there is a slight delay; to provide public comment, please use the phone number listed above.

**MISSION:** To heal, relieve suffering, and advance wellness as your publicly accountable health partner.

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|
| **1. CALL TO ORDER/ROLL CALL** | Lanhee Chen, Board Chair | | **5:30 – 5:31 pm** |
| **2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Lanhee Chen, Board Chair | | **information 5:31 – 5:32** |
| **3. PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.*<br>b. Written Correspondence | Lanhee Chen, Board Chair | | **information 5:32 – 5:35** |
| **4. MEDICAL STAFF REPORT** | Apurva Marfatia, MD<br>Medical Chief of Staff,<br>Mountain View | | **information 5:35 – 5:45** |
| **5. QUALITY COMMITTEE REPORT** | Julie Kliger,<br>Chair of Quality Committee;<br>Dr. Holly Beeman,<br>Chief Quality Officer | | **information 5:45 – 5:55** |
| **6. BOARD OFFICER ELECTIONS** | Lanhee Chen, Board Chair | *public comment* | **motion required 5:55 – 6:10** |
| **7. ADJOURN TO CLOSED SESSION** | Lanhee Chen, Board Chair | *public comment* | **motion required 6:10 – 6:11** |
| **8. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Lanhee Chen, Board Chair | | **information 6:11 – 6:12** |
| **9.** *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets:<br>**FY23 STRATEGIC GOALS** | Dan Woods,<br>Chief Executive Officer | | **discussion 6:12 – 6:42** |
| **10.** Report involving *Gov't Code Section 54957(b)* for discussion and report on personnel matters:<br>**EMPLOYEE RECOGNITION** | Dan Woods,<br>Chief Executive Officer | | **discussion 6:42 – 6:57** |
| **11.** *Report involving Gov't Code Section 54957(b)* for discussion and report on personnel matters:<br>**CEO REPORT** (Verbal) | Dan Woods,<br>Chief Executive Officer | | **discussion 6:57 – 7:07** |
| **12.** Report involving *Gov't Code Section 54957(b)* for discussion and report on personnel performance matters – Senior Management:<br>**EXECUTIVE SESSION** | Lanhee Chen, Board Chair | | **discussion 7:07 – 7:17** |
| **13. CONSENT CALENDAR**<br>*Any Board Member may remove an item for discussion before a motion is made.* | Lanhee Chen, Board Chair | | **motion required 7:17 – 7:27** |

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

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|
| ***Approval***<br>*Gov't Code Section 54957.2:*<br>a. Minutes of the Closed Session of the Hospital Board (05/11/2022)<br>***Reviewed and Recommended for Approval by the Quality, Patient Care, and Patient Experience Committee***<br>*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:*<br>b. Credentialing and Privileges Report<br><br>***Information***<br>***Approved by the Executive Compensation Committee***<br>*Gov't Code Section 54957* and *54957.6* for a report and discussion on personnel matters:<br>c. Executive Compensation Approvals<br>***Reviewed and Recommended for Approval by the Finance Committee***<br>*(Approval in second Open Session)*<br>*Health and Safety Code Section 32106(b)*<br>*Physician Contracts*<br>d. MV General Surgery Call Panel Renewal<br>e. Enterprise Pathology Medical Director Renewal<br>f. Enterprise Cancer Program Medical Director Renewal<br>g. MV Cath Lab Medical Director Renewal<br>h. MV Respiratory Care Services Medical Director Renewal<br>i. MV Cardiac Rehab Medical Director Renewal | | | |
| **14. ADJOURN TO OPEN SESSION** | Lanhee Chen, Board Chair | | **motion required 7:27 – 7:28** |
| **15. RECONVENE OPEN SESSION/ REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Lanhee Chen, Board Chair | | **information 7:28 – 7:29** |
| **16. CONSENT CALENDAR ITEMS:**<br>*Any Board Member or member of the public may remove an item for discussion before a motion is made.* | Lanhee Chen, Board Chair | *public comment* | **motion required 7:29 – 7:39** |
| ***Approval***<br>a. Hospital Board Minutes (05/11/22) Open Session Minutes<br>b. 2022 ECH CHNA and FY23 ECH Implementation Strategy Report and Community Benefit Plan | | | |
| ***Reviewed and Recommended for Approval by the Finance Committee***<br>c. MV General Surgery Call Panel Renewal<br>d. Enterprise Pathology Medical Director Renewal<br>e. Enterprise Cancer Program Medical Director Renewal<br>f. MV Cath Lab Medical Director Renewal<br>g. MV Respiratory Care Services Medical Director Renewal<br>h. MV Cardiac Rehab Medical Director Renewal | | | |

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|
| ***Reviewed and Recommended for Approval by the Governance Committee***<br>i. FY23 Master Calendar<br>j. Progress against FY22 Committee Goals<br>k. FY23 Committee Goals<br>l. FY23 Committee Pacing Plans<br>m. FY23 Committee and Liaisons Appointments<br>n. Committee Charter Updates<br>***Reviewed and Recommended for Approval by the Medical Executive Committee***<br>o. Medical Staff Report<br>p. Policies, Plans, and Scope of Services<br>***Information***<br>q. Governance Committee Report | | | |
| **17. FY23 ORGANIZATIONAL GOALS** | Dan Woods,<br>Chief Executive Officer | *public comment* | **motion required 7:39 – 7:49** |
| **18. EMPLOYEE RECOGNITION** | Dan Woods,<br>Chief Executive Officer | *public comment* | **possible motion 7:49 – 7:50** |
| **19. CEO REPORT**<br>a. Update<br>b. Pacing Plan | Dan Woods,<br>Chief Executive Officer | | **information 7:50 – 7:55** |
| **20. BOARD COMMENTS** | Lanhee Chen, Board Chair | | **information 7:55 – 7:59** |
| **21. ADJOURNMENT** | Lanhee Chen, Board Chair | *public comment* | **motion required 7:59 – 8:00** |

# PLACEHOLDER

**This document is in process and will be available on Tuesday, June 7, 2022.**
***(Directly following the Quality Committee Meeting on June 6, 2022)***

**EL CAMINO HOSPITAL**
**BOARD MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors
**From:** Mary Rotunno, General Counsel
**Date:** June 8, 2022
**Subject:** Board Officer Election

**Summary:**

**1.** Situation: Board Officer Elections were last held in May 2021. The results were as follows:

- Director Lanhee Chen as ECH Board Chair for a one-year term of service, effective July 1, 2021, through June 30, 2022.
- Director Bob Rebitzer as ECH Board Vice-Chair for a two-year term of service, effective July 1, 2021, through June 30, 2023.
- Director Julia Miller as ECH Board Secretary/Treasurer for a two-year term of service, effective July 1, 2021, through June 30, 2023.
- Vice-Chair Bob Rebitzer has declared interest in the Board Chair position.

Recommendation(s):

I. Motion to select Bob Rebitzer as ECH Board Chair for a two-year term of service effective July 1, 2022.
II. Motion to select _____ as ECH Board Vice-Chair to fill the vacancy effective July 1, 2022 for the remainder of the Vice-Chair term through June 30, 2023.

**2.** Authority: Board Officer Nomination and Selection Procedures provide the procedure to be followed.

**3.** Background: N/A

**4.** Assessment: N/A

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

**6.** Outcomes: N/A

**List of Attachments:**

**1.** Board Officer Nomination and Selection Procedures
**2.** Director Bob Rebitzer's Position Statement

**Suggested Board Discussion Questions:** None.

El Camino Health

**HOSPITAL BOARD OFFICERS**
**NOMINATION AND SELECTION PROCEDURES**
**FOR FY23**

*Draft Revised 05/11/2022*

Any current Director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms begin the 1st day of July. El Camino Hospital Board Officer elections shall be held in June annually (if needed). Following the election, it shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

**Hospital Board Chair:**

1. Interested Directors will declare their interest to the CEO or designee by no later than the 1st day of April. If requested by the CEO, interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies no later than the 15th day of April.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the June meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital website when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

    a. What do you see as the ECH strategic priorities over the coming two years?
    b. Name three defining roles of an effective Board Chair.
    c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the June meeting, interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

    a. Each interested Director will read their Position Statement
    b. Each interested Director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
    c. The Public will be invited to ask interested Directors any questions related to the candidate's interest in the position and relevant experience as it relates to the Hospital Board Chair competencies
    d. The Board will be invited to ask interested Directors any additional questions related to an interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.

a. Preliminary Balloting

i. Each Board member shall vote for a candidate via electronic submission or paper ballot simultaneously to a neutral party who will announce the vote cast by each Director.
ii. In the event a majority is not achieved, the vote will be announced for each candidate, and the candidate receiving the lowest number of votes will be dropped from the next ballot.
iii. This procedure will continue until one candidate receives a majority of the votes cast.
iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), interested Directors may be asked additional questions by Hospital Board members, and the balloting procedure will continue until a majority is achieved by one candidate.

b. Selection of a Board Chair

i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in their favor.
ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

**Hospital Vice-Chair:**

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions which relate to the candidate's experience by other Hospital Board members in public session.

3. Voting will follow the same procedure described in the Hospital Board Chair selection and appointment process above.

4. The Vice-Chair is the presumptive Chair at the end of the current Chair's term.

**Hospital Secretary/Treasurer:**

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.

2. Interested Directors will be asked questions which relate to the candidate's experience by other Hospital Board members in public session.

3. Voting will follow the same procedure described in the Hospital Board Chair selection and appointment process above.

To: El Camino Hospital Board of Directors
From: Bob Rebitzer
Date: May 31, 2022
Subject: Hospital Board Chair Position Statement

It has been an honor and a privilege to serve with all of you on the board of El Camino Health. The accomplishments of El Camino Health (ECH) over the past few years have been remarkable. The system has weathered the COVID-19 epidemic, embarked on an ambitious new strategy and continued to deliver outstanding healthcare services to our community. Under the extraordinary leadership of Lanhee Chen, we have become a more effective and collegial board that is better able to make use of the diverse talents and experiences that each of you bring to our work.

As chair of the ECH board I see three priorities for the coming two years. First, we must focus on executing our strategic plan. This means continuing – and accelerating - our transition from a hospital system to a differentiated health system with a broader reach and scope of services than we have had before.

Second, we must continue to improve our governance model. This means continuing to strengthen our committee system by cultivating and incorporating the talents of our community members. It also means continuing to simplify our governance processes so that board members can focus their attention on the important strategic issues.

Finally, we must continue to enhance the resilience of our organization. The past few years have taught us to expect the unexpected: pandemics, financial crises, unexpected market conditions, political upheaval, etc. Our ability to adapt to unexpected and sometimes trying circumstances depends critically on the trust that exists among the board members and between the board and management. We must do all we can to foster these trusting relationships through direct communication and timely and transparent exchange of information. Under Lanhee's leadership we have made great strides in this area. I hope to build on this foundation.

I view ECH as a marvelous legacy left to us by preceding boards. I am deeply grateful for the opportunity to work with all of you to maintain and enhance this legacy for those who will follow us.

El Camino Health

**Minutes of the Open Session of the**
**El Camino Hospital Board of Directors**
**Wednesday, May 11, 2022**

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

| Board Members Present | Board Members Absent | Members Excused |
|---|---|---|
| **Lanhee Chen,** Chair<br>**Peter Fung, MD**<br>**Julie Kliger, MPA, BS**<br>**Julia E. Miller,** Secretary/Treasurer<br>**Carol A. Somersille, MD**<br>**George O. Ting, MD**<br>**Don Watters****<br>**John Zoglin** | **via telepresence | None |

***Bob Rebitzer,*** *Vice-Chair, joined at 5:31 pm.*
***Jack Po, MD, Ph.D.*****, *joined at 5:33 pm.*

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call, excluding Directors Rebitzer, Po, and Fung. Chair Chen reviewed the logistics for the meeting. 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. | ***Called to order at 5:30 pm*** |
| **2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Chen asked the Board of Directors for declarations of conflict of interest with any items on the agenda, and none were reported. | |
| **3. PUBLIC COMMUNICATION** | Chair Chen invited the members of the public to address the Board of Directors, and none were reported. | |
| **4. SPOTLIGHT RECOGNITION** | Chery Reinking, CNO, presented Judy Van Dyck with a Resolution of the Board of Directors of El Camino Hospital in Recognition of Service and Support. Ms. Van Dyck was recognized for her service, commitment, and dedication to providing patients and their families tender loving care as a leader for the El Camino Hospital Auxiliary for the past 60 years. In addition to being a registered nurse, she served as president of the El Camino Hospital Auxiliary from 1995 to 1997. She also received the community service award from the Silicon Valley Board of Realtors in 2001.<br><br>**Motion:** To approve Resolution 2022-05: Recognition of Judy Van Dyck.<br><br>**Movant**: Fung<br>**Second**: Kliger<br>**Ayes**: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Resolution 2022-05 was approved*** |
| **5. BOARD OFFICER ELECTIONS PROCEDURE** | Chair Chen opened the discussion of the Board of Officer Elections Procedures and asked Shiraz Ali, Director, Office of the CEO, to provide clarification on the revisions. Mr. Ali noted the following items: | |

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| | • The current Hospital Board Officers Nomination and Selection Procedures specify dates for each fiscal year and therefore require annual updates. The recommended changes standardize the dates and allow for a perennial procedure.<br>• El Camino Hospital Board Officer elections are held in June as standard procedure. The procedure is first reviewed and approved by the Governance Committee.<br><br>Director Zoglin stated that historically the elections are held in May to allow the Chair-Elect to work with the Hospital CEO to develop a slate of Board Advisory Committee Chairs and members.<br><br>Chair Chen asked that the Governance Committee review the procedure for FY23 and realign with the historical practice of holding the Board Elections in May.<br><br>**Motion:** To Approve Board Officer Elections Procedures.<br><br>**Movant**: Miller<br>**Second**: Kliger<br>**Ayes**: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters<br>**Noes**: None<br>**Abstentions**: Zoglin<br>**Absent**: None<br>**Recused**: None | |
| **6. QUALITY COMMITTEE REPORT** | Director Kliger referred the Board of Directors to the Quality Committee Report as submitted in the packet materials and specifically noted the following items:<br><br>• CDI Dashboard – We are only performing at a moderate level in some of the Core measures such as patient populations like psychiatric patients. The Quality Committee discussed adding psychiatric patient care to our pacing plan so the committee can be kept informed about the ongoing care for this fragile population.<br>• Committee Goals – Great support for advancing health care equity and disparities as one of the potential goals of the committee. Only at the beginning stage with more defining work, identifying best practices, adopting best standard measurements, and ensuring greater alignment with the larger organizational effort.<br>• ECH Medical Network – Many in the committee feel that having a strong primary care network is critical for patient care and the ability to compete with organizations such as Palo Alto Medical Foundation and Kaiser Permanente. | |
| **7. ADJOURN TO CLOSED SESSION** | To adjourn to closed session at 6:25 pm pursuant to Gov't Code Section 54957.2 for approval of the Minutes of the Closed Session of April 13, 2022, Hospital Board Meeting; pursuant to Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: (Medical Staff Credentialing & Privileges Report); pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO, and a CEO Report.<br><br>**Motion:** to adjourn to closed session at 6:25 pm.<br><br>**Movant**: Fung<br>**Second**: Kliger<br>**Ayes**: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin | ***Adjourned to closed session at 6:25 pm*** |

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| | **Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | |
| **8. AGENDA ITEM 15: RECONVENE OPEN SESSION/ REPORT** | Open Session reconvened at 8:13 pm by Chair Chen. Agenda Items 8-14 were addressed in the closed session.<br><br>During the closed session, the El Camino Hospital Board of Directors approved the Closed Session Minutes of April 13, 2022, Hospital Board and the Credentials and Privileges Report; by a unanimous vote of all Directors present (Directors Chen, Fung, Kliger, Miller, Po, Somersille, Ting, Watters, and Zoglin). | |
| **9. AGENDA ITEM 16: CONSENT CALENDAR ITEMS** | Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar for discussion.<br><br>Director Somersille requested to remove 16a – Hospital Board Minutes (04/13/22) Open Session Minutes for discussion.<br><br>**Motion:** to approve consent calendar to include:<br>b. FY22 Period 09 Financials<br>c. Medical Staff Report<br><br>**Movant:** Miller<br>**Second:** Zoglin<br>**Ayes:** Chen, Fung, Kliger, Miller, Somersille, Ting, Watters, Zoglin, Rebitzer, Po<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None<br><br>Director Somersille requested that section 9 of the minutes be revised to "Director Somersille requested that the Perinatal Diagnostic Center MV policy be revised to *remove* specific vendor names.<br><br>**Motion:** to approve Hospital Board Minutes (04/13/22) Open Session Minutes as revised.<br><br>**Movant:** Miller<br>**Second:** Somersille<br>**Ayes:** Chen, Fung, Kliger, Miller, Somersille, Ting, Watters, Zoglin, Rebitzer, Po<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | ***Consent calendar approved*** |
| **10. AGENDA ITEM 17:**<br><br>**RESOLUTION 2022-06:** Approving OB/GYN Call Panel Agreement for Carol A. Somersille, MD | Director Somersille recused herself from the discussion of this item and left the Boardroom.<br><br>Chair Chen open the discussion to formally add Director Carol Sommersille, MD to the OB/GYN Call Panel at the Mountain View campus and asked Dr. Adams to provide more detail.<br><br>Dr. Adams stated that Director Somersille, MD will serve as a backup for the OB hospitalists in the OBED, and be compensated at the same payment rate as the other physicians on the call panel; the maximum per diem rate will be $1,000 per day plus $500 per activation, with twelve independent physicians expected to be on the OB/GYN call | |

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| | panel.<br><br>**Movant:** Miller<br>**Second:** Fung<br>**Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** Somersille<br><br>**Director Somersille re-joined the Board Meeting at 8:26 pm* | |
| **11. AGENDA ITEM 18: CEO REPORT** | Dan Woods, CEO, highlighted the following updates for the month of April:<br>• Nurses Week is nationally celebrated from May 6th through May 12th every year, but this year, the American Nurses Association (ANA) has declared the whole month of May as "Nurses Month<br>• Accept Nothing Less brand advertising campaign launched on local news programming, cable, and various streaming services.<br>• Human Resources continued to provide key leadership to the High-Reliability Organization journey<br>• Employee Engagement/Culture of Safety Pulse Survey is being finalized and the survey will be implemented in May<br>• El Camino Health has reached Epitop-levelevel known as "Gold Stars 10" in the area of Analytics for Cogito, the Epic Analytics<br>• El Camino Health Foundation allocated $863,450.00<br>• Auxiliary donated 3,593 volunteer hours | |
| **12. AGENDA ITEM 19: BOARD COMMENTS** | *No comments were made.* | |
| **13. AGENDA ITEM 20: ADJOURNMENT** | **Motion**: to adjourn at 8:31 pm<br><br>**Movant:**<br>**Second:**<br>**Ayes:** Chen, Fung, Kliger, Miller, Somersile, Ting, Watters, Zoglin, Rebitzer<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Po<br>**Recused:** None | ***Meeting adjourned at 8:31 pm*** |

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

_____ _____

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Stephanie Iljin, Manager of Administration
Heidi Parker, Executive Assistant II

El Camino Health

**EL CAMINO HOSPITAL BOARD OF DIRECTORS**
**COMMITTEE MEETING MEMO**

**To:** El Camino Health Board of Directors
**From:** Jon Cowan, Senior Director, Government Relations & Community Partnerships
**Date:** June 8, 2022
**Subject:** 2022 CHNA and FY23 Implementation Strategy Report and Community Benefit Plan

**Recommendation:**

To approve the 2022 Community Health Needs Assessment (CHNA) and the FY23 El Camino Health Implementation Strategy Report and Community Benefit Plan (Plan).

**Summary:**

**1.** Situation:

**CHNA**

Every three years, the CHNA is conducted in compliance with IRS requirements per the Affordable Care Act of 2010. An implementation strategy is then adopted, which explains the actions that the hospital intends to take to address the health needs and the anticipated impact of these actions.

**Plan**

The Plan reflects a total request of $3,410,000 and includes funding recommendations for grants, sponsorships, and placeholders.

- The Plan outlines strategies to address the top unmet health needs identified in the 2022 ECH 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: The written CHNA is approved by the Hospital Board. Per the Community Benefit Grants Policy approved by the ECH Board of Directors, the Finance Committee reviews and approves the annual Plan.

Background:

**CHNA**

Per the Affordable Care Act of 2010, El Camino Hospital conducted a community health needs assessment from January 2021 through March 2022. Four nonprofit hospitals/healthcare systems, with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct a 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 assets and resources related to identified health needs.

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

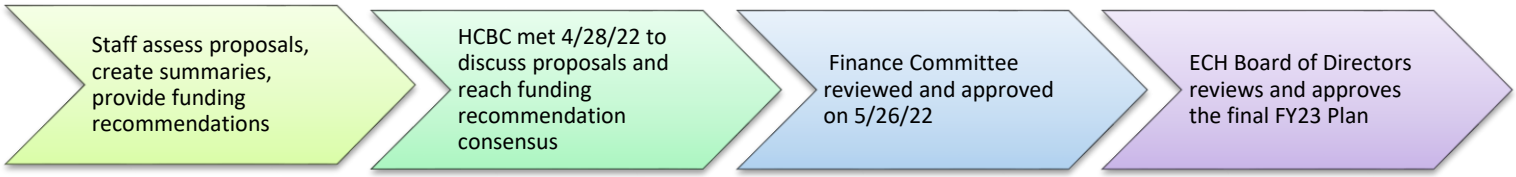
- Health Care Access & Delivery
- Behavioral Health

- Diabetes & Obesity
- Chronic Conditions
- Economic Stability

**Plan**
Plan includes grant proposals, sponsorships, and placeholders.

**Grant proposals review process:**

- December 2021: Community Benefit (CB) FY23 application and Grant Guide released online with an announcement to the 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)

  **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**

**3.** Assessment: N/A

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

**5.** Outcomes: ECH Board of Directors reviews and approves CHNA and Plan, including funding for grants, sponsorships, and placeholder. Board votes to fund the original Plan or Plan with approved amendments.

**6.** **List of Attachments:**

**1.** 2022 ECH Community Health Needs Assessment
**2.** FY23 ECH Implementation Strategy Report and Community Benefit Plan
**3.** Resolution 2022-07

**Suggested Committee Discussion Questions:** N/A

# 2022 Community Health Needs Assessment

June 2022



El Camino Health

## 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
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### EL CAMINO HOSPITAL CEO AND BOARD OF DIRECTORS



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

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

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# 1. EXECUTIVE SUMMARY

## BACKGROUND

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

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

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

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

## PROCESS AND METHODS

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

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

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

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

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

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

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

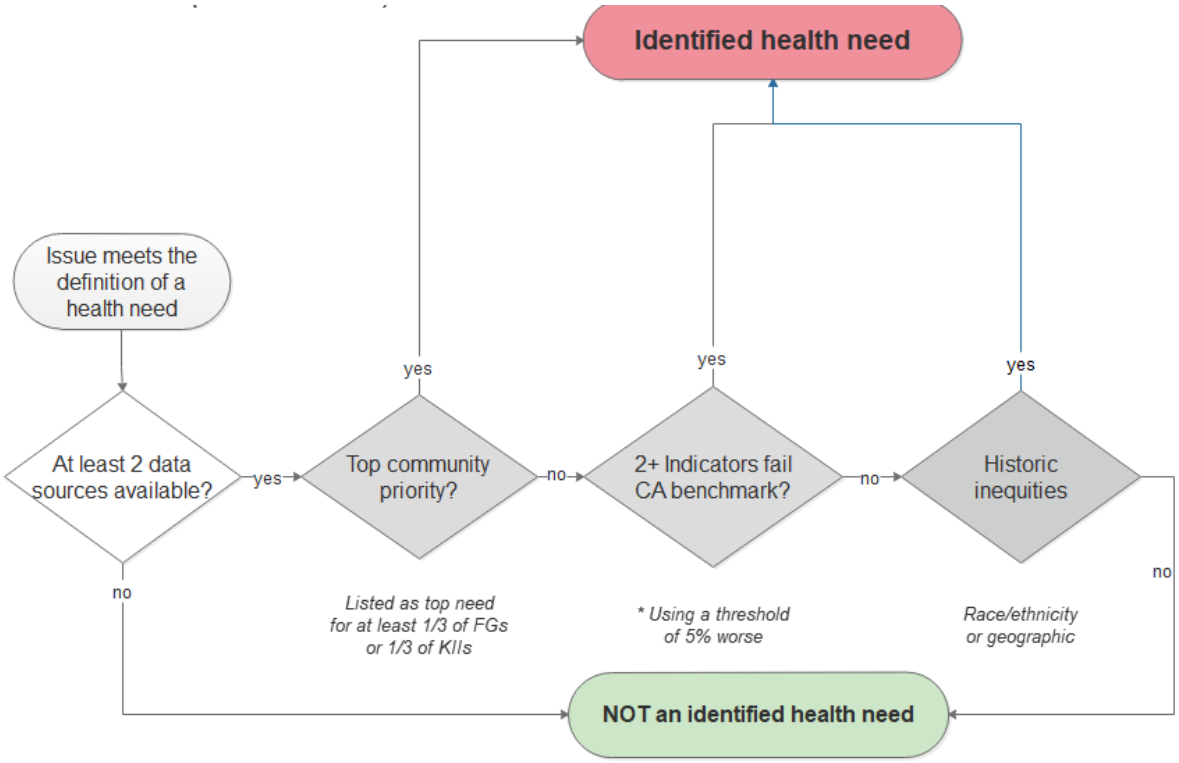
Health needs described in this report are either a poor health outcome and its health driver(s), or a health driver associated with a poor health outcome. El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which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

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

## DEFINITIONS

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

### Health Needs Identification Criteria




## HEALTH NEEDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## KEY TAKEAWAYS

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

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

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

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

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

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

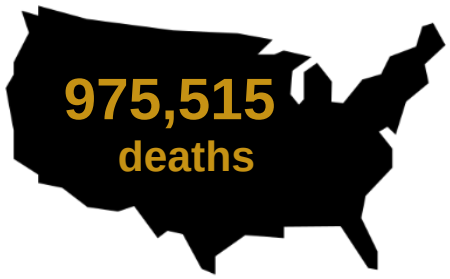
**Access to Healthcare:** El Camino Health has focused on access to healthcare in every CHNA because access is crucial to improving the health of community members, in terms of both prevention and intervention. The Affordable Care Act and subsequent Medi-Cal expansion provided more opportunities for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

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

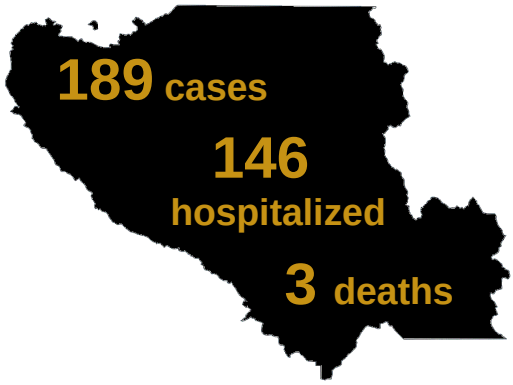
[9] Recent news reports state: "Roughly a quarter of Santa Clara County households don't have access to the internet. In San José, 36% of Latino families and 47% of African American families lacked broadband internet, according to a 2017 study. Approximately 70,000 county residents don't have access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

## COVID-19

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




### Santa Clara County Daily Averages[14]




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

**86%**
**vaccinated**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[26] See various articles related to essential workers and risk during the COVID-19 pandemic:

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

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

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

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

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

## NEXT STEPS

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

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

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

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

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

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

# 2. BACKGROUND

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

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

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

## CHNA PURPOSE AND ACA REQUIREMENTS

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

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

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

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

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

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

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

## BRIEF SUMMARY OF 2019 CHNA

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

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

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

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

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

## WRITTEN PUBLIC COMMENTS ON 2019 CHNA

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

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

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

# 3. ABOUT EL CAMINO HEALTH

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

MISSION

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

HISTORY IN BRIEF

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

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

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

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

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

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

## SPECIALTY CARE AND INNOVATIONS

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

Some programs and accomplishments unique to El Camino Health are:

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

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

## COMMUNITY BENEFIT PROGRAM

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

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

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

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

## DEMOGRAPHIC PROFILE OF COMMUNITY SERVED

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

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

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

## Map of Service Area


Orange stars represent El Camino Hospital campuses.

## Santa Clara County

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

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

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

Race/Ethnicity in Santa Clara County

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

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

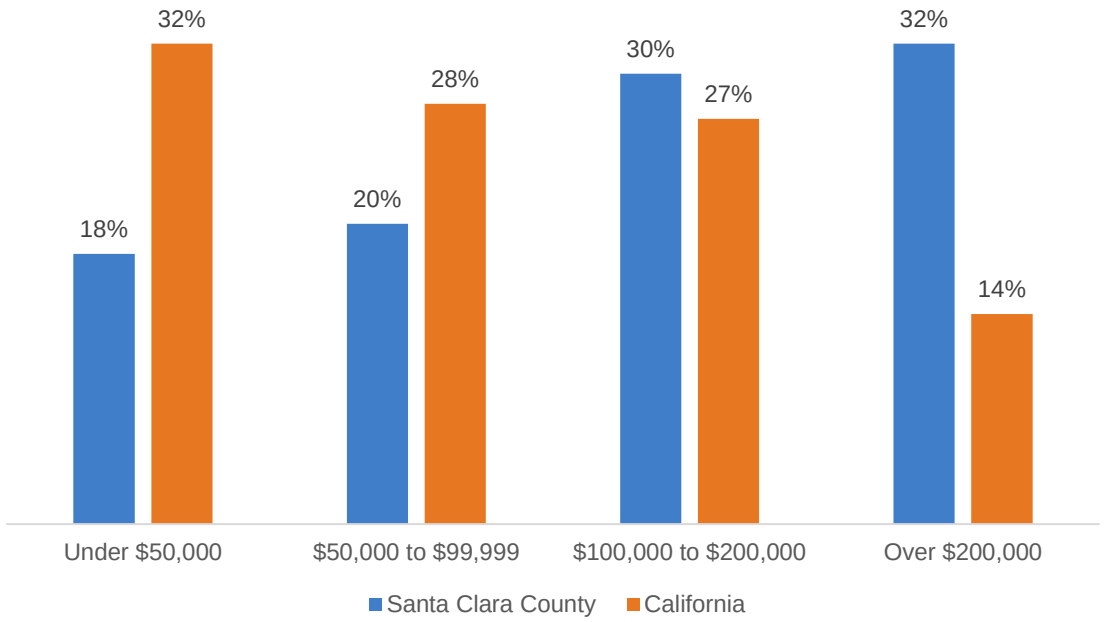
Nearly four in ten (39%) people in Santa Clara County were born outside the United States. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[40] Our communities earn some of the highest annual median incomes in the U.S., but they also bear some of the highest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

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

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

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

### Area Household Income Ranges




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

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

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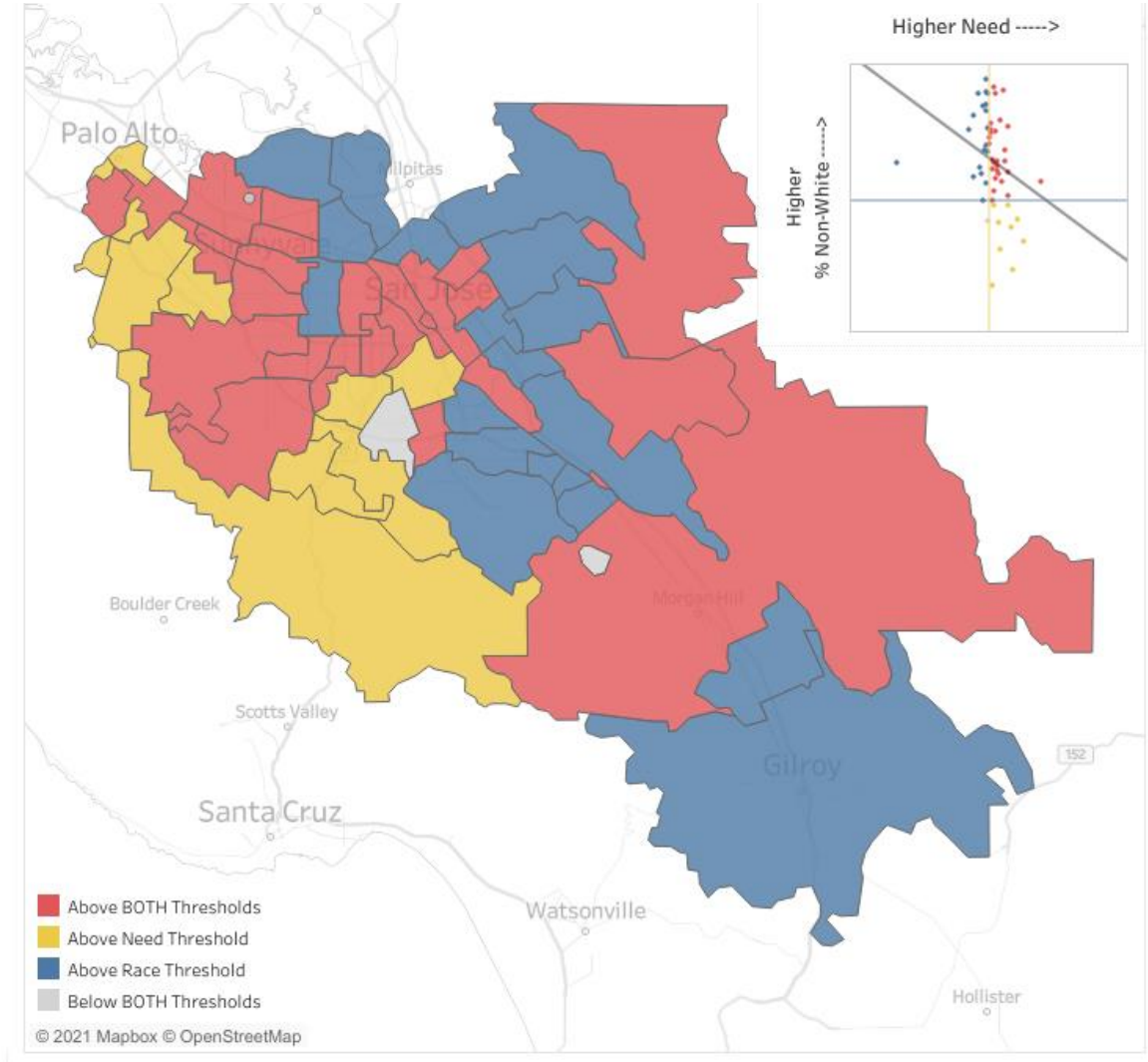
[42] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org

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

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

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

**Correlation Between Income Inequality & Non-White Population, By Zip Code**




Map: Parts of the county exhibit income inequality (red and yellow areas). In many places where income inequality is high, non-white community members are also in the majority (red areas). “Need Threshold” is the U.S. Gini Index, 0.4. “Race Threshold” is 50% non-white.

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

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

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

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

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

# 4. ASSESSMENT TEAM

## HOSPITALS AND OTHER PARTNER ORGANIZATIONS

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

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

## IDENTITY AND QUALIFICATIONS OF CONSULTANTS

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

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

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

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

[48] https://actionablellc.com/

# 5. PROCESS AND METHODS

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


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

## SECONDARY DATA COLLECTION

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

As a further framework for the assessment, the collaborative requested that the data analysis address the following questions:

- How do these indicators perform against accepted benchmarks (statewide rates and averages)?
- What are the inequitable outcomes and conditions for people in the community?

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

## PRIMARY DATA COLLECTION (COMMUNITY INPUT)

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

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

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

The assessment included input from key informants and focus group participants representing these populations:[50]

- Low-income
- Minority
- Medically underserved
- Homeless
- Older adults
- Youth

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

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

### Key Informant Interviews

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

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

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

The discussions centered around four questions for each health need that was prioritized by interviewees:

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

### Details of Key Informant Interviews

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

### Focus Groups

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

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

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

### Details of Focus Groups

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

* Indicates resident/community member group.

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

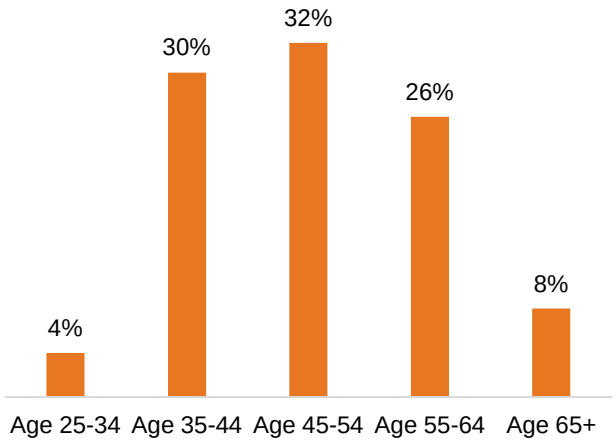
[52] Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

### CHNA Participant Demographics

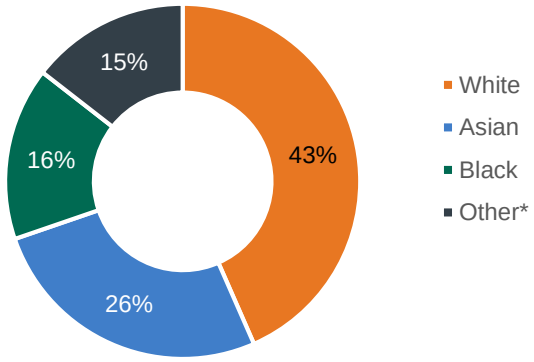
A total of 77 people participated in focus groups or interviews for the CHNA. More than three out of every four (77%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder represented Santa Clara County only (23%).

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

**Participant Age Groups**




**Participant Racial/Ethnic Groups**




* "Other" includes American Indian/AK Native & Native HI/Pacific Islander.

## INFORMATION GAPS AND LIMITATIONS

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

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

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

3. In years past, our CHNAs relied on the California Healthy Kids Survey (CHKS) for data about child and adolescent mental health and emotional wellbeing. However, Santa Clara County has not opted in to conduct the CHKS in recent years. Therefore, these data are lacking for the county.
4. Because of the pandemic, it was not safe to bring community members together in person. Moreover, while it was possible to conduct focus groups and interviews virtually (i.e., via Zoom), the most vulnerable community members often did not have access to the technology needed for a virtual meeting. Also, nonprofit partners advised that the community was severely stressed (financially and emotionally) by the pandemic and felt it was inappropriate to burden them with CHNA data collection requests. Although Actionable Insights was able to conduct one focus group with safety net clinic patients, in order to best represent the perspectives and experiences of low-income, minority, and underserved community members during the pandemic, they spoke with a wide array of nonprofit staff who work with vulnerable populations. We acknowledge this as a limitation in our 2022 CHNA data.

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

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

## PROCESS OF IDENTIFYING COMMUNITY HEALTH NEEDS

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

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

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

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

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

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

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

   **and**

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

   **and**

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

   **or**

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

   **or**

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

## DEFINITIONS

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

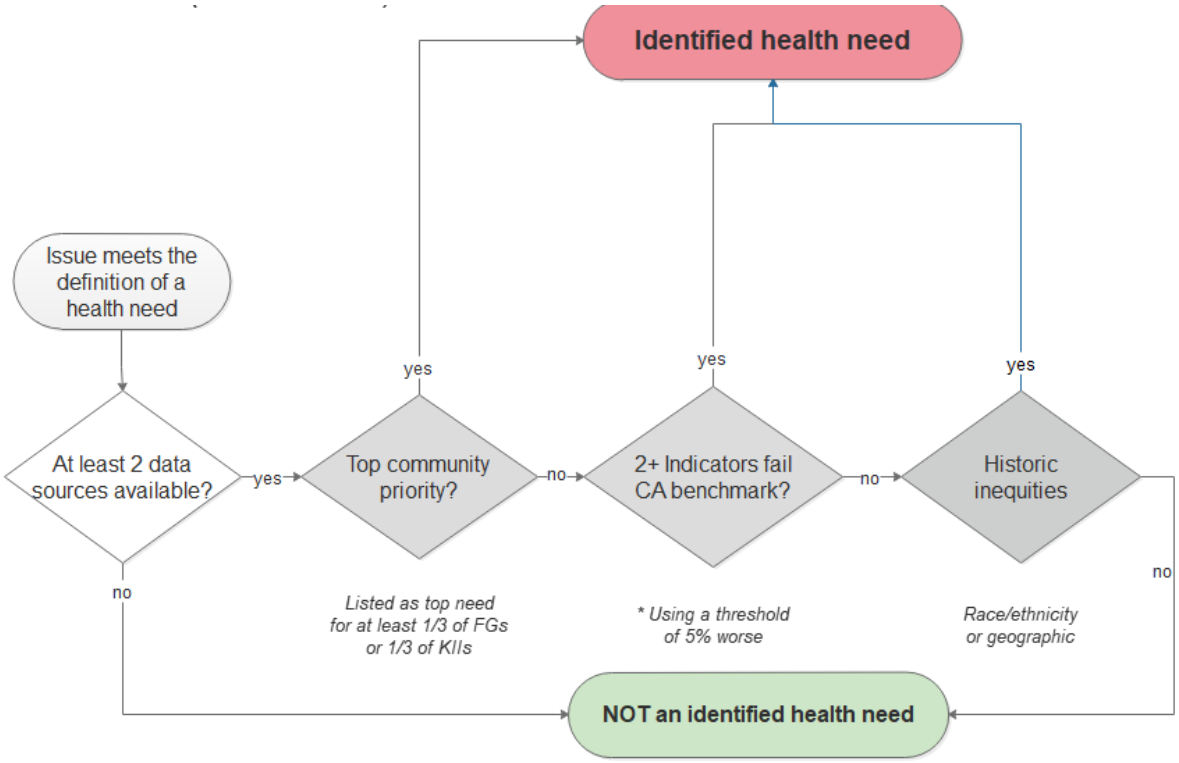
**Health driver:** A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes. May be a social determinant of health.

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

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

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

### Health Needs Identification Criteria




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

## PROCESS OF PRIORITIZING THE HEALTH NEEDS

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

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

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

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

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

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

# 6. PRIORITIZED COMMUNITY HEALTH NEEDS

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

## ECONOMIC STABILITY

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

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

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

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

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

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

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

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

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

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

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

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

## BEHAVIORAL HEALTH

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

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

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

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

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

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

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

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

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

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

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

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

## HOUSING & HOMELESSNESS

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

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

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

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

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

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

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

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

## HEALTH CARE ACCESS & DELIVERY

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

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

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

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

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

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

## DIABETES & OBESITY

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

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

### Students Meeting Healthy Body Composition Standards[63]

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

### Students Meeting All Fitness Standards

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

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

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

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

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

## CANCER

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

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

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

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

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

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

## MATERNAL & INFANT HEALTH

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

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

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

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

## ORAL/DENTAL HEALTH

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

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

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

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

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

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

## CLIMATE/NATURAL ENVIRONMENT

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

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

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

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

## UNINTENDED INJURIES/ACCIDENTS

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

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

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

## COMMUNITY SAFETY

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

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

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

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

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

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

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

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

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

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

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

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

## SEXUALLY TRANSMITTED INFECTIONS

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

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

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

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

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

## 7. EVALUATION OF 2020–2022 IMPLEMENTED STRATEGIES

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

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

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

The health needs fall under three health priority areas:


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

- Behavioral Health
- Cognitive Decline

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

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

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

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

## 8. CONCLUSION

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

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

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

Next steps for El Camino Health:

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

## 9. LIST OF ATTACHMENTS

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

## ATTACHMENT 1. COMMUNITY LEADERS, REPRESENTATIVES AND MEMBERS CONSULTED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ATTACHMENT 2. SECONDARY DATA INDICATORS LIST

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# ATTACHMENT 3. COMMUNITY ASSETS AND RESOURCES

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

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

## GENERAL RESOURCES

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

## COMMUNITY HEALTH NEEDS

### BEHAVIORAL/MENTAL HEALTH

#### *Assets*

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

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

***Resources***

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

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

## CANCER

### *Assets*

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

### *Resources*

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

## CLIMATE/NATURAL ENVIRONMENT

### *Assets*

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

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

## COMMUNITY SAFETY

### *Assets*

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

### *Resources*

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

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

## DIABETES & OBESITY

See Economic Stability for free food resources.

### *Assets*

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

### *Resources*

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

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

## ECONOMIC STABILITY

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

### *Assets*

- California Budget & Policy Center
- Silicon Valley Leadership Group

### *Resources*

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

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

### *Food Resources*

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

## HEALTH CARE ACCESS AND DELIVERY

### *Health Care Facilities and Systems*

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

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

### *Community Clinics*

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

### *Mobile Health Services*

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

### *Other Access-Related Assets*

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

### *Other Access-Related Resources*

- Avenidas
- City Team Ministries

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

## HOUSING & HOMELESSNESS

### *Assets*

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

### *Resources*

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

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

## MATERNAL/INFANT HEALTH

### *Assets*

- Healthier Kids Foundation
- March of Dimes

### *Resources*

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

## ORAL/DENTAL HEALTH

### *Assets*

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

### *Resources*

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

## SEXUALLY TRANSMITTED INFECTIONS

### *Assets*

- Santa Clara County HIV Commission

### *Resources*

- Asian Americans for Community Involvement: HOPE Program

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

## UNINTENDED INJURIES/ACCIDENTS

### *Assets*

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

### *Resources*

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

## ATTACHMENT 4. QUALITATIVE RESEARCH PROTOCOLS

# CHNA KII Protocol - Professionals (60 min.)

### PREP

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

### INTRODUCTION (5 MIN.)

*[Start recording from the beginning of the session.]*

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

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

**KICK ON ZOOM RECORDING!**

## HEALTH NEEDS DISCUSSION (35 MIN.)

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

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

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

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

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

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

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

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

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

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

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

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed since COVID began?

### ADDITIONAL COMMENTS (TIME PERMITTING)

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

### REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

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

### CLOSING (1 MIN.)

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

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

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

# CHNA FG Protocol - Professionals (90 min.)

## PREP

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

## INTRODUCTION (10 MIN.)

*[Start recording from the beginning of the session.]*

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

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

## HEALTH NEEDS DISCUSSION (45 MIN.)

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

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

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

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

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

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

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

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

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

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

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

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

I know you didn't identify the coronavirus as a specific need; would you mind...

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

## ADDITIONAL COMMENTS (TIME PERMITTING)

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

## REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 MIN.)

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

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

## CLOSING (1 MIN.)

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

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

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

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

## PREP

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

## INTRODUCTION (10 MIN.)

*[Start recording from the beginning of the session.]*

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

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

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

## HEALTH NEEDS DISCUSSION (45 MIN.)

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

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

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

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

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

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

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

## YOUR PANDEMIC EXPERIENCE (15 MIN.)

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

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

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

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

## YOUR PERCEPTION OF EQUITY ISSUES (20 MIN.)

As you probably know, people have been talking about issues of equity much more than ever before. "Equity" means fairness and unbiased treatment. When it comes to health care, what's your perspective about equity and cultural competence? For example:

- What do you think are the barriers to everyone having the same access to health care?
- What do you think are the barriers to everyone getting the same quality of health care?
- We've heard that not all providers know how to care for people in a respectful and culturally competent way. What do you think those providers are missing? What do you think they need to learn?
- What can hospitals and health systems do to best address equity for you and the people in your community?

## CLOSING (1 MIN.)

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

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

# ATTACHMENT 5. IRS CHECKLIST

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

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

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

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

Further IRS requirements available:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Implementation Strategy Report and Community Benefit Plan, FY2023

June 2022



El Camino Health

## 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<br>EIN 94-3167314 |
| **Address of Hospital Organization:** | El Camino Hospital<br>2500 Grant Road<br>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, Sunnyvale, 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 4$^{th}$-graders, is significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4).[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.

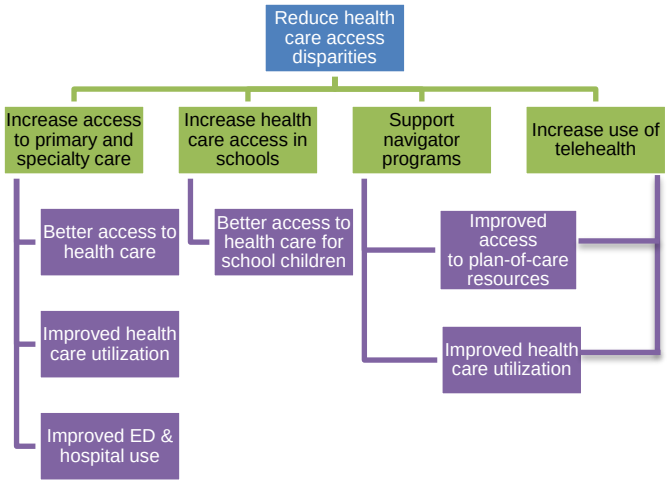
## HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

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

INITIATIVES

ANTICIPATED IMPACTS

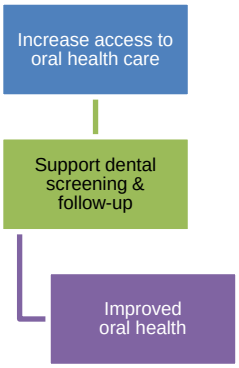



| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 1. Reduce disparities in access to high-quality care | A. Support increased access to primary care and specialty care services for vulnerable individuals[48, 49, 50, 51, 52, 53, 54, 55, 56, 57] | (i) Individuals experience better access to health care<br>(ii) Improved health care utilization<br>(iii) Reduced unnecessary ED visits and hospitalizations |
| | B. Support greater access to healthcare in schools[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] | |

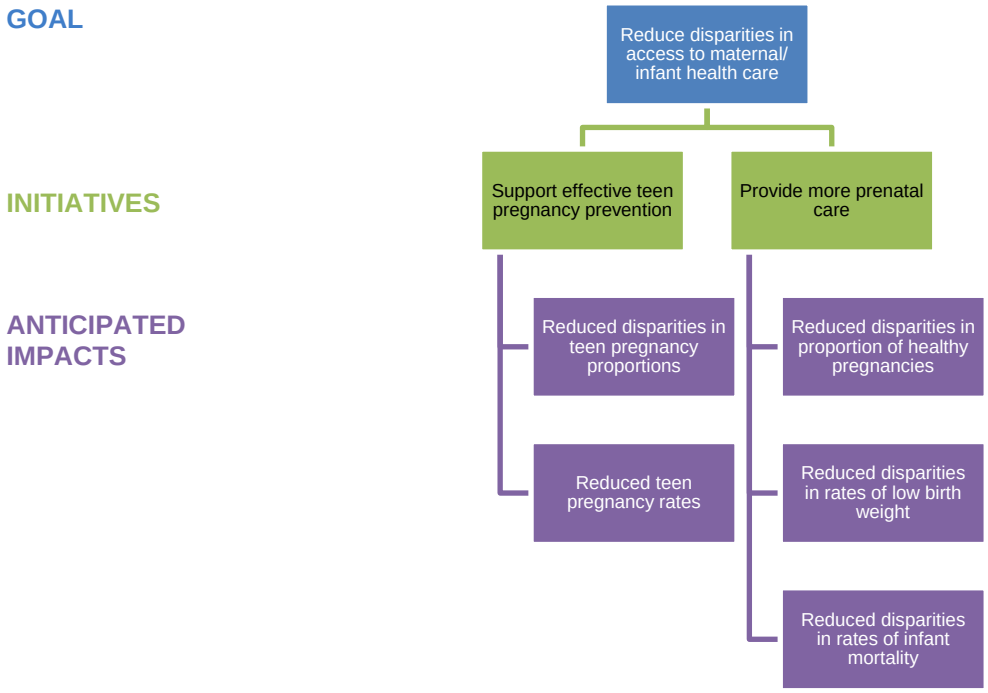
**GOAL**

**INITIATIVE**

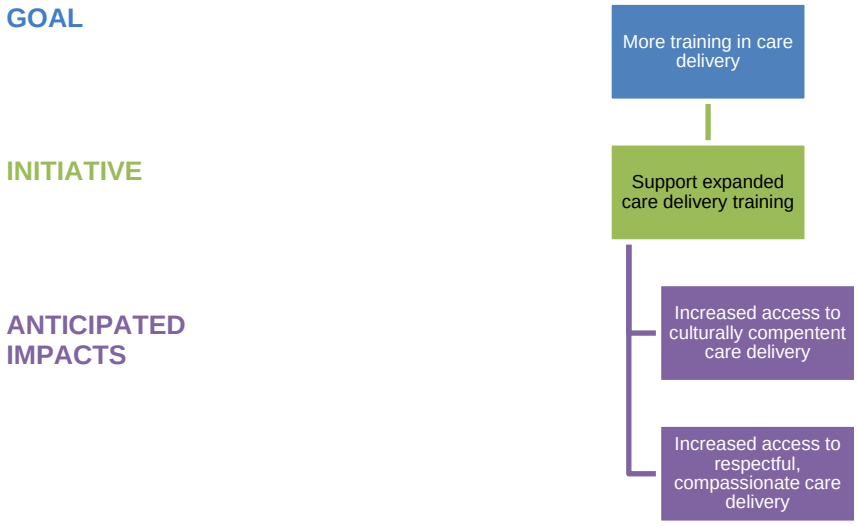
**ANTICIPATED IMPACT**




| 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<br>(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:<br>(i) Proportions of women with healthy pregnancies<br>(ii) Rates of low birth weight<br>(iii) Rates of infant mortality |




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

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

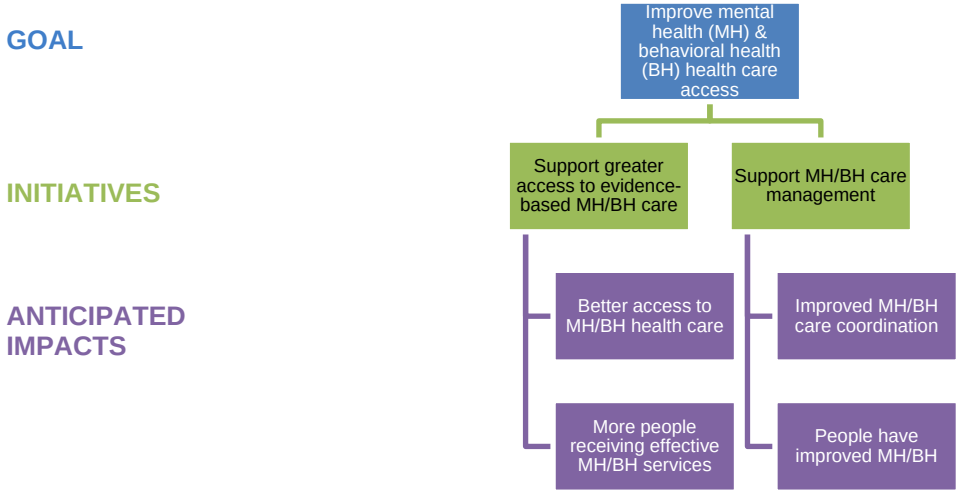
| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | FY23 Approved |
|---|---|---|---|---|---|---|
| Campbell Union School District - School Nurse Program | | | | $231,000 | $215,000 | $215,000 |
| County of Santa Clara Health System - Better Health Pharmacy | | | | $75,000 | $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

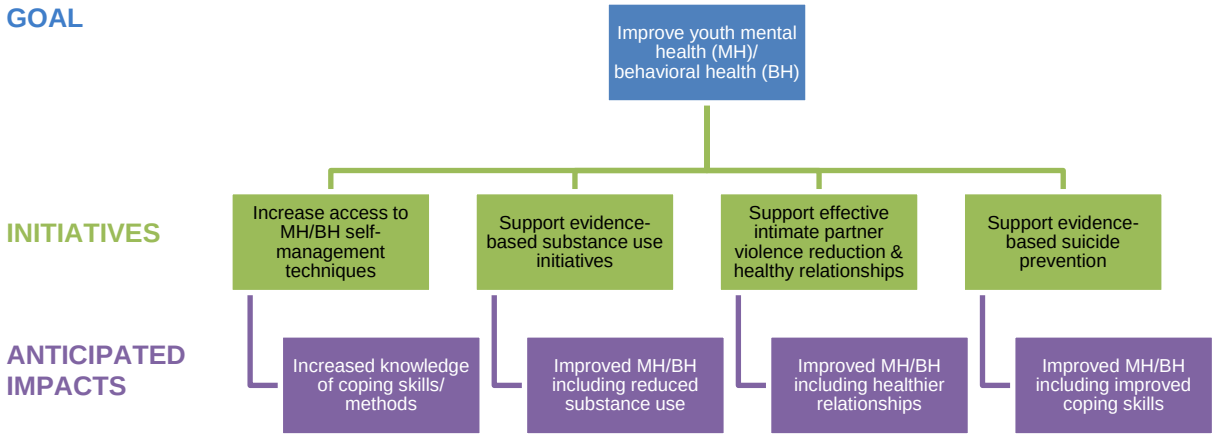
**Proposals within each color grants are organized alphabetically

## BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

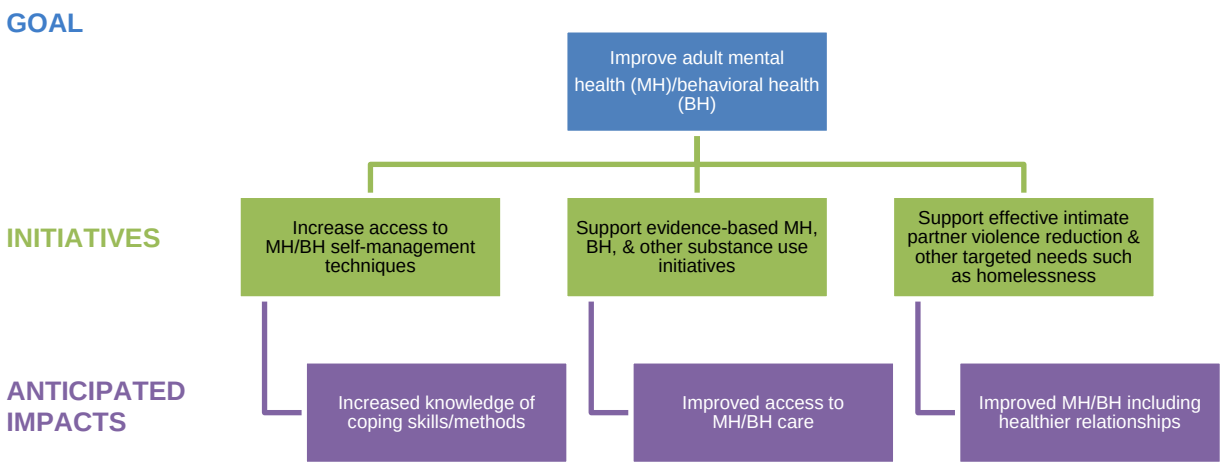
Even prior to the pandemic, data indicated that behavioral health (including mental health, trauma, and substance use) was a significant health need, especially with respect to the supply of providers. Community input during the 2022 CHNA emphasized how much worse and more widespread behavioral health 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<br>(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<br>(ii) Improved mental/behavioral health among those served |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Improve mental/ behavioral health of youth in the community | A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[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<br><br>(ii) Improved utilization of clinical and community resources among those served |

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

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | FY23 Approved |
|---|---|---|---|---|---|---|
| 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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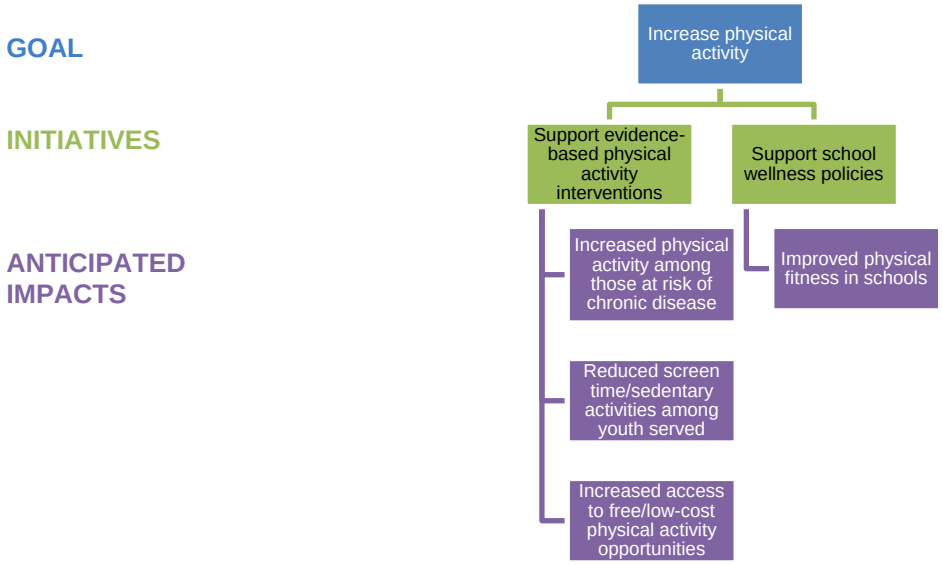
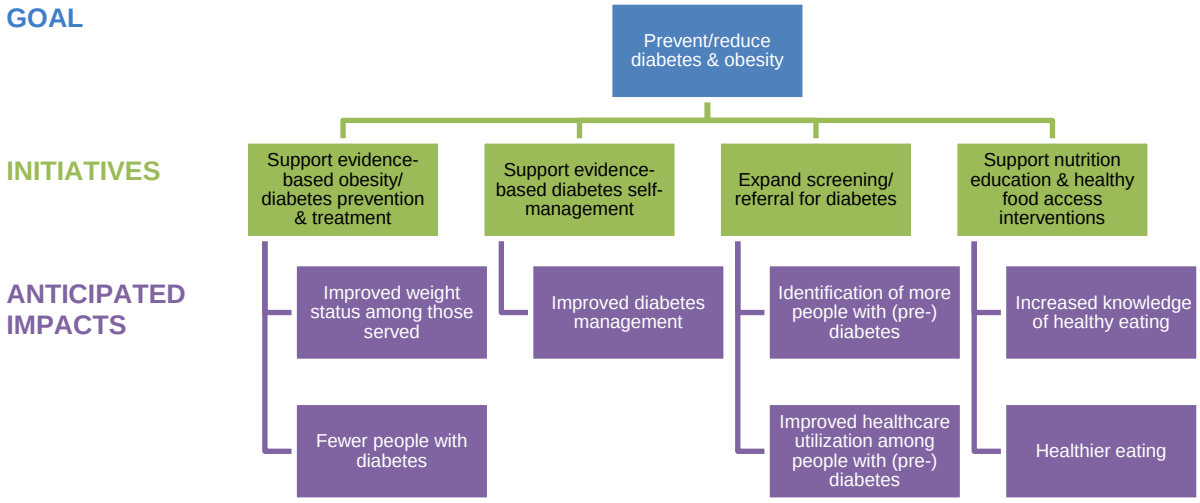
**Proposals within each color are organized alphabetically

## 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<br>(ii) Reduced screen time & time on sedentary activities among youth served<br>(iii) Increased access to and utilization of free/low-cost opportunities for physical activity |
| | B. Support implementation of school wellness policies for promoting physical activity[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<br>(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<br>(ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes |
| | D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[126, 127, 128, 129] | (i) Increased knowledge and understanding about healthy eating among people served<br>(ii) Healthier eating among community members receiving interventions |

## DIABETES & OBESITY PROPOSAL RECOMMENDATIONS

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | FY23 Approved |
|---|---|---|---|---|---|---|
| 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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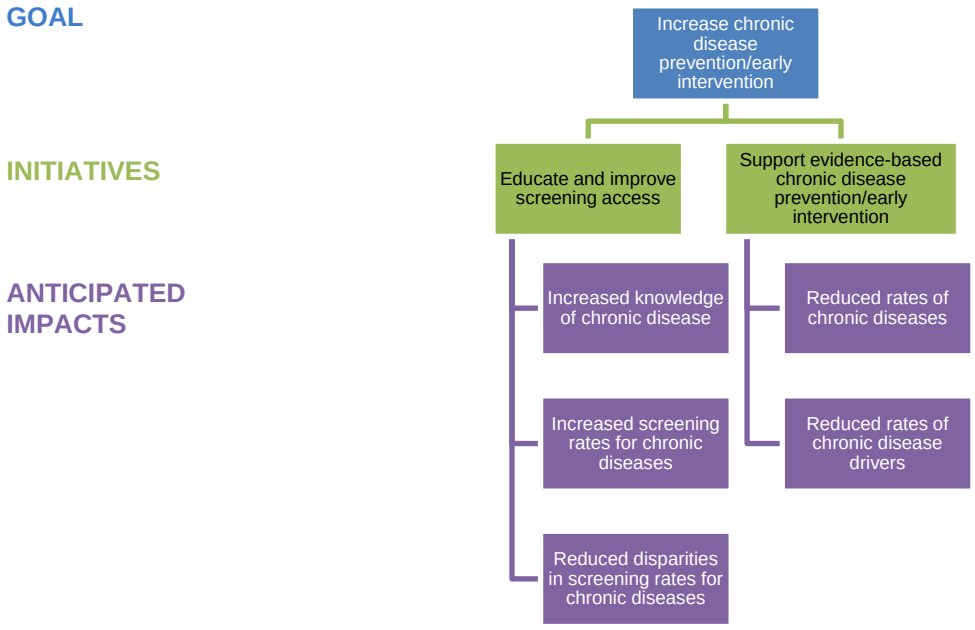
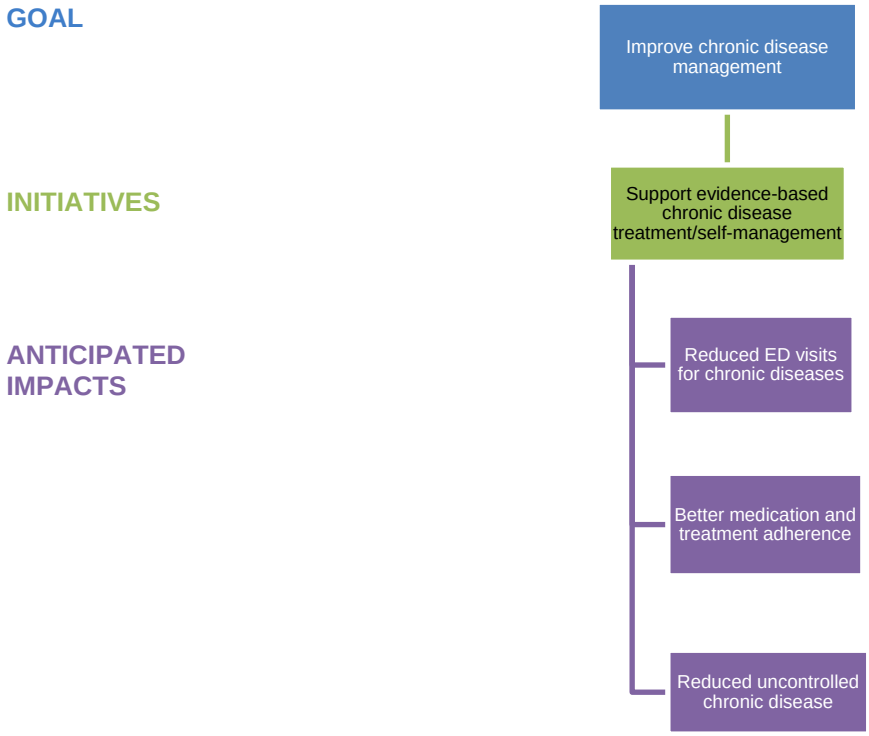
## OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

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<br>(ii) Increased rates of screening for chronic disease<br>(iii) Reduced disparities in chronic disease screening rates |
| | B. Support evidence-based chronic disease prevention and early intervention programs[137, 138, 139] | (i) Reduced rates of chronic diseases<br>(ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc. |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Improve chronic disease management among community members | A. Support evidence-based chronic disease treatment and self-management programs[140, 141, 142] | (i) Reduced rates of ER/ED visits for chronic diseases<br>(ii) Improved medication and treatment adherence<br>(iii) Reduced rates of uncontrolled chronic disease |

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

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | FY23 Approved |
|---|---|---|---|---|---|---|
| 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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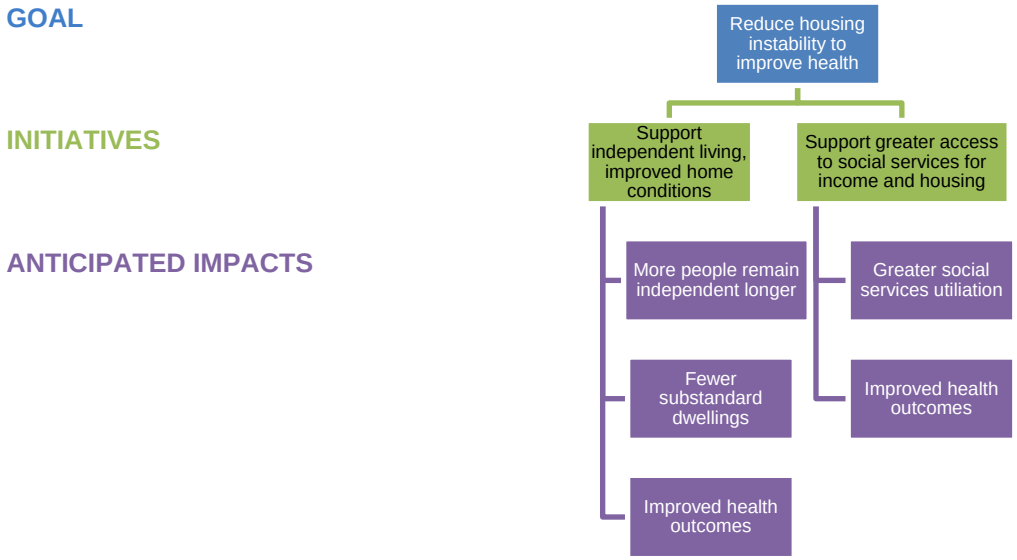
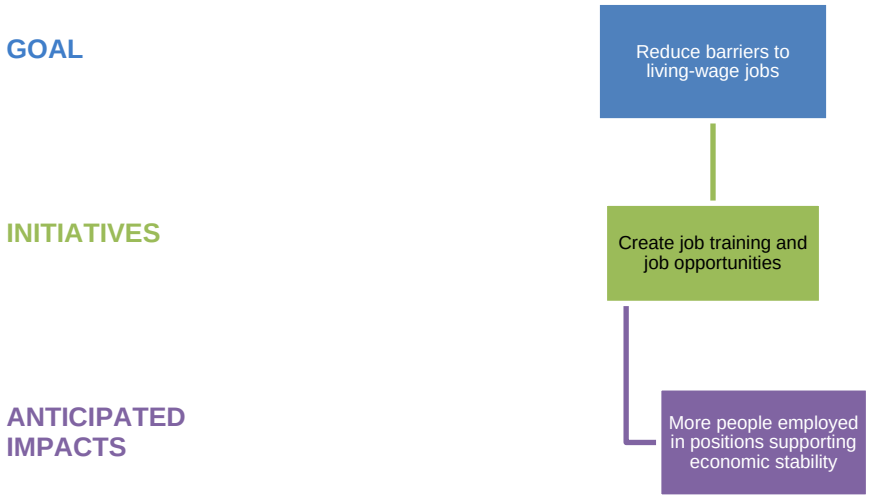
## ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS)

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<br>(ii) Reduced number of sub-standard dwellings<br>(iii) Improved health outcomes for those at-risk of and/or experiencing homelessness |
| | B. Support efforts to improve access to social services that address income and housing insecurity[146, 147, 148] | (i) Increase in social services utilization<br>(ii) Improved health outcomes for those at-risk of and/or experiencing homelessness |




| Goal | Initiative | Anticipated Impact |
|---|---|---|
| 2. Reduce barriers to employment/ careers that provide community members with a living wage | A. Create workforce training and employment opportunities for underrepresented populations[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<br>(ii) Reduced food insecurity |

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

| Agency | New | DNF | Dual Request | Requested | FY22 Approved (if applicable) | FY23 Approved |
|---|---|---|---|---|---|---|
| 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:<br><br>(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.<br><br>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.<br><br>(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.

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**EL CAMINO HOSPITAL**

**RESOLUTION 2022-07**

**RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING THE 2022 COMMUNITY HEALTH NEEDS ASSESSMENT AND THE IMPLEMENTATION STRATEGY REPORT AND COMMUNITY BENEFIT PLAN, FISCAL YEAR 2023**

**WHEREAS**, El Camino Hospital (the "**Hospital**") operates two nonprofit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care, and primary care locations across Santa Clara County. As a 501(c)(3) nonprofit public benefit corporation, the Hospital is committed to identifying, prioritizing, and serving the health needs of the communities it serves;

**WHEREAS**, on March 23, 2010, the Patient Protection and Affordable Care Act (the "**ACA**") was signed into federal law;

**WHEREAS**, the ACA requires a nonprofit hospital organization to conduct a Community Health Needs Assessment ("**CHNA**") every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA;

**WHEREAS**, the CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and be made widely available to the public;

**WHEREAS**, the Hospital has completed its 2022 CHNA and prepared a written Implementation Strategy Report and Community Benefit Plan for fiscal year 2023 (the "**IS Plan**"); and

**WHEREAS**, the Board of Directors of the Hospital (the "**Board**") has reviewed the 2022 CHNA and 2023 IS Plan, as presented and attached as **Exhibit A** and **Exhibit B**, respectively.

**NOW THEREFORE BE IT RESOLVED**, that the Board hereby adopts the 2022 CHNA and 2023 IS Plan;

**FURTHER RESOLVED**, that the officers or agents of the Hospital be, and each of them with full power to act without the others is, hereby authorized and empowered to do or cause to be done all such acts or things as they or any of them may deem necessary, advisable or appropriate to effectuate or carry out the purposes and intent of the foregoing resolutions; and

**FURTHER RESOLVED**, that any and all actions heretofore or hereafter taken by any officer or agent of the Hospital within the terms of the foregoing resolutions be and are hereby ratified and confirmed as the authorized acts and deeds of the Hospital.

**PASSED AND ADOPTED** at the regular meeting of the Board of Directors of El Camino Hospital held on June 08, 2022 by the following vote:

**AYES:**

**NOES:**

**ABSENT:**

**ABSTAIN:**

_____

**Lanhee J. Chen, JD, PhD, Chair**

**ATTEST:**

_____

**Julia E. Miller, Secretary/Treasurer**

**Exhibit A**

**2022 COMMUNITY HEALTH NEEDS ASSESSMENT**

Please see the attached.

**Exhibit B**

**IMPLEMENTATION STRATEGY REPORT AND COMMUNITY BENEFIT PLAN, FISCAL YEAR 2023**

Please see the attached.

**FY23 ECHD and ECH Board & Committee Master Calendar**
May 26, 2022

*Federal / Religious Holiday & School Dates

## JULY 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 29 | 30 | 1 | 2 |
| 3 | 4 Indep. Day | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24/31 | 25 | 26 | 27 | 28 | 29 | 30 |

## AUGUST 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 31 | **1 QC** | **2 GC** | 3 | **4 ECHMN** | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | **15 FC** | 16 | **17 ECHB** | 18 | 19 | 20 |
| 21 | **22 IC** | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | 1 | 2 | 3 |

## SEPTEMBER 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 28 | 29 | 30 | 31 | **1** | 2 | 3 |
| 4 | 5 Labor Day | **6 QC** | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | **14 ECHB** | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | **22 ECC** | 23 | 24 |
| 25 | 26 Rosh Hashanah | **27 FC** | **28 CAC** | 29 | 30 | 1 |

## OCTOBER 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 25 | 26 | 27 | 28 | 29 | 30 | 1 |
| 2 | 3 | 4 | 5 Yom Kippur | 6 | 7 | 8 |
| 9 | 10 Columbus Day | 11 | **12 ECHB** | 13 | 14 | 15 |
| 16 | 17 | **18 ECHD** | 19 | **20 ECHMN** | 21 | 22 |
| 23/30 | 24/31 | **25 GC** | 26 | 27 | 28 | 29 |

## NOVEMBER 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 30 | 31 | 1 | 2 | **3 ECC** | 4 | 5 |
| 6 | **7 QC** | 8 | **9 ECHB** | 10 | 11 Veterans Day | 12 |
| 13 | **14 IC** | 15 | 16 | 17 | 18 | 19 |
| 20 | **21 FC** | 22 | 23 | 24 Thanksgiving | 25 | 26 |
| 27 | 28 | 29 | **30 CAC** | 1 | 2 | 3 |

## DECEMBER 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 27 | 28 | 29 | 30 | **1 ECHMN** | 2 | 3 |
| 4 | **5 QC** | 6 | **7 ECHB** | 8 | 9 | 10 |
| 11 | 12 | **13 ECHD** | 14 | 15 | 16 | 17 |
| 18 | 19 Hanukkah Begins | 20 | 21 | 22 | 23 | 24 Xmas Eve |
| 25 Xmas | 26 Kwanzaa | 27 | 28 | 29 | 30 | 31 NYE |

## JANUARY 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 NYD | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | **12 ECHMN** | 13 | 14 |
| 15 | 16 MLK | 17 | **18 ED Session** | **19** | 20 | 21 |
| 22 Chinese New Year | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | **30 FC \| IC** | 31 | 1 | 2 | 3 | 4 |

## FEBRUARY 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 29 | 30 | 31 | 1 | 2 | 3 | 4 |
| 5 | **6 QC** | **7 GC** | 8 | 9 | 10 | 11 |
| 12 | **13 IC** | 14 | **15 ECHB** | 16 | 17 | 18 |
| 19 Ski Week | 20 Pres. Day | 21 | **22 CAC** | 23 | 24 | 25 |
| 26 | 27 | **28 ECHD** | 1 | 2 | 3 | 4 |

## MARCH 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 1 | **2 ECC** | 3 | 4 |
| 5 | **6 QC** | 7 | **8 Retreat** | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | **16 ECHMN** | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 Ramadan Begins | 24 | 25 |
| 26 | **27 FC** | **28 ECHD** | 29 | 30 | 31 Cesar Chavez | 1 |

## APRIL 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 29 | 30 | 31 | 1 |
| 2 | **3 QC** | 4 | **5 ECHB** | 6 Passover | 7 | 8 |
| 9 Easter | 10 Spring Break | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 Ramadan Ends | 22 Eid al-Fitr |
| 23/30 | 24 | 25 | **26 CAC** | 27 | 28 | 29 |

## MAY 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 30 | **1 QC** | **2 GC** | 3 | **4 ECC** | 5 | 6 |
| 7 | **8 IC** | 9 | **10 ECHB** | 11 | 12 | 13 |
| 14 | 15 | **16 ECHD** | 17 | 18 | 19 | 20 |
| 21 | **22 FC** | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 Mem. Day | 30 | 31 | 1 | 2 | 3 |

## JUNE 2023

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 28 | 29 | 30 | 31 | **1 ECHMN** | 2 | 3 |
| 4 | **5 QC** | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | **14 ECHB** | 15 | 16 | 17 |
| 18 | 19 Juneteenth | **20 ECHD** | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | **28 CAC** | 29 | 30 | 1 |

| District Board \| ECHD | Hospital Board \| ECHB | ECH Board Retreat | Educational Sessions | Executive Comp \| ECC | Finance \| FC | Quality \| QC | Compliance \| CAC | Governance \| GC | Investment \| IC | ECHMN |
|---|---|---|---|---|---|---|---|---|---|---|
| 5x per year<br>3rd Tuesday<br>1x Study Session | 9x per year<br>2nd Wednesday | 1x per year | 1x per year<br>4th Wednesday | 4x per year<br>Thursdays | 6x per year<br>4th or Last Monday | 9x per year<br>1st Monday | 5x per year<br>3rd Thursday | 4x per year<br>1st Tuesday | 4x per year<br>2nd Monday | 6x per year<br>Thursdays |

El Camino Health

# FY22 COMMITTEE GOALS

Compliance and Audit Committee

## PURPOSE

The purpose of the Compliance and Audit Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight of Corporate Compliance, Privacy, Internal and External Audit, Enterprise Risk Management, and Information Technology (IT) Security. The Committee will accomplish this by monitoring the compliance policies, controls, and processes of the organization and the engagement, independence, and performance of the internal auditor and external auditor. The Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

**STAFF**: **Diane Wigglesworth**, Sr. Director, Corporate Compliance (Executive Sponsor)

The Sr. Director, Corporate Compliance 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 or outside consultants may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Provide guidance to the organization on risk tolerance related to Enterprise Risk Management. | Q1 FY22 ( ~~Presenting 9/30/21~~)<br>Revised to present on 11/18/21 | Committee reviews and provides recommendations to the Compliance Officer and recommends if any information should be presented to the Board. Reviewed on 11/18/21 |
| **2.** Receive education on new OIG guidance regarding compliance programs and fraud alerts. | Q3 FY22 (Presenting 1/27/22) | Committee receives education and recommends information that should be presented to the Board. Education presented on 1/27/22 |
| **3.** Review identified cyber risks for the organization in the context of critical business functions and how the cybersecurity plan and initiatives are protecting critical business activities within the IT strategic plan. | Q4 FY22 (Presenting 5/19/22) | Committee reviews and provides recommendations to the CIO and CISO. Reviewed on 5/19/22 |

**SUBMITTED BY**:

**Chair**: Jack Po, MD
**Executive Sponsor**: Diane Wigglesworth

El Camino Health

# FY22 COMMITTEE GOALS AND PACING PLAN

## Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

**STAFF**: **Greg Souza**, Interim Chief Human Resources Officer (Executive Sponsor)

The CHRO 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 and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

| GOALS | TIMELINE | METRICS/PACING PLAN |
|---|---|---|
| **1.** Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design | **Q1** 09/28/21 | - Review and approve FY22 executive base salaries- **COMPLETED**<br>- Review and recommend FY21 Organizational Incentive Score- **COMPLETED**<br>- Review and approve FY21 individual incentive scores- **COMPLETED**<br>- Review and approve FY21 executive payout amounts - **COMPLETED** |
| | **Q2** 11/04/21 | - Review and approve of letter of reasonableness – **COMPLETED** |
| | **Q3** 03/03/22 | - Recommend FY23 Committee goals - **COMPLETED**<br>- Receive update leadership development - **COMPLETED**<br>- Receive update on strategic plan - **COMPLETED**<br>- Review potential policy changes – **N/A** |
| | **Q4** 05/18/22 | - Review and recommend proposed FY23 organizational incentive goals - **COMPLETED**<br>- Review and approve FY23 individual executive strategic pick goals - **COMPLETED** |
| **2.** Evaluate the effectiveness of the independent compensation consultant | **Q2** 11/04/21 **Q4** 05/18/22 | - Conduct semi-annual evaluation of ECC consultant - **COMPLETED** |

**SUBMITTED BY**: **Chair**: Bob Miller | **Executive Sponsor**: Greg Souza

Last revised: 05-26-22

El Camino Health

# 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** (May 2022) |
| | Q4 | **ECHMN** (April -2022), **Joint Venture – Pathways** (May - 2022) |
| **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

El Camino Health

# FY2022 COMMITTEE GOALS

Investment Committee

## PURPOSE

The purpose of the Investment Committee is to develop and recommend to the El Camino Hospital (ECH) Board of Directors ("Board") the investment policies governing the Hospital's assets, maintain current knowledge of the management and investment funds of the Hospital, and provide oversight of the allocation of the investment assets.

**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 or hospital staff may participate in the meetings upon the recommendation of the CFO and at the discretion of the Committee Chair. The CEO is an ex-officio member of this Committee.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review performance of consultant recommendations of managers and asset allocations | Each quarter - ongoing | Committee to review selection of money managers and make recommendations to the CFO \| **Completed** |
| **2.** Education Topic: Investment Allocation in Uncertain Times | FY2022 Q1 | Complete by the August 2021 meeting \| **Completed** |
| **3.** Asset Allocation, Investment Policy Review and ERM framework including Efficient Frontier | FY2022 Q3 | Completed by ~~March 2022~~ June 2022\| **Completed** |

**SUBMITTED BY:**
**Chair**: Brooks Nelson
**Executive Sponsor**: Carlos Bohorquez, CFO

El Camino Health

# FY22 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

## PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods, and assuring appropriate resource allocation to achieve this purpose.

**STAFF**: **Holly Beeman, MD, MBA** Chief Quality Officer (Executive Sponsor)

The CMO 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 clinical representatives and 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. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality | - FY21 Achievement and Metrics for FY22 (Q1 FY22)<br>- FY23 Goals (Q3 – Q4) | Review management proposals; provide feedback and make recommendations to the Board **Completed** |
| **2.** Alternatively (every other year) review peer review process and medical staff credentialing process; include OPPE and FPPE education | Q2, Q3 | - Receive update on implementation of peer review process changes (FY22) - **Completed**<br>- Receive update on OPPE and FPPE (FY22) - **Completed** |
| **3.** Review Quality, Patient Care and Patient Experience reports and dashboards | - FY22 Quality Dashboard (Q1-Q2 review; monthly consent for review and discussion, if needed)<br>- CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS),<br>- Leapfrog, CMS Star, Readmission Penalty, HAC penalty, VBP results annually | Review reports per Pacing Plan timeline – **Completed** |
| **4.** Review Board Dashboard using STEEEP Methodology and propose changes as appropriate | Semi – Annually Q2 and Q4 | Review Dashboard and Recommend Changes to the Board - **Completed** |
| **5.** All committee members regularly attend and are engaged in committee meeting preparation and discussions | Using closing wrap up time, review quarterly at the end of the meeting | Attend 2/3 of all meetings in person - **N/A (AB361)**<br>Actively participate in discussions at each meeting - **Completed** |

**SUBMITTED BY**: **Chair**: Julie Kliger, MPA, BSN
**Executive Sponsor**: Holly Beeman, MD, MBA, CQO

El Camino Health

# FY22 COMMITTEE GOALS
## Governance Committee

**PURPOSE**

The purpose of the Governance Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, *i.e.*, the nomination and appointment/reappointment process. The Governance Committee ensures the Board and Committees are function at the highest level of governance standards.

**STAFF**: **Dan Woods**, Chief Executive Officer (Executive Sponsor)

The CEO 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.** Review the governance structure of the Hospital Board, conduct research, and make recommendations on preferred competencies | Q1 FY22<br><br>Q4 FY22<br><br>Q1 FY22 | - Recommendation for high-priority Hospital Board member competencies made to Hospital and District Board **(Completed)**<br>- Chair nominates Governance Committee member to serve on District Board Ad Hoc Committee and participate in the Non-District Board Member recruitment/interview process as requested by the District Board **(Completed)**<br>- Assess implementation of changes to ECH Board Structure and make recommendations **(Completed)** |
| **2.** Promote, enhance, and sustain competency-based, efficient, effective governance | Q4 FY21 – Q1 FY23<br><br>Q2- FY22 | - FY21 Self-Assessment Survey Completed (Q1 FY22) **(Completed)**<br>- FY22 Self-Assessment Tool recommended to the Board (Q3) and survey completed (Q4 FY22 – Q1 FY23) **(Completed)**<br>- Reports are completed and made available to the Board and the District Board (Q1) **(Completed)**<br>- Develop FY22 Board Action Plan (Q2) **(Completed)** |
| **3.** Develop Board and Committee Education Plan for FY21 | Q2 FY22<br>Q1 FY22 | - Develop and recommend FY22 Board and Committee Education Plan **(Completed)**<br>- Recommend FY22 Annual Retreat Agenda to the Board **(Completed)** |
| **4.** Propose a strategy to increase diversity to the Hospital Board and Committees | Q2 FY22 | - Develop and recommend a strategy to the Hospital Board on increasing diversity to the Hospital Board of Directors and the committees **(Completed)** |

**Chair**: Don Watters
**Executive Sponsor**: Dan Woods

El Camino Health

# FY23 COMMITTEE GOALS

Compliance and Audit Committee

## PURPOSE

The purpose of the Compliance and Audit Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight of Corporate Compliance, Privacy, Internal and External Audit, Enterprise Risk Management, and Information Technology (IT) Security. The Committee will accomplish this by monitoring the compliance policies, controls, and processes of the organization and the engagement, independence, and performance of the internal auditor and external auditor. The Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

**STAFF**: **Diane Wigglesworth**, Sr. Director, Corporate Compliance (Executive Sponsor)

The Sr. Director, Corporate Compliance, 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 or outside consultants may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the results of an enterprise Compliance Program Effectiveness Review for the hospital and all affiliated entities conducted by a third party. | Q2 FY23 | Committee reviews report and gap analysis and provides recommendations to the Compliance Officer. |
| **2.** Review and evaluate the enterprise's standardized due diligence pre-acquisition process for physician mergers, acquisitions, or individual recruitment into affiliated medical groups. | Q3 FY22 | Committee reviews and provides recommendations to the Compliance Officer and CEO. |

**SUBMITTED BY**:

**Chair**: Jack Po, MD
**Executive Sponsor**: Diane Wigglesworth

El Camino Health

# FY23 COMMITTEE GOALS AND PACING PLAN

## Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

**STAFF**: **Greg Souza**, Interim Chief Human Resources Officer (Executive Sponsor)

The CHRO 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 and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

| GOALS | TIMELINE | METRICS/PACING PLAN |
|---|---|---|
| **1.** Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design | **Q1** | - Review and approve FY23 executive base salaries<br>- Review and recommend FY22 Organizational Incentive Score<br>- Review and approve FY22 individual incentive scores<br>- Review and approve FY22 executive payout amounts |
| | **Q3** | - Recommend FY24 Committee goals<br>- Receive update leadership development<br>- Receive update on strategic plan<br>- Review potential policy changes |
| | **Q4** | - Review and recommend proposed FY24 organizational incentive goals<br>- Review and approve FY24 individual executive strategic pick goals |
| **2.** Evaluate the effectiveness of the independent compensation consultant | **Q4** | - Conduct annual evaluation of ECC consultant |

**SUBMITTED BY**: **Chair**: Bob Miller | **Executive Sponsor**: Greg Souza

El Camino Health

# 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

El Camino Health

# FY23 COMMITTEE GOALS

Investment Committee

## PURPOSE

The purpose of the Investment Committee is to develop and recommend to the El Camino Hospital (ECH) Board of Directors ("Board") the investment policies governing the Hospital's assets, maintain current knowledge of the management and investment funds of the Hospital, and provide oversight of the allocation of the investment assets.

**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 or hospital staff may participate in the meetings upon the recommendation of the CFO and at the discretion of the Committee Chair. The CEO is an ex-officio member of this Committee.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review performance of consultant recommendations of managers and asset allocations | Each quarter - ongoing | Committee to review selection of money managers and make recommendations to the CFO |
| **2.** Education Topic: Investment Allocation in Uncertain Times | FY23 Q1 | Complete by the August 2022 meeting |
| **3.** Asset Allocation, Investment Policy Review and ERM framework including Efficient Frontier | FY23 Q3 | Completed by March 2023 |

**SUBMITTED BY:**
**Chair**: Brooks Nelson
**Executive Sponsor**: Carlos Bohorquez, CFO

El Camino Health

# FY23 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

## PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods, and assuring appropriate resource allocation to achieve this purpose.

**STAFF**: **Holly Beeman, MD, MBA,** Chief Quality Officer (Executive Sponsor)

The CQO and Senior Director of Quality shall serve as the primary staff to support the Committee and are responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives and 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. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large. The

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality | - FY22 Achievement and Metrics for FY22 (Q1 FY23)<br>- Review FY23 Incentive Goal recommendations for Quality, Safety and Patient Experience measures | Review management proposals; provide feedback and make recommendations to the Board |
| **2.** Every other year, review peer review process and medical staff credentialing process; include OPPE and FPPE education. FY22 process review completed and animated. | FY24 review peer review and credentialing process. | - n/a |
| **3.** Review Quality, Patient Care and Patient Experience reports and dashboards | - Review reports per Pacing Plan timeline. | Explanation of measure methodology and benchmarks included with each report. |
| **4.** Review Board Dashboard using STEEEP Methodology and propose changes as appropriate | Semi – Annually Q2 and Q4 | Review Dashboard and Recommend Changes to the Board |
| **5.** All committee members regularly attend and are engaged in committee meeting preparation and discussions | Using closing wrap up time, review quarterly at the end of the meeting | Attend 2/3 of all meetings in person<br>Actively participate in discussions at each meeting |

**SUBMITTED BY**: **Chair**: Julie Kliger, MPA, BSN
**Executive Sponsor**: Holly Beeman, MD, MBDA, Chief Quality Officer

El Camino Health

# FY23 COMMITTEE GOALS

## Governance Committee

**PURPOSE**

The purpose of the Governance Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, *i.e.*, the nomination and appointment/reappointment process. The Governance Committee ensures the Board and Committees are function at the highest level of governance standards.

**STAFF**: **Dan Woods**, Chief Executive Officer (Executive Sponsor)

The CEO 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.** Review the governance structure of the Hospital Board, conduct research, and make recommendations on preferred competencies | Q1 FY23 | - Recommendation for high-priority Hospital Board member competencies made to Hospital and District Board |
| | Q4 FY23 | - Chair nominates Governance Committee member to serve on District Board Ad Hoc Committee and participate in the Non-District Board Member recruitment/interview process as requested by the District Board |
| | Q1 FY23 | - Assess implementation of changes to ECH Board Structure and make recommendations |
| **2.** Promote, enhance, and sustain competency-based, efficient, effective governance | Q4 FY23 – Q1 FY23 | - FY22 Self-Assessment Survey Completed (Q1 FY23)<br>- FY23 Self-Assessment Tool recommended to the Board (Q1) and survey completed (Q4 FY23 – Q1 FY24) |
| | Q2- FY23 | - Reports are completed and made available to the Board and the District Board (Q1)<br>- Develop FY23 Board Action Plan (Q2) |
| **3.** Develop Board and Committee Education Plan for FY23 | Q2 FY23<br>Q1 FY23 | - Develop and recommend FY22 Board and Committee Education Plan<br>- Recommend FY23 Annual Retreat Agenda to the Board |

**Chair**: Don Watters
**Executive Sponsor**: Dan Woods

El Camino Health

DRAFT

# Compliance and Audit Committee

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **STANDING AGENDA ITEMS** | | | | | | | | | | | | |
| Review Results of Internal Audits | | | ✓ | | ✓ | | | ✓ | | ✓ | | ✓ |
| **DISCUSSION ITEMS / COMMITTEE ACTIONS** | | | | | | | | | | | | |
| IT Security Program Status | | | | | ✓ | | | | | | | ✓ |
| Review ERM | | | ✓ | | | | | | | ✓ | | |
| Review Prior FY Enterprise Annual Compliance Report | | | ✓ | | | | | | | | | |
| Review Prior FY Annual Patient Safety/Claim Report | | | ✓ | | | | | | | | | |
| Review and Approve Next FY Hospital and SVMD Compliance Work Plans | | | | | | | | | | | | ✓ |
| Receive Results of Financial Auditors Consolidated Financial Statements | | | ✓ | | | | | | | | | |
| Receive 403(b) and Cash Balance Audit | | | ✓ | | | | | | | | | |
| Review Management's Summary Report of Physician Financial Agreements | | | | | | | | ✓ | | | | |
| Approve Next FY Committee Goals, Dates | | | | | | | | | | ✓ | | |
| Review current FY Annual Financial Audit Plan | | | | | | | | ✓ | | | | |
| Review OIG Work Plan and Management's Response | | | | | | | | ✓ | | | | |
| Review and Approve Next FY Internal Audit Assessment and Work Plan | | | | | | | | | | | | ✓ |
| **Committee Goals** | | | | | | | | | | | | |
| Review Identified Cyber Risks for the Organization | | | | | | | | | | | | ✓ |

El Camino Health

# FY23 COMMITTEE GOALS AND PACING PLAN

## Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

**STAFF**: **Greg Souza**, Interim Chief Human Resources Officer (Executive Sponsor)

The CHRO 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 and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

| GOALS | TIMELINE | METRICS/PACING PLAN |
|---|---|---|
| **1.** Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design | **Q1** | - Review and approve FY23 executive base salaries<br>- Review and recommend FY22 Organizational Incentive Score<br>- Review and approve FY22 individual incentive scores<br>- Review and approve FY22 executive payout amounts |
| | **Q3** | - Recommend FY24 Committee goals<br>- Receive update leadership development<br>- Receive update on strategic plan<br>- Review potential policy changes |
| | **Q4** | - Review and recommend proposed FY24 organizational incentive goals<br>- Review and approve FY24 individual executive strategic pick goals |
| **2.** Evaluate the effectiveness of the independent compensation consultant | **Q4** | - Conduct annual evaluation of ECC consultant |

**SUBMITTED BY**: **Chair**: Bob Miller | **Executive Sponsor**: Greg Souza

El Camino Health

# 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**<br>• Standing Consent Agenda Items<br>• Minutes (motion)<br>• Candidate Interviews and Recommendation to Appoint<br>• Financial Report (FY2022 Periods 11 and 12)<br>**Discussion Items**<br>• Financial Report (Pre-Audit Fiscal Year End 2022 Results)<br>• Service Line / Business Affiliate Review: CONCERN<br>• Medical Staff Development Plan<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session<br>• Post Implementation Review ("PIR") Per Attached Schedule | **Approval Items**<br>• Standing Consent Agenda Items<br>• Minutes (motion)<br>• Financial Report (FY2023 Periods 1 and 2)<br>• Financial Report Fiscal Year End 2022 Results<br>**Discussion Items**<br>• Service Line / Business Affiliate Review: ECHMN Update & Urology<br>• Progress Against FY2023 Committee Goals & Pacing Plan<br>• Project Update: Women's and Newborn Hospital Project<br>• PIR<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session |
| **FY2023 FC Pacing Plan – Q2** | | |
| **October 2022** | **November 21, 2022** | **December 2022** |
| **No Scheduled Finance Committee Meeting** | **Approval Items**<br>• Standing Consent Agenda Items<br>• Minutes (motion)<br>• Financial Report (FY2023 Periods 3 and 4)<br>**Discussion Items**<br>• Service Line Review: Orthopedics<br>• Foundation Strategic Plan Update<br>• FY2024 Community Benefit Grant Application Guiding Principles / Process<br>• Review Progress on Opportunities / Risks Identified for FY2023<br>• Strategic Plan Update<br>• PIR<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session | **No Scheduled Finance Committee Meeting** |

**Updated 5/30/22**

El Camino Health

# FY2023 Finance Committee Pacing Plan

| FY2023 FC Pacing Plan – Q3 | | |
|---|---|---|
| **January 30, 2023** | **February 2023** | **March 27, 2023** |
| **5:30pm**<br>**Joint Meeting with the Investment Committee:**<br>**Topic: Long Term Financial Forecast**<br><br>**6:30pm**<br>**Approval Items**<br>• Standing Consent Agenda Items<br>• Minutes (motion)<br>• Financial Report (FY2023 Periods 5 and 6)<br>**Discussion**<br>• Service Line / Business Affiliate Review: ECHMN Quarterly Financial Update & Cardiology<br>• Managed Care Update<br>• PIR<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session | **No Scheduled Finance Committee Meeting** | **Approval Items**<br>• Standing Consent Agenda Items<br>• Minutes (motion)<br>• Financial Report (FY2023 Periods 7 and 8)<br>**Discussion Items**<br>• FY2024 Budget Preview: Key Operating Assumptions / Target<br>• FY2024 Community Benefit Grant Program Update<br>• Summary Physician Financial Arrangements (Year-End)<br>• Service Line Report: Oncology<br>• FY2024 Committee Planning: Goals, Pacing Plan and Meeting Dates<br>• Revenue Cycle Update<br>• PIR<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session |
| **FY2023 FC Pacing Plan – Q4** | | |
| **April 24, 2023** | **May 22, 2023** | **June 2023** |
| **No Scheduled Finance Committee Meeting** | **Approval Items**<br>• Financial Report (FY2023 Period 9 & 10)<br>• Progress Against FY2023 Committee Goals & Pacing<br>• FY2024 Organizational Goals<br>• FY2024 Committee Planning: Goals, Pacing Plan and Meeting Dates<br>• FY2024 El Camino Hospital Community Benefit Grant Program<br>**Discussion Items**<br>• FY2024 Budget: Review Prior to Submission to BOD for Approval<br>• Service Line Report: Pathways JV & ECHMN Quarterly Financial Update<br>• PIR<br>• Report on Board Actions<br>• Other Standing Agenda Items<br>• Executive Session | **No Scheduled Finance Committee Meeting** |

**Updated 5/30/22**

FY2023 INVESTMENT COMMITTEE PACING PLAN **DRAFT**
Proposed 2/14/2022

| FY2023 - Q1 | | |
|---|---|---|
| **JULY – NO MEETING** | **AUGUST 8, 2022 Meeting** | **SEPTEMBER – NO MEETING** |
| Participate in Committee Self –Assessment Survey | ▪ Capital Markets Review and Portfolio Performance<br>▪ Tactical Asset Allocation Positioning and Market Outlook<br>▪ Education Topic: Investing In Uncertain Times<br>▪ CFO Report Out – Open Session Finance Committee Materials | N/A |
| **FY2023 - Q2** | | |
| **OCTOBER – NO MEETING** | **NOVEMBER 14, 2022 Meeting** | **DECEMBER – NO MEETING** |
| *Board and Committee Educational Session* | ▪ Capital Markets Review and Portfolio Performance<br>▪ Tactical Asset Allocation Positioning and Market Outlook<br>▪ Investment Policy Review<br>▪ CFO Report Out – Open Session Finance Committee Materials | N/A |
| **FY2023 - Q3** | | |
| **JANUARY 23, 2023** | **FEBRUARY 13, 2023 Meeting** | **MARCH – NO MEETING** |
| *Joint Finance Committee and Investment Committee meeting: Long Range Financial Forecast* | ▪ Capital Markets Review and Portfolio Performance<br>▪ Tactical Asset Allocation Positioning and Market Outlook<br>▪ CFO Report Out – Open Session Finance Committee Materials<br>▪ Proposed FY2024 Goals/Pacing Plan/Meeting Dates<br>▪ Asset Allocation and ERM Framework | N/A |
| **FY2023 - Q4** | | |
| **APRIL – NO MEETING** | **MAY 8, 2023 Meeting** | **JUNE – NO MEETING** |
| *Board and Committee Educational Session* | ▪ Capital Markets Review and Portfolio Performance<br>▪ Tactical Asset Allocation Positioning and Market Outlook<br>▪ CFO Report Out – Open Session Finance Committee Materials<br>▪ 403(b) Investment Performance<br>▪ Approve FY2024 Committee Goals<br>▪ Review status of FY2023 Committee Goals | N/A |

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE**
**FY23 Pacing Plan - DRAFT**

| FY2023 Q1 | | |
|---|---|---|
| **JULY 2022** | **AUGUST 1, 2022** | **SEPTEMBER 6, 2022** |
| No Committee Meeting<br><br>Routine (Always) Consent Calendar Items:<br>▪ Approval of Minutes<br>▪ Report on Board Actions<br>▪ FY 23 Enterprise Quality Dashboard<br>▪ Progress Against FY 2023 Committee Goals (Quarterly)<br>▪ FY23 Pacing Plan (Quarterly)<br>▪ Med Staff Quality Council Minutes (Closed Session)<br>▪ Quality Committee Follow-Up Items | Standing Agenda Items:<br>1. Consent Calendar<br>a. FY23 Pacing Plan<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items<br>5. Health Care Equity<br>6. Q4 FY22 **STEEEP** Dashboard Review<br>7. EL Camino Health Medical Network Report<br>8. Q4 FY22 Quarterly Quality and Safety Review of reportable events | Standing Agenda Items:<br>1. Consent Calendar<br>a. ED Patient Satisfaction<br>b. Progress Against FY 2023 Committee Goals<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda items:<br>5. Annual Patient Safety Report<br>6. Pt. Experience (HCAHPS)<br>7. High Reliability progress |
| **FY2023 Q2** | | |
| **OCTOBER 2022** | **NOVEMBER 7, 2022** | **DECEMBER 5, 2022** |
| No Committee Meeting | Standing Agenda Items:<br>1. Consent Calendar<br>a. CDI Dashboard<br>b. Core Measures<br>c. FY23 Pacing Plan<br>d. Safety Report for the Environment of Care<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Culture of Safety Survey Results<br>6. Q1 FY23 Quarterly **STEEEP** Dashboard Review<br>7. EL Camino Health Medical Network Report<br>8. Q1 FY23 Quarterly Quality and Safety Review of reportable events<br>9. Medical Staff Office Audit Report | Standing Agenda Items:<br>1. Consent Calendar<br>a. Progress Against FY 2023 Committee Goals<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda items:<br>5. Report on Medical Staff Peer Review Process<br>6. Safety Report for the Environment of Care<br>7. PSI Report<br>8. Readmission Dashboard<br>9. Sepsis Mortality Index |

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE**
**FY23 Pacing Plan - DRAFT**

| FY2023 Q3 | | |
|---|---|---|
| **JANUARY 2023** | **FEBRUARY 6, 2023** | **MARCH 6, 2023** |
| No Committee Meeting<br><br>Routine (Always) Consent Calendar Items:<br>▪ Approval of Minutes<br>▪ Report on Board Actions<br>▪ FY 23 Enterprise Quality Dashboard<br>▪ Progress Against FY 2023 Committee Goals (Quarterly)<br>▪ FY23 Pacing Plan (Quarterly)<br>▪ Med Staff Quality Council Minutes (Closed Session)<br>▪ Quality Committee Follow-Up Items | Standing Agenda Items:<br>1. Consent Calendar<br>a. FY23 Pacing Plan<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Q2 FY23 **STEEEP** Dashboard Review<br>6. EL Camino Health Medical Network Report<br>7. Q2 FY23 Quarterly Quality and Safety Review of reportable events | Standing Agenda Items:<br>1. Consent Calendar<br>a. Progress Against FY 2023 Committee Goals<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Health Care Equity<br>6. High Reliability progress |
| **FY2023 Q4** | | |
| **APRIL 3, 2023** | **MAY 1, 2023** | **JUNE 5, 2023** |
| Standing Agenda Items:<br>1. Consent Calendar<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Value Based Purchasing Report<br>6. Propose FY24 Quality Committee Goals<br>7. Propose FY24 Committee Meeting Dates<br>8. Propose FY24 Enterprise Organizational Goals | Standing Agenda Items:<br>1. Consent Calendar<br>a. CDI Dashboard<br>b. Core Measures<br>c. FY23 Pacing Plan<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Q3 FY23 **STEEEP** Dashboard Review<br>6. Approve FY24 Organizational Goals, QC Charter, FY24 Pacing Plan, and FY24 QC dates<br>7. EL Camino Health Medical Network Report<br>8. Q3 FY23 Quarterly Quality and Safety Review of reportable events | Standing Agenda Items:<br>1. Consent Calendar<br>a. Leapfrog<br>b. Progress Against FY 2023 Committee Goals<br>2. Patient Story<br>3. Serious Safety/Red Alert Event as needed<br>4. Credentials and Privileges Report<br><br>Special Agenda Items:<br>5. Medical Staff Credentialing Process<br>6. Approve Quality Assessment and Performance Improvement Plan (QAPI) |

El Camino Health

DRAFT

# Governance Committee

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **STANDING AGENDA ITEMS** | | | | | | | | | | | | |
| Consent Agenda items | | ✓ | | ✓ | | | | ✓ | | | ✓ | |
| Approve Minutes | | ✓ | | ✓ | | | | ✓ | | | ✓ | |
| **DISCUSSION ITEMS / COMMITTEE ACTIONS** | | | | | | | | | | | | |
| Board Education | | ✓ | | | | | | ✓ | | | | |
| Board Actions | | ✓ | | | | | | | | | | |
| Assess ECH Board Structure | | ✓ | | | | | | | | | | |
| Confirm Self-Assessment Sent to District | | ✓ | | | | | | | | | | |
| GC Self-Assessment Results | | | | ✓ | | | | | | | | |
| Review Policy and Procedure for Advisory Committee Member Nomination Selection | | | | ✓ | | | | | | | | |
| Assess Progress against Board Against Plan | | | | | | | | ✓ | | | ✓ | |
| Hospital Board Member Competencies, Including Diversity | | | | | | | | ✓ | | | | |
| Delegation of Authority to Approach ECH Community Benefit Grant Funding to Finance Committee | | | | | | | | ✓ | | | | |
| Set Gov. Committee Dates | | | | | | | | ✓ | | | | |
| Assess Governance Structure Resiliency | | | | | | | | ✓ | | | | |
| Review Advisory Committee Structure | | | | | | | | ✓ | | | | |
| Develop next FY Gov. Committee Goals | | | | | | | | | | | ✓ | |
| Review Advisory Committee and Committee Chair Assignments | | | | | | | | | | | ✓ | |
| Review Progress Against Goals | | | | | | | | | | | ✓ | |
| Finalize Next FY Master Calendar | | | | | | | | | | | ✓ | |
| **PLANNING SESSIONS** | | | | | | | | | | | | |
| Plan for October Joint Education Session | | ✓ | | ✓ | | | | | | | | |
| Board Education Plan | | | | ✓ | | | | | | | | |
| Plan for February Board Retreat | | | | ✓ | | | | | | | | |
| Plan for April Board Education Session | | | | | | | | ✓ | | | | |

El Camino Health

# FY23 El Camino Hospital Board of Directors
# Advisory Committee & Liaison Appointments

| COMMITTEE APPOINTMENTS | | | | | | |
|---|---|---|---|---|---|---|
| COMMITTEE | COMPLIANCE & AUDIT | EXEC COMPENSATION | FINANCE | GOVERNANCE | INVESTMENT | QUALITY |
| CHAIR | Jack Po, MD | Bob Miller | Don Watters | Lanhee J. Chen | Brooks Nelson | Carol Somersille, MD |
| BOARD MEMBERS | Lanhee J. Chen | Julie Kliger | Peter C. Fung, MD | Don Watters | Peter C. Fung, MD | Jack Po, MD |
| | Julie Kliger | George O. Ting, MD | | Julia E. Miller | John Zoglin | John Zoglin |
| | Julia E. Miller | Carol Somersille, MD | | | | |
| COMMUNITY MEMBERS | Lica Hartman | Teri Eyre | Joseph Chow | Christina Lai | Nicola Boone | Alyson Falwell |
| | Sharon Anolik Shakked | Jaison Layney | Wayne Doiguchi | Ken Alvares | John Conover | Krutica Sharma |
| | Christine Sublett | Estrella Parker | Bill Hooper | Mike Kasperzak | Richard Juelis | Melora Simon |
| | | Alessandra Yockelson | Cynthia Stewart | | | Terrigal Burn, MD |
| MEDICAL STAFF OFFICERS & MEDICAL NETWORK BOARD MEMBERS | | | | | | Prithvi Legha, MD |
| | | | | | | Philip Ho, MD |
| | | | | | | Steve Xanthopoulos, MD *Alternate* |
| | | | | | | Shahram Gholami, MD *Alternate* |

| LIAISON APPOINTMENTS | | LEGEND: *Hospital Board Members *District Board Members *Community & Staff Members | |
|---|---|---|---|
| COMMUNITY BENEFIT ADVISORY COUNCIL (CBAC) (Liaison) | Carol Somersille, MD | ECH FOUNDATION BOARD OF DIRECTORS (Liaison) | Julia E. Miller |

**Approved by Hospital Board of Directors: TBD**

**Updated by Lanhee Chen & Bob Rebitzer: 6/3/2022**

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# El Camino Hospital Board of Directors
# Quality, Patient Care and Patient Experience Committee Charter

## Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). The Committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the Organization's strategic plan related to delivering high quality healthcare to all patients. High quality care is defined as care that is: safe, timely, effective, efficient, equitable, and person-centered.

The Organization will provide to the Committee standardized quality metrics with appropriate benchmarks so that the Committee can adequately assess the level of quality care being provided.

## Authority

All governing authority for the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated to a specific board committee. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. 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, *ex-officio* members and alternates 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 Committee shall also include the Enterprise Chief of the Medical Staff and the Los Gatos Campus Chief of Staff as *ex officio* voting members of the Committee. The Enterprise Vice Chief of Staff or the Los Gatos Vice Chief of Staff shall serve as alternate voting members of the Committee and replace, respectively the Enterprise Chief of Staff or the Los Gatos Chief of Staff if such person is absent from a Committee meeting.

- The Quality Committee may also include 1) no more than nine (9) Community members[1] with expertise in in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors or *ex-officio* members or alternates.

integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine Community members are recommended to serve on this Committee.

- All Committee members, with the exception of new Community members, *ex-officio* members and alternates, 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 each year, 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 Director, the Vice Chair of the Committee shall be a Hospital Board Director.

## Staff Support and Participation

The Chief ~~Medical~~ Quality Officer (CQ~~M~~O) 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 clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the CQ~~M~~O and subsequent approval from both the CEO and Committee Chair..

## General Responsibilities

The Committee's primary role is to develop a deep understanding of the Organizational strategic plan, the quality plan, and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. 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 1) ensuring that performance metrics meet the Board's expectations; 2) align those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring that communication to the Board and external constituents is well executed.

## Specific Duties

The specific duties of the Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT).

- Review and approve an annual "Quality Dashboard" for tracking purposes.

- Oversee management's development of the Organization's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services.

- Review reports related to Organization-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:

    - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - Organization-wide patient safety goals and hospital performance relative to patient safety targets.
    - Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - Organization-wide LEAN management activities and cultural transformation work.
    - Organization-wide patient satisfaction and patient experience surveys.
    - Organization-wide physician satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to including, but limited to, The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.

- Review Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts as per the hospital and board policy.

- Oversee organizational quality and safety performance improvement for both the Organization's and medical staff activities.

- Ensure that the Organization's scope of service and community activities and resources are responsive to community need.

- Review the Medical Executive Committee's monthly credentialing and privileging reports and make recommendations to the Board.

## Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

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## 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. 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.

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# El Camino Hospital Board of Directors
# Executive Compensation Committee Charter

## Purpose

The purpose of the Executive Compensation Committee ("Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee shall advise the Board to meet all applicable legal and regulatory requirements as it relates to executive compensation.

## Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, engage and supervise a consultant to advise the Board and the Committee on executive compensation issues. 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.

## Membership

- The Executive Compensation Committee shall be comprised of two (2) or more Hospital Board members. The Committee may also include 2-5~~4~~ Community[1] members with knowledge of executive compensation practices, executive leadership and/or corporate human resource management.

- Executive compensation consultants will be retained as appropriate and participate as directed.

- 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.

- 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.

- All members of the Committee must be independent directors with no conflict of interest regarding compensation or benefits for the executives whose compensation is reviewed and recommended by the Committee. Should there be a potential conflict, the determination regarding independence shall follow the criteria approved by the Board and as per the Independent Director Policy (*see* attached Appendix).

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

## Staff Support and Participation

The Chief Human Resources Officer 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. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may attend meetings at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

## General Responsibilities

The Committee is responsible for recommending to the full Board policies, processes and procedures related to executive compensation philosophy, operating performance against standards, executive development and succession planning.

## Specific Duties

The El Camino Hospital Board has adopted Resolution 2018-05 delegating certain decision-making authority to the Executive Compensation Committee. Resolution 2018-05 controls in the case of any inconsistency between this Charter and the Resolution or attachments to the Resolution. The specific duties of the Executive Compensation Committee include the following:

**A. Executive Compensation**

- Develop a compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based. Recommend the philosophy for approval by the Board.
- Develop executive compensation policies to be approved by the Board.
- Review and maintain an executive compensation and benefit program consistent with the executive compensation policies, which have been approved by the Board. Recommend any material changes in the program for approval by the Board.
- Review the CEO's salary range, performance incentive program, benefit plan, and perquisites. Recommend to the Board any salary change to base salary range and/or base salary as well as performance incentive payouts based on organizational performance.
- Review the CEO's recommendations regarding salary and performance incentive payouts for the upcoming year for the executives whose compensation is subject to review by the Committee based on the CEO's evaluation of the executives' individual performance. Approve recommendations for any salary range or base salary changes and/or any performance incentive payouts within established guidelines based on the CEO's evaluation of the executives' individual performance. Recommend to the Board any salary changes and/or performance incentive payments that are outside established guidelines.
- Periodically evaluate the executive compensation program, including the charter, policies, and philosophy on which it is based, to assess its effectiveness in meeting the Hospital's needs for recruiting, retaining, developing, and motivating qualified leaders to execute the Hospital's strategic and short term objectives..

- ~~Periodically review the total value, cost and reasonableness of severance and benefits for executives.~~

- ~~Annually review and present for Board acceptance the letter of rebuttable presumption of reasonableness.~~

- Review market analyses and recommendation of the Committee's independent executive compensation consultant.

- Approve ~~-~~salary ranges for each new executive and approve placement in the range for those executives eligible for the plan within established guidelines. Recommend a salary range to the Board and placement therein for the CEO and or actions for other executives that are outside established guidelines.

**B. Performance Goals Setting and Assessment**

- Review and provide input into the CEO's recommendations regarding annual organization goals and measures used in the Executive Performance Incentive Plan. Recommend organizational performance incentive goals and measurements for approval by the Board.

- Provide input into establishing the CEO's annual individual performance incentive goals and performance appraisal process to execute the Hospital's strategic plan. Recommend the CEO's individual annual goals and measures for approval by the Board.

- Provide input into establishing the executive team's annual performance incentive goals to execute the Hospital's strategic plan and approve the annual goals and measures.

**C. Executive Succession and Development**

- Review annually the CEO's own succession plan, including a leadership and professional development plan based on the previous year's talent assessment.

- Review annually the CEO's succession plan for the executive team members, which shall include the process by which potential executives are identified and developed.

## Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and workplan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. In addition, the Committee shall provide counsel and advice to the Board as requested.

## 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. 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 advisory 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 advisory committees may also be called by resolution of the Board and the Committee Chair. Notice of any special meetings of the Committee requires a 24 hour notice.

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# Appendix

## Definition of Independent Director – Compensation Committee

1. An independent director is a more limited and narrow classification of director than otherwise required by law and is not meant to expand or limit the definition of interested director for purposes of the El Camino Hospital Conflict of Interest Policy or to expand or reduce the scope of any legal duty or otherwise applicable legal obligation of a director. The Board of Directors, by separate resolution, may determine to limit membership on particular committees to independent directors to avoid even the appearance of a conflict of interest.

2. A member of the Board of Directors of El Camino Hospital shall be deemed to be an independent director so long as such director (and any spouse, sibling, parent, son or daughter, son- or daughter-in-law or grandparent or descendant of the director):

    i. has not, within the preceding twelve (12) months, received payments from El Camino Hospital, a subsidiary or affiliate of El Camino Hospital in excess of Ten Thousand Dollars ($10,000), excluding reimbursement of expenses or other permitted payments to a director related to service as a director;

    ii. does not own an interest in an entity, or serve as a Board member or executive of an entity, that is a direct competitor of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital) for patients or services, located within ten (10) miles of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital). An entity is not a direct competitor if it provides competing services in the above area that do not exceed ten percent (10%) of such entity's revenues.

3. If a director is an owner of an entity, then the amount received from El Camino Hospital during any period shall be determined by multiplying the percentage ownership interest of the director in such entity by the total amount paid by El Camino Hospital to such entity during such period.

4. Each director appointed to the Compensation Committee and the Compliance and Internal Audit Committee shall be, at the time of appointment and while a member of such Committee, an independent director as defined above.

5. **Note**: Other laws may prohibit certain contracts or interests in their entirety and this definition is not intended to narrow or otherwise limit the application of any such law.

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**EL CAMINO HOSPITAL BOARD OF DIRECTORS**
**BOARD MEETING MEMO**

**To:** El Camino Hospital Board of Directors
**From:** Apurva Marfatia, MD, Enterprise Chief of Staff
Michael Kan, MD Chief of Staff Los Gatos
**Date:** June 8, 2022
**Subject:** Medical Staff Report – Open Session

**Recommendation:**

To approve the Medical Staff Report, including Policies and Procedures identified in the attached list

**Summary:**

**1.** Situation: The Medical Executive Committee met on May 26, 2022

**2.** Background: MEC received the following informational reports.

a. Quality Council – The Quality Council met on May 4, 2022. Reports and performance dashboards were reviewed and approved by the following ECH Departments/Service Lines:
   I. Core Measures PI Report CY 2021
   II. Hospital-Basedased Inpatient Psychiatric Services Core Measures CY 2021
   III. CPR PI Report CY 2021
   IV. Clinical Laboratory and Pathology Services FY 2022

b. Leadership Council – The Leadership Council met on May 10, 2022, and discussed the following:

   I. Inauguration update
   II. MICRA update
   III. PEC Membership
   IV. HRO Training
   V. Changes to the Rules & Regulations
   VI. Vice-Chair Surgery; Los Gatos
   VII. Low Volume Physicians
   VIII. Medical Directors (Pulmonary and ICU)

c. The CEO Report was provided
d. The CMO Report was provided
e. The CNO Report was provided

**List of Attachments:** Policies, Plans and Scope of Services

**Suggested Board Discussion Questions:** None

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**EL CAMINO HOSPITAL BOARD OF DIRECTORS**
Policies, Plans, and Scope of Services for Review
June 8, 2022

| Department | Policy Name | Change | Document | Notes | Committee Approvals |
|---|---|---|---|---|---|
| **New Business** | | | | | |
| Pharmacy | 1. Multidisciplinary Drug Diversion Surveillance | Revised | Policy | Updated Sections: Purpose and Procedure | • P&T<br>• ePolicy |
| Respiratory Care | 2. Scope of Service: Respiratory Care Services | Revised | Scope of Svc | Updated Sections: Types and Ages of Patients Served, and Organization, Chain of Command, Level of Supervision | • Dept Med Dir<br>• ePolicy<br>• MEC |
| Safety & Security | 3. Workplace Violence Prevention Plan | None | Plan | No Changes; 3-year approval (Regulatory Requirement) | • Central Safety<br>• PESC<br>• ePolicy<br>• MEC |
| Patient Experience | 4. Administrative – Complaint and Grievance Management | Revised | Policy | Updated Sections: Definitions and Procedure | • ePolicy<br>• MEC |
| Palliative Care | 5. Scope of Service – Palliative Care Services | Revised | Scope of Svc | Updated Sections: Types and Ages of Patient Served, Scope and Complexity, Appropriateness, Necessity, and Timeliness of Services, Staffing, and Standard of Practice | • Med Dept Exec Cmte<br>• ePolicy<br>• MEC |
| Clinical Education | 6. Musculoskeletal Injury Prevention Plan and Policy (MIPP) | Revised | Plan | Minor change | • Safe Patient Handling<br>• HR Leadership<br>• ePolicy<br>• MEC |
| Compliance | 7. Privacy Breach Notification | Revised | Procedure | Updated Sections: Purpose and Procedure | • Compliance Dir<br>• ePolicy<br>• MEC |
| Rehab Services | 8. Scope of Service: Rehabilitation Services | Revised | Scope of Svc | Updated Sections: Scope and Complexity of Services Offered, Rehabilitation Services Provides, and Standards of Practice | • Dept Med Dir<br>• ePolicy<br>• MEC |

Status **Pending** PolicyStat ID **11058826**

El Camino Health

| | |
|---|---|
| Origination | 11/2020 |
| Last Approved | N/A |
| Effective | Upon Approval |
| Last Revised | 02/2022 |
| Next Review | 3 years after approval |

| | |
|---|---|
| Owner | Jen Huang |
| Area | Pharmacy |
| Document Types | Policy |

# Multidisciplinary Drug Diversion Surveillance



## COVERAGE:

All El Camino Health Staff, Anesthesiologists and Patient Care Providers.

## PURPOSE:

To have a MultiDisciplinary Team (MDT) for Medication Diversion Prevention that is charged with developing a coordinated and systematic approach to prevent, detect and report medication diversion. MDT must meet periodically, at a minimum, ~~on a monthly basis~~4 times a year.

A comprehensive drug diversion prevention and detection program includes core administrative elements (e.g. legal and regulatory requirements, organizational oversight and accountability), system-level controls (human resource management, automation and technology, monitoring and surveillance, and investigation and reporting), and provider level controls (e.g. chain of custody; storage and security; internal pharmacy controls; prescribing and administration; returns, waste, and disposal).

- To ensure patient safety related to Controlled Substances (CS) administration with appropriate dosing regimen and assessments.
- To provide a consistent process for surveillance of early detection of drug diversion, medication control irregularities and effective actions taken.
- To describes measures to ensure safe controlled substance management for all processes related from procurement to wastage.
- To monitor controlled substances by utilizing technology tools such as Diversion Detection software.
- To train employees on their roles in CS management and diversion prevention.

- To comply with federal and state controlled substance laws and regulation. The MDT Committee has the responsibilities and oversight on CS management at El Camino Health.

Establishing a sustainable drug diversion prevention program requires engaged leadership oversight that promotes a culture of organizational awareness, implements and evaluates the effectiveness of systems and processes, and works toward continuous improvement. With this approach, we will improve patient and provider safety and benefit the community we serve.

# DEFINITIONS:

MDT: MultiDisciplinary Team

CS: Controlled Substances per FDA Scheduled medication

ADCs: Automated Dispensing Cabinets

EHR: Electronic Health Record

Drug Diversion: the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use.

Chain-of-custody: Chain-of-custody procedures and documentation are utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations.

HIPAA: Health Insurance Portability & Accountability Act



# REFERENCES:

Condition of Participation: (State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals)

§482.13 (c)(2) – The patient has the right to receive care in a safe seting– Hospital must protect vulnerable patients and identify and evaluate problems and patterns of incidents.

§482.25(a)(3) – Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.

DEA: https://www.deadiversion.usdoj.gov/crim_admin_actions/

Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis) PolicyStat ID: 7660821 Revised 5/2020

Pyxis Anesthesia System PolicyStat ID: 7624626 Revised 5/2020

Reporting by Pharmacy Personnel of Theft of Controlled Substances or Impairment PolicyStat ID: 7380242

https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1301.76

https://www.deadiversion.usdoj.gov/fed_regs/rules/2005/fr0812.htm

# PROCEDURE:

System specific and appropriate actions required to effective management of ALL stages of medication use process to prevent drug diversion prevention.

A. MDT must meet periodically, at a minimum, ~~on a monthly basis~~4 times a year.~~.~~

B. The following individuals are required MDT members: Administration, Physician (anesthesiologists), Nursing Leadership, Pharmacy, Risk Management and Compliance/Legal. ~~Mandatory MDT members that are unable to attend an MDT meeting must notify the Director of Pharmacy or designee prior to the meeting and ensure an alternate member is present.~~

C. The following individuals are Ad Hoc members: HR & Employee Health, Diversion Specialist, Environmental Care and Security,

D. MDT meeting minutes clearly capture discussion about events, actions to be taken, and follow-up of prior month's unresolved issues. MDT meeting minutes, including ad hoc meetings, are documented on most up-to-date MDT Meeting Minutes Template and capture all required audits/reviews.

E. ~~Proactive Diversion Reporting and Reviews utilizing Diversion Detection Software are conducted pursuant to the Medication Diversion Prevention MDT.~~Proactive Diversion Reporting and Reviews utilizing Diversion Detection Software are conducted pursuant to the Medication Diversion Prevention MDT.

   1. Drug surveillance software will compare activities with prescribed doses, MAR documentation and Automated Dispensing Cabinets wastage.
   2. Managers will attempt to reconcile open alerts within 3 days of the initial event. Findings will be documented within the event contained in the surveillance software.
   3. Pharmacy will review documented responses and close alerts that are reconciled for appropriateness.
   4. For discrepancies that could not be reconciled, these cases will be brought to the Committee for discussion/follow up.

F. All suspected, active, and confirmed diversions are reported immediately to the Pharmacist in Charge~~, DEA registrant, and~~ and/or members of MDT.

G. Surveillance of Controlled Substance Procurement: The receiving process includes a reconciliation of controlled substances received against the invoice of purchase and subsequently load to the Narc Vault. Note and document any shortage, breakage, or discrepancy on the invoice / Controlled Substance received.

   1. Maintaining the purchasing summary available from drug suppliers, or a written history of all controlled substance purchases made by the facility for the month, sorted by date

H. Surveillance of Controlled Substances Storage:

   1. Controlled substances and PCA keys in patient care areas, pharmacy and/or designated storage areas are maintained in Automated Dispensing Cabinets (ADCs ), or mobile storage device (clear box secured on IV pole for IVPBs containing

Controlled Substances).

2. Controlled substances administered via Patient-Controlled Analgesia (PCA) pumps and epidural pumps are administered in locked systems.
3. During delivery of Controlled Substances to the units, the cart is lockable and the technicians attend to the cart.

I. Surveillance of Controlled Substances Dispensing:

1. Override Monitoring: Controlled substances removed utilizing the override functionality are reviewed and reconciled ~~daily by the pharmacy staff designee~~ to ensure the existence of a valid corresponding order. (also refer to Policy: PolicyStat ID: 7660841: Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)
2. ~~Chain of Custody Documentation: only conducted in rare situations and fully document in the EHR.~~Chain of Custody: Chain-of-custody is utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations of Controlled Substances Administration.
3. Anesthesia Audit: Assess medication dispensed, medication documented, dose documented, amount wasted, witness signature, Chain of Custody (if appropriate), appropriate variance reporting and follow up if necessary.

J. Surveillance of ~~Chain-of-custody~~Controlled Substance Administration Time: ~~Documentation of chain-of-custody is utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations of Controlled Substances Administration~~

1. Timely Administration of CS: Ensure the time retrieval from ADC to the administration to the patients meet the policy requirement (within 30 minutes for stat medication and within 60 minutes for routine medication).
2. Monitoring Patients' Response: Ensure medication administered in compliance with pain scale prescribed.
   Conduct pain assessments per pain assessment policy.
3. Pain score assessments and documentations to be recorded timely and accurately in iCare.

K. Surveillance of Controlled Substances Wastage, Returns and Disposal.

1. Non-retrievable Waste Container in compliant with TJC Standards and DEA non-retrievable requirement. Pro-actively swap out as needed or no longer than every 90 days by the vendor per agreement regardless of fill levels.
2. Expired controlled substances removed from the inventory are placed in a designated expired controlled substances drawer/bin in a locked area separate from non-controlled medications until the time of removal.
3. ~~Expired~~At Pharmacy, expired controlled substances are reconciled by the person holding a DEA Power of Attorney (POA) with the DEA-222 form provided by the reverse distributor.

L. ~~Resolution of unreconciled CS discrepancies:~~

1. ~~Unreconciled discrepancies resulted from dosage administered, wastage or documentations are reviewed daily.~~
2. ~~Contact users and nursing manager with screen shots from the EHR complete with relevant information on transactions provided.~~
3. ~~Provide a period of 24-48 hours for user to follow up and respond.~~
4. ~~A second reminder is sent to user and nursing manager. For anesthesiologists, a second reminder will also be sent to Medical Director of Anesthesiology.~~
5. ~~A report on the onliEl Camino Health on-line incident reporting system, will be filed if no response received after 24 hours of the second reminder.~~

IRIS (Individual Risk Identifier Score) Monitoring and Surveillance for High Ranked Users Flagged by Software

1. IRIS report is conducted monthly at the 1st week of the month to review statistical deviations from the previous month.
2. Pharmacy will initiate investigation for all users flagged as red (IRIS score >=4.6)
3. Nursing/anesthesia directors/managers will respond to investigations initiated by the pharmacy., as requested through the Diversion Software program (with analytics and documentations of all activities of the investigation).
    a. For the IRIS investigation checklist and training for nurses or steps to take during their review of high ranked IRIS users to look at the different analytics that made that user high that month.
    b. Pharmacist can provide an objective consistent process to investigate based on all the different analytics.
    c. Require Nurse Managers to have conversations with employee, even if no diversion is suspected, to coach to practice and to document date and time of conversation can be noted in the investigation portfolio under "Nurse Manager reviewed all pertinent reports'.
4. If diversion is not suspected, rationale will be documented and investigation closed.
5. If diversion is suspected, the Committee will be notified and activated. Individuals who repeatedly appear as outliers should be reviewed by the multidisciplinary drug diversion prevention committee and a recommended process (e.g., drug test) from the committee for escalation of identified high risk individuals.

M. Patient's Own Medication: Patient-owned controlled substances must have a documented chain of custody from the
time of receipt to the time of return. Logging the patient's controlled substances consists of counting and verifying the
controlled substances by two licensed workforce members count and verification of the medications.

N. Surveillance of Controlled Substances Inventory Count: The compliance rates will be reported to the monthly MDT meetings.

1. Weekly nursing inventory is completed by the unit's Nurse Manager/Supervisor or designee. Inventory is completed for all accessed controlled substances. If the unit is closed, notify pharmacy to deactivate access and notify pharmacy for opening. Without deactivation, weekly inventory count is still required on units that are temporarily closed.
2. Monthly CS Inventory Count:CII Safe/ Pharmacy Vault Monthly Inventory, including keys, conducted with two authorized
witness: signature and date of inventory is documented.
3. 90-day CII inventory count conducted per Board of Pharmacy.

O. Investigation and Reporting

1. A drug diversion investigation may be conducted in the following instances;
a. Discovered or suspected diversion based on IRIS reports
b. A significant loss of drug
c. Continued unresolved discrepancies
d. Users identified/observed as having erratic or strange behavior
2. Information Collection, Gathering and sharing: Pharmacy will initiate investigations. Documentation of investigations will be conducted through Software for Controlled Substances Investigation Portfolio. If diversion is suspected, the Human Resources department will be notified and the represented by the Director of Pharmacy, the Inpatient Pharmacy Supervisor, Nursing Administration, Anesthesia, Human Resources, and Employee Health. This team will provide consultation for suspected diversion incidents
3. Reporting at the conclusion of investigations
    a. Health care workers suspected of being impaired will be removed from delivering patient care as to prevent further access to drugs and ensure safe care of patients.
    b. Report of significant loss:
    When a significant loss occurs, the Pharmacist in Charge will complete a DEA-106 report there by notifying the DEA as well as the State Board of Pharmacy.
    c. Report of Theft: Theft will be reported to the DEA regardless of a significant losses or not. Based on the regulations, all theft regardless of volume should be reported to DEA.
    d. Diversion incidences will also be report to local law enforcement and appropriate State Boards

P. Culture, Education, Competency and Experiences

1. Pre-employment background checks for those with controlled substances access in their job descriptions.
2. The organization’s culture must support empowerment of staff to stop, question and act. Health care workers must be expected and empowered to speak up when something seems abnormal or unsafe.
    a. Observation: recognizing clear signals such as abnormal behaviors,

altered physical appearance, and poor job performance, are vital to detecting diversion and often the only way to identify an impaired colleague.

Q. Resources of hardware deterrent for drug diversion prevention and surveillance

1. Current hardware deterrent:
    a. Secured waste containers, badges system for medication room entry for retrievable entry history, IV-to Pole secured CS ~~IVPBs~~IV bags/admixtures and secured CS transportation carts are utilized for CS security.
    b. Community drug take back to limit unnecessary access in community, a secured medication take back kiosk is located at El Camino Health Outpatient Pharmacy for secure disposal of CS for the customers.
2. Next phase in the planning stage: camera video surveillance as deterrent and also to support investigation:
    a. Ensure all stationary ADCs have cameras installed at the appropriate angle to visualize actions being taken at the station, the scope captures return bin activities.
    This does not include ~~Pyxis~~ADCs placed in patient care areas (Surgical, ER Trauma, patient rooms…) in compliance with ~~HIPPA~~HIPAA.Within the pharmacy department, ensure all areas of packaging, storage, waste and areas where medications are placed to be checked, or pending delivery are under adequate camera surveillance.

    ~~Within the pharmacy department, ensure all areas of packaging, storage, waste and areas where medications are placed to be checked, or pending delivery are under adequate camera surveillance.~~
    b. Ensure camera video is recording 24 hours per day and retention is set to 90 days



*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Attachments

RoadmapSummary.pdf

SoftwareOnePageInstruction.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|

| | | |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 02/2022 |
| P & T Committee | Mojgan Nodoushani: Manager Clinical Pharmacy | 01/2022 |
| | Jen Huang: Director Pharmacy | 01/2022 |

Status **Pending** PolicyStat ID **11057698**

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| Effective | Upon Approval | Document Types | Scope of Service/ADT |
| Last Revised | 03/2022 | | |
| Next Review | 3 years after approval | | |

# Scope of Service: Respiratory Care Services



## Types and Ages of Patients Served

The department of Respiratory Care Services, which includes Respiratory Therapy, Interventional Bronchoscopy Team, Pulmonary Health(Diagnostics Lab), Respiratory Care Specialists, Lung Nodule Program, Tobacco Cessation Program, Chronic Respiratory Disease Program and CLIA licensed POCT Blood Gas Lab, ~~Respiratory Care Specialists, and CLIA licensed POCT Blood Gas Lab,~~ is organized as a treatment and diagnostic service for the needs of both Inpatients and Outpatients at both the Mountain View and Los Gatos campuses.

Respiratory Care Services serves all patient ages from Neonatal to Geriatric with the exception of a Pediatric Intensive Care. Those pediatric patients whose condition is beyond the scope of care at ECH are stabilized and transferred to an appropriate facility.

## Assessment Methods

Diagnostic and therapeutic respiratory services provided to patients are assessed by physicians, NP, and respiratory care practitioners who monitor patient's response to treatment, progress with treatment, validity of arterial blood gas and pulmonary function testing based on internal quality controls, external proficiency testing as well as pre-established protocols for patients on mechanical, noninvasive ventilation and oxygen therapy.

## Scope and Complexity of Services Offered

A full complement of core treatment services is available to all service lines within the hospital on a 24-hour basis. An extensive array of diagnostic services is available to all patients and clients in the

system Monday-Friday, from 7:00 a.m. to 4:30p.m. Selected tests and services are available to specific service lines.

Services provided, classified as therapeutic and diagnostic, are described below.

A. Therapeutic Services: include, but are not limited to:
    1. Adult and neonatal mechanical ventilation
    2. Adult and Neonatal high frequency oscillatory ventilation
    3. Adult Inhaled Nitric Oxide Administration
    4. Neonatal Inhaled Nitric Oxide Administration (MV campus only)
    5. Surfactant Administration
    6. Attendance at High Risk Deliveries
    7. Adult and Neonatal Noninvasive ventilation
    8. Long term ventilation
    9. Cardiopulmonary resuscitation / member of Code Blue team
    10. Adult, Pediatric, and Neonatal Intubation
    11. Oxygen therapy – Low flow & High flow therapies
    12. Small volume nebulizer treatments, Continuous Nebulizer treatments (ED)
    13. Chest Physiotherapy via different methods such as chest vest, Aerobika (PEP device), or Metaneb
    14. Oximetry
    15. ETCO2 monitoring (Capnography)
    16. Medication Administration via HHN or MDI
    17. Tracheostomy Care, which could include but are not limited to: changing trach, suctioning, weaning and Passy Muir Valve application
    18. Adult & Neonatal transport assistance
    19. Therapeutic and Diagnostic bronchoscopy
    20. Patient & Family education and discharge teaching
    21. MRI transport and MRI ventilator support
    22. Rapid Response Team
    23. Sepsis Alerts
    24. OSA consults
    25. COPD consults
    26. Asthma consults
    27. Pneumonia consults
    28. Tobacco Cessation Program

B. **Diagnostic Services:** include but are not limited to:

1. Blood gas analysis including co-oximetry and EPOC electrolyte and metabolic panels
2. Home Sleep Tests
3. Complete pulmonary function studies
4. Bedside spirometry/flow volume loops
5. Body plethysmography
6. Calorimetry Studies
7. 6 Minute Walk Test
8. Pulmonary Exercise Studies
9. Cardiopulmonary stress testing
10. Peak flow and vital capacity measurement
11. NIF, MVV, MIF/NIF
12. High altitude simulation studies
13. Bronchoprovocation studies
14. Capnography and oximetry studies
15. Nocturnal saturation studies
16. Sputum induction for AFB, PCP, TB
17. Lung Nodule Surveillance Program
18. Diagnostic video bronchoscopy
19. Interventional Bronchoscopy: including but not limited to:
    a. Robotic Bronchoscopy with Cone Beam CT
    b. Narrow Band Imaging
    c. Argon/Cryo Airway Recannulization
    d. Fiducial Placements
    e. Electromagnetic Navigational Bronchoscopy
    f. Rigid Bronchoscopy/Thoracoscopy
    g. Ultrasound thoracentesis with chest tube placement
    h. Endobronchial Ultrasound
    i. Pulmonary Dilation/Stent Placement
    j. Bronchial Valve Placement
    k. Bronchial Thermoplasty
    l. Confocal Laser Microscopy



# Appropriateness, Necessity and

## ~~Timelines~~Timeliness of Services

The Respiratory Care Services Department assesses the appropriateness and necessity of diagnostic and therapeutic procedures by evaluating the patient's clinical history against pre-established criteria for individual therapies and by assessment of the patient's condition prior to the initiation of treatment and at regular intervals thereafter, as described in the policies and procedures of the department.

Timeliness of services is addressed in departmental policies and procedures, which describe the hours of operation as well as performance of routine and stat procedures.

Documentation of assessments of patients on adult and neonatal mechanical ventilation is completed within one hours of initiation and stabilization of the patient and every four hours thereafter. Documentation of blood gas results are with 20 minutes of receipt for analysis. All other routine assessments are documented within two hours of initiation if appropriate and should be completed by end of the shift.

# Staffing Plan/Staff Mix

Staffing is maintained according to an expected standard of 50-60 work units per therapist with limited exceptions. On day shift a flex therapist is assigned for emergency and unplanned procedure volume. The Lead therapist or Charge therapist carries a half workload or takes Emergency Department cases and new patient starts if there is no flex therapist. Assignments are established by points where one point is equal to ten minutes. Sixty points is equal to ten hours' worth of assigned work in a twelve hour shift.



Minimum Staffing levels are established as:

| | |
|---|---|
| 1. MV Day shift: | Minimum of 7 at all times; 8-10 during peak census |
| 2. MV Night shift: | Minimum of 5 at all times; 6-9 during peak census |
| 3. LG Day Shift: | Minimum of 2 at all times, with exceptions; ~~2 –~~ 3 during peak census |
| 4. LG Night Shift: | Minimum of 2 at all times, with exceptions; ~~2 –~~ 3 during peak census |
| 5. Respiratory Care Spec. | Minimum or 2 at all times; RCS cover both MV and LG campuses |
| 6. Pulmonary Lab: | Monday- Friday, 7:00a.m. – 4:30p.m; Minimum of 2 Mon-Fri; staff cover both MV and LG campuses |
| 7. Interventional Pulm. Team | Monday – Friday – 7A – ~~7~~5P; 4 therapists at all times to cover MV and LG campuses |

Staffing is assessed every four hours for current and subsequent shift with staffing increased with the use of per diem staff or with pre-approval, the use of outside labor contract therapists. Staffing is adjusted downward through the use of daily cancellation, (DC SEIU) as outlined in departmental staffing guidelines and CBA (SEIU).

At Mountain View Campus, minimum core staffing of two trained therapists per shift is always maintained for NICU, CCU, Pulmonary Lab, Charge, and main hospital 24 hours/day. Included in the

minimum core for day shift, are 2 therapists trained in Bronchoscopy. At Los Gatos Campus, staff is trained in all areas which include but not limited to ICU, NICU, L&D, ER, and bronchoscopies.

In the event workload exceeds staffing levels and the need to implement the Therapy Prioritization Policy may be deemed necessary, the Lead or Charge therapist contacts the Director, Manager, Asst Manager or designee, to determine the need to initiate Respiratory Care Therapy Prioritization System (as defined in Therapy Prioritization Policy).

Professional medical services for Respiratory Care Services are directed by Medical Directors in which there are (3) three. Administrative direction of Respiratory Care Services is provided by a Registered Respiratory Therapist. Pulmonary Diagnostic Services are supported by a Manager, who oversees Respiratory Care Specialists, Interventional Bronchoscopy procedures, blood gas and Pulmonary Labs who is a Registered Pulmonary Function Technologist. Administrative Director & Diagnostics Manager have Asst Manager handling some of the operational oversight of department. Asst. Manager is a Registered Respiratory Therapist. Lung Nodule Program has NP as navigator and reports to Administrative Director and (1) Medical Director.

Respiratory Care Services Staff providing care and services are all California licensed respiratory care practitioners (RCPs).

# Level of Service Provided

The levels of services provided by the department are consistent with the diagnostic and therapeutic needs of the patients as determined by the Medical Directors.

Respiratory Care services are designed to meet patient needs by accurately performing and interpreting diagnostic and therapeutic procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which the Respiratory Care Services Department meets patients' needs.

# Standards of Practice

Respiratory Care Services is governed by California state and federal regulations as outlined in Title 22, CMS Conditions of Participation 482.57, and standards established by The Joint Commission. The Blood Gas Labs comply with CLIA standards in addition to the above. The department also follows guidelines set forth by the American Association for Respiratory Care. Additional practices are described in department policies and procedures.

# Organization, Chain of Command, Level of Supervision

A. The purpose is to ensure the availability of Lead Therapists and management personnel oversight of staff to ensure minimal errors in patient care. When an error occurs during patient care:
    1. Generate QRR

2. Email Director or designee to notify of QRR
3. Address error correction with staff ensuring both patient and employee satisfaction when appropriate

B. Organization

1. Respiratory Care Services is an enterprise department comprised of Respiratory Therapy, Pulmonary Diagnostics Lab, Respiratory Care Specialists, and Interventional Bronchoscopy, organized as a diagnostic and treatment service reporting to the Chief Nursing Officer.

C. Medical Direction

1. The Medical Direction of the enterprise department is provided by an active and Emeritus El Camino Hospital physician specializing in Pulmonary Medicine, who is accountable to the Chief Medical Officer and managed through the medical staff office. There is a Medical Director at both the Mountain View and Los Gatos campuses.

D. Technical Direction

1. The Technical Direction of the enterprise department is provided by a Registered Respiratory Care Practitioner, who has the responsibility for operation of the department and is accountable to the Chief Nursing Officer.

E. Chain of Command Medical Problems

1. When a Respiratory Care Practitioner encounters a medical problem that may cause serious complications to a patient the therapist shall contact the Lead or Charge Therapist if the Lead is not available, to inform and discuss the circumstances.
2. The Lead or Charge Therapist will evaluate the situation and make recommendations for the therapist to discuss with the attending physician or will contact the Medical Director if appropriate.
3. In the event of high census or staffing shortages the Lead Therapist or Charge Therapist shall contact the department Director or Department designee of any need to initiate department's prioritization policy.

F. Chain of Command Technical Problems

1. All technical problems, errors, occurrences, equipment failures should be brought to the attention of the Lead Therapist and Department Director or designee as soon as possible prior to end of shift.
2. The Lead shall take corrective actions as necessary and inform the Director or designee of actions taken.
3. Director will ensure appropriate corrective actions have been taken, the necessary individuals have been involved or informed and the necessary documentation has been completed.

G. Levels of Supervision

1. All licensed Respiratory Care Practitioners work under the Direction of the Medical

Directors and all applicable Federal and State regulations covering the practice of Respiratory Therapy. Staff is under the direct supervision of the Lead Therapist or Charge Therapist. Additionally, the Medical Directors have an interactive relationship with the staff therapists acting as clinical advisors and active consultants. The Medical Directors participate actively in the performance, quality, improvement process and other regulations of the department.

2. All Respiratory Therapy Students on Clinical affiliations at the hospital shall have supervision by a designated therapist preceptor, or college instructor in the immediate area.

H. Applicable Regulations

1. Title 22

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## Approval Signatures



| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 03/2022 |
| Department Medical Director or Director for non-clinical Departments | Jolie Fournet: Dir Resp Care & Min Inv Prog | 01/2022 |
| | Jolie Fournet: Dir Resp Care & Min Inv Prog | 01/2022 |

Status **Pending** PolicyStat ID **11039516**

No Changes; 3-year approval (Regulatory Requirement)

El Camino Health

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| Area | Security Management |
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# Workplace Violence Prevention Plan



## COVERAGE:

This plan covers all employees, physicians, contractors/supplemental workers, students, volunteers, members, patients, and visitors.

## PURPOSE:

This WORKPLACE VIOLENCE PREVENTION PLAN is developed to meet our commitment to the safety and well-being of all employees. This Plan meets the requirements of Title 8 of the California Code of Regulations, Chapter 4, New Section 3342 (Cal/OSHA Workplace Violence Prevention in Health Care) regulations. The Plan is part of the overall Injury and Illness Prevention Program (IIPP), and includes assessment, violence incident log, annual review, training, reporting and record keeping.

The purpose of this Plan is to provide guidance to operationalize Cal/OSHA regulatory requirements aimed at preventing workplace violence.

## PLAN STATEMENT:

El Camino Hospital (ECH) takes reasonable preventive measures to provide a safe environment for everyone on ECH premises. ECH has zero tolerance for acts or threats of violence, and/or intimidation that involve or affect ECH workers or that occur on ECH premises. See HR-Discrimination and Harassment Policy.

This plan outlines the prevention and management to safeguard all employees, physicians, contractors/ supplemental workers, students, volunteers, patients, and visitors to ECH premises from violence, threats, and/or intimidation by addressing threats and aggressive behavior at the earliest stage; define

and mitigate inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

# DEFINITIONS

Regulatory Definitions as outlined by Cal/OSHA Title 8, Chapter 4, New Section 3342, Workplace Violence Prevention in Health Care

- **Alarm**: a mechanical, electrical or electronic device that does not rely upon an employee's vocalization in order to alert others.
- **Dangerous weapon**: an instrument capable of inflicting death or serious bodily injury.
- **Engineering controls**: an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the health care provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.
- **Environmental risk factors**: factors in the facility or area in which health care services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.
- **Field operation**: an operation conducted by employees that is outside of the employer's fixed establishment, such as mobile clinics, health screening and medical outreach services, or dispensing of medications.
- **Intimidation or Harassing Behavior.** Threats or other conduct which in any way creates a hostile environment, impairs operations; or frightens, alarms, or inhibits others. Psychological intimidation or harassment includes making statements which are false, malicious, disparaging, derogatory, rude, disrespectful, abusive, obnoxious, insubordinate, or which have the intent to hurt others' reputations. Physical intimidation or harassment may include holding, impeding or blocking movement, following, stalking, touching, or any other inappropriate physical contact or advances.
- **Patient contact**: providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.
- **Patient specific risk factors**: factors specific to a patient, such as use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease process that would cause confusion and/or disorientation or history of violence, which may increase the likelihood or severity of a workplace violence incident.
- **Threat of violence**: a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured and that serves no legitimate purpose.

- **Work practice controls**: procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.
- **Workplace violence**: any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:
    a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
    b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;
    c. Four workplace violence types:
        - **Type 1 violence**: workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
        - **Type 2 violence:** workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
        - **Type 3 violence**: workplace violence against an employee by a present or former employee, supervisor, or manager.
        - **Type 4 violence:** workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.



# REFERENCES:

1. ECH Policy: HR-Discrimination and Harassment Policy.
2. Cal/OSHA Title 8, Chapter 4, New Section 3342, Workplace Violence Prevention in Health Care https://www.dir.ca.gov/Title8/3342.html

# SCOPE

A. The Plan covers all locations operated by El Camino Hospital. The Plan applies to all employees, physicians, Supplemental Workers, patients, and visitors and volunteers[1].

B. Cal/OSHA Regulation Title 8 NEW SECTION 3342 – "THE PLAN"

Below are the 11 provisions that are required in to be included in the Plan by Cal/OSHA. These provisions cannot change.

1. Site Specific Locations(s) and title of person(s) accountable for implementing the Plan.

2. Procedures to obtain active involvement of physicians, employees and their representatives in developing, implementing and reviewing the Plan including their participation in identifying, evaluating and correcting workplace violence hazards, designing and implementing training and reporting and investigating incidents.
3. Methods to coordinate with other employers on site including training and reporting, investigating and recording of incidents.
4. A policy prohibiting the employee from disallowing an employee or taking punitive or retaliatory action against an employee for seeking assistance and intervention from local emergency services or law enforcement when an violent incident occurs.
5. Procedures to ensure that supervisory and non-supervisory employees comply with the plan.
6. Procedures to communicate with employees regarding workplace violence matters, including;
    a. How the employees will document and communicate between shifts and units regarding conditions that may increase potential for workplace violence incidents
    b. How an employee can report a violent incident, threat or concern
    c. How employees can communicate workplace violence concerns without fear of reprisal
    d. How employees concerns will be investigated and how employees will be informed of the results of the investigations and any corrective actions to be taken. The incident reporting process gives employees the ability to raise concerns in all areas including workplace violence.
7. Procedures to develop and provide training
8. Assessment procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation
9. Procedures to identify and evaluate patient specific risk factors and assess visitors
10. Procedures to correct workplace violence hazards in a timely manner.
11. Procedures for post incident response and investigation. The incident reporting process gives employees the ability to raise concerns in all areas including workplace violence. Additionally the Code Grey critique and Security report provide a detailed account of any reported workplace violence event.

# ECH PLAN:

1. Plan Owner(s)
    a. At El Camino Hospital, the responsibility for implementing the Workplace Violence Prevention Plan (Plan) lies with the Hospital Safety Officer.
2. Engaging Employees and their Representative's
    a. El Camino Hospital will use a variety of procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing

the Plan, including participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents.

3. Coordination with External Employers for Supplemental Workers
    a. El Camino Hospital will coordinate implementation of the Plan with other employers whose employees work in the health Care facility, service, or operation, to ensure that those employers and employees have a role in implementing the Plan. These methods will ensure that employees of other employers and temporary employees are provided the appropriate training and will ensure that workplace violence incidents involving those employees are reported, investigated, and recorded.
        1. Training for Supplemental Workers: Supplemental Workers are required to have training based on their roles and responsibilities
            a. Initial/Basic Training
            b. Specialized Training
                - Annual training for those involved with patient contact activities
                - Initial and Annual training for those involved in confronting or controlling persons exhibiting aggressive or violent behavior
                - Initial and annual for those assigned to respond to alarms or other notifications of violent behavior or threats.



4. Adherence to Retaliation Policy
    a. The hospital's Human Resources policy (HR-Discrimination and Harassment) protects employees and other individuals who report misconduct and describe El Camino Hospitals obligation to take no retaliatory action against any person for reporting ethics issues or suspected violations of laws and regulatory requirements (including false claims acts), accreditation requirements, or El Camino Hospitals policies, or exercising their rights under federal or state laws.

5. Compliance
    a. El Camino Hospital has established procedures to ensure that both supervisory and non-supervisory employees comply with the plan. The ECH Policy Security Management- Prevention of Workplace Violence sets expectations for compliance. **Managers will work with Human Resources and/or Labor Relations if the policies are not followed**.

6. Communication
    a. El Camino Hospital has established procedures to communicate with employees regarding workplace violence matters. This includes how employees will document and communicate between shifts and units or at any time regarding conditions that may increase potential for workplace violence incidents.
    b. Employees are encouraged to report workplace violence concerns to their managers

or to the Safety and Security Department without fear of reprisal. This may involve director communication or submission of a Quality Review Report (QRR), Accident, Injury or Exposure Report (AIER), Code Gray Critique Forms or Security Incident reports.

c. To assure a timely response to situations involving an actual or potential physical threat to physicians, personnel, visitors or property, it is the policy of El Camino Hospital's security program that when dealing with a confrontational and/or combative patient, employee and/or visitor the following employee responses will be followed:

    1. Aggressor without a weapon: Activate a Code Gray (angry or violent patient) by calling the emergency line (55) to summon assistance from security services and trained staff. All personnel will be encouraged to recognize activities leading to actual or potential physical threats to personnel, visitors or property. Refer to Code Gray Policy (Security Management- Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation )
    2. Aggressor with a weapon (excluding a gun): Activate Code Silver through the emergency line (55). Since Code Silver is used to inform Security that a patient, visitor, or employee has a weapon, it is important for the Safety of the staff, patients, and security personnel to respond accordingly. Refer to Code Silver Policy (Security Management- Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation )
    3. Aggressor with a gun: Activate an Active Shooter through the emergency line (55). Upon notification of an Active Shooter, Security will contact local law enforcement for assistance. Refer to Active Shooter procedure (Security Management - Active Shooter).

d. Communication about threats or incidents will vary depending on the situation and the work environment. Utilize existing emergency notification communication and documentation procedures that apply to the following situations:

    - Individual situations within departments
    - Larger scale situations across departments
    - Wide scale situations involving a significant portion of a facility/campus

    1. The following should be considered when determining the appropriate communication:
        a. Identify the party(ies) providing the communication
        b. the urgency of the situation
        c. the recipients of the communication
        d. The mode of transmission (overhead page, email, nurse shift exchanges, group text, etc.)
        e. How an employee can report a violent incident, threat or concern
            1. The preferred notification process for all workplace

violence incidents is through the following reports:

a. **Accident, Injury or Exposure Report** (AIER): Report of any injuries or assaults to Employee Wellness and Health. This should be completed as soon as possible by the employee of their supervisor.

b. **Code Gray Critique Form:** This form is completed after each code gray incident. Forms are available under the Safety tab on the Toolbox

c. **Incident Reporting**: The incident reporting system for hospital and medical staff to report clinical or safety related concerns. This may include information about workplace violence events..

d. **Security Incident Reports:** Security incident reports are generated for all security responses. If the report notes a workplace violent incident, it may be used to log the incident by the team as noted below.



The information collected will be used to complete the Violent Incident Log and providing the information needed for the 24/72 hour hospital report to Cal/OSHA.

f. Cal/OSHA Reporting Hospital Reporting Requirements for Incidents Occurring in Hospitals

1. Any incident involving physical violence against an employee will be reported regardless of whether this resulted in an injury to the employee or not.

a. If there are any questions of whether the incident should be reported, the *Workplace Violence Incident Reporting Team* will review the incident and make a determination.

2. The designated person will then complete the internal WPV Reporting Log and the Cal-OSHA Workplace Violence Incident Online Report on the OSHA website.

7. Training

Employees will be assigned to complete Prevention of Workplace Violence Training based on their job description.

a. Awareness/Basic training:

Training for employees and supplemental workers is required initially when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which training is required. Refresher training will be required whenever there is a change to the Plan or operations impacting the potential for workplace violence. Employees will be given the opportunity to submit questions and receive a response within 24 hours.

b. High Risk Training

Advanced training is required for all employees and supplemental workers involved in confronting or controlling persons exhibiting aggressive or violent behavior. For El Camino Hospital, this includes high risk departments such as ED, Behavioral Health, Hospital Supervisors, Security officers and Facilities Engineering. This training will include the elements of the Awareness and Patient Contact training and includes defensive techniques and controls for patients exhibiting violent physical behaviors. This training shall be completed annually by all identified employees.

8. Environmental Risk Assessment

The Director of Safety/Security and the EH&S Manager will assess and establish procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation. The assessment shall include a review of all workplace violence incidents that occurred within the previous year.

a. Department and area managers will participate in completing area assessments with staff to determine and list high and general risk areas.

- ***Workplace Violence Department Risk Assessment***

  This tool is to recognize and consider historical hazards and risks (minimally – past 12 months), as well as current hazards and risks, confronting staff. It is to be used to engage and solicit participation from department/service-line staff and representatives in order to develop, implement and review the workplace violence Plan, as well as gain greater insight and obtain solutions and/or alternatives for making the workplace a safer environment.

b. The Security Manager and Director may include campus/facility maps to create an assessment that addresses external risk factors that may have an adverse impact on the campus or services delivered (e.g., local law enforcement crime data, etc.).

c. The Security Manager and Director may also address risks and protective measures for the Facilities, Operations and Services including Common Areas, Hospital, clinics, and Administrative Buildings.

9. Procedures to identify and evaluate patient specific risk factors and assess visitors

a. Procedures are being developed to identify and evaluate patient-specific physical and mental risk factors, including;

1. Patient's mental status and conditions that may cause the patient to be

non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively or aggressively.

2. Patient's treatment and medication status, type, and dosage as it is known.
3. Patient's history of violence, as it is known.
4. Patient's disruptive or threatening behavior.

b. Department and services subject to higher behavioral risks may include the Emergency Department, Behavioral Health, and other high risks departments. Typical characteristics of patients and/or family members displaying threatening or disruptive behavior within these higher risk departments include:

1. Emotionally charged over injury or injury of loved one
2. Perceived delay in treatment
3. History of aggressive behavior or violence
4. Substance abuse
5. Feels victimized blames others
6. Emotionally depressed
7. Behaving belligerently using harassing or abusive language and
8. Unfavorable medical diagnosis

These higher risk departments and services are independently assessed as a result of the greater potential for escalated patient/family member behavioral encounters. Enhanced training and engineering and work practice controls are provided to increase staff's awareness, understanding and competency, for de-escalation/ protective practices in order to minimalize psychological and physical harm resulting from the higher likelihood of threatening behavior.

Procedures to identify, evaluate and remediate vulnerabilities based on behavioral risk factors for and visitors, include, but are not limited to implementation of enhanced staff training, enhanced engineering and enhanced work practice controls.

10. Procedures to correct workplace violence hazards in a timely manner

a. El Camino Hospital has developed the following procedures to correct workplace violence hazards in a timely manner. Risks identified during the environmental risk assessment, reported to managers or found as a result of a workplace violence incident must be addressed within the following time-frames:

1. Imminent hazards – Employees must be protected immediately.
2. Serious hazards – must be corrected within 7 days of discovery.

NOTE: Interim measures may be taken to abate the imminent or serious hazard while completing the permanent corrective action plan.

b. Corrective Action shall include Enhanced Engineering and Work Practice Controls

Engineering controls and Work Practice Controls are used to eliminate or minimize employee exposure to the identified workplace hazards. Remedial measures to protect employees from imminent hazards shall be taken immediately. Remediation activity (Engineering and Work Practice Controls) will be planned and implemented within 7-days following discovery of a serious hazard. If remediation cannot be completed during the specified time-frame, interim measures to abate imminent or seriousness of the hazard may be taken while completing permanent control measures. Enhanced Engineering and Work Practice Controls shall include, but not limited to:

1. Engineering Control considerations
    a. Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
    b. Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
    c. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.
2. Work Practice Control considerations
    a. Minimizing, removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2* violence are reasonably anticipated to be present.
    b. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.
    c. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.
    d. Establishing an effective response plan for actual or potential

workplace violence incidents emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.

e. Assigning or placing minimum numbers of staff, to reduce patient-specific Type 2* workplace violence hazards.

f. Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.

g. Maintaining reasonable sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.

h. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1* or Type 2* violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.



11. Incident Response and investigation

    a. El Camino Hospital has procedures for post incident response and investigation based on the below language.

        1. Providing immediate medical care or first aid to all employees affected by the incident.
        2. Identifying all employees involved in the incident.
        3. Providing trauma counseling via Employee Assistance Program (EAP)[2].
        4. Conducting a post incident debriefing as soon as possible after the incident with all employees, supervisors and security involved.
        5. Reviewing any patient-specific risk factors and risk reduction measures that were specified for that patient.
        6. Reviewing whether appropriate corrective measures were effectively implemented.
        7. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause and where any measure would have prevented the injury.

NOTE: Ensure there is appropriate communication and coordination with the employers of supplemental workers.

12. Annual Review
    a. The Plan must be reviewed annually, in conjunction with employees, regarding their respective work areas, services, operations as related to prevention of workplace violence. this includes:
        1. Staffing, staffing patterns, patient classification systems
        2. Sufficiency of security systems, including alarms, emergency response, and security personnel availability
        3. Job design, equipment and facilities
        4. Security risks associated with specific areas and times of day
        5. A review of the violent incident log
    b. The annual review will take place via the Workplace Violence Prevention Committee and reported to the Central Safety Committee. Results of the annual review will be used to revise the Plan.

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[1] Volunteers are not employees and are not covered by the regulations. However, they should be oriented to the Prevention of Workplace Violence plan.

[2] The EAP at El Camino Hospital is Concern: EAP (www.concern-eap.com, 650-940-7100).



*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Attachments

- Workplace Violence Prevention (WPV) Risk Assessment Checklist

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |

| | | |
|---|---|---|
| ePolicy | Patrick Santos: Policy and Procedure Coordinator | 03/2022 |
| Patient and Employee Safety Committee | Delfina Payer: Projects Coordinator | 02/2022 |
| Central Safety | Matthew Scannell: Director Safety & Security Services | 02/2022 |
| | Matthew Scannell: Director Safety & Security Services | 02/2022 |

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El Camino Health

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| Owner | Christine Cunningham |
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# Administrative - Complaint and Grievance Management



## ~~I. COVERAGE:~~

## COVERAGE:

El Camino Hospital (ECH) ~~employees and medical staff.~~Staff and Medical Staff

## ~~II. PURPOSE:~~

## PURPOSE:

The complaint and grievance policy of ECH is to provide patients and families a process to file complaints and grievances as outlined below. ECH and its Medical Staff are dedicated to maintaining quality medical care, improving the patient experience, and providing advocacy services for patients, families, employees, physicians, and auxiliary members who have concerns about the quality of medical care which patients receive.

Regulatory agencies such as California Department of Public Health (CDPH), Center for Medicare & Medicaid Services (CMS) and accreditation bodies require that the internal and external customers have the ability to raise concerns. The hospital has responsibility in preventing problems that can have or have had a serious impact on patients. ECH employees who report concerns can do so without fear of retaliation from the hospital.

## ~~III. POLICY STATEMENT:~~

## POLICY STATEMENT:

ECH supports patient and families' right to file complaints and grievances about care and services provided by the hospital. The complaint and grievance management outlines requirements regarding management of patient complaints and grievances to ensure a timely and accurate response according to regulatory guidelines.

Staff at ECH are encouraged to invite feedback from patients and families, and work immediately to resolve any concerns. The Board of Directors has designated the Grievance Committee to have responsibility and oversight of the investigation and resolution of patient grievances. The Grievance Committee consists of multidisciplinary team members who provide a consistent and effective complaint and grievance process.

## ~~IV. DEFINITIONS:~~

## DEFINITIONS:



A. Complaint: Verbal expression of dissatisfaction regarding care or services provided at the hospital which can be resolved at the time the concern is presented or shortly thereafter. Generally, a complaint can be resolved while the patient is still receiving care at the facility.

B. Grievance is defined as any of the following:

1. Any complaint that cannot be resolved promptly by staff present
2. Any grievance received in writing, including ~~emails~~email, regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs
3. Complaints that are attached to a patient satisfaction survey and request a resolution
4. Any complaint involving abuse, neglect or issues of compliance relating to Medicare Conditions of Participation
5. Any complaint where the patient and/or the authorized representative requests a written response
6. Medicare beneficiary billing complaints related to rights and limitations

## ~~V. PROCEDURE:~~

## PROCEDURE:

A. Notification to Patients/Authorized Representatives of Process to file Complaints/Grievances:

1. Each patient and/or patient representative is informed of his/her right to file a complaint or grievance upon entry into the facility. Patients have the right to complain without fear of reprisal. ~~For inpatients~~Patients, ~~patients~~and or authorized representatives, are ~~given a copy of 'Your Hospital Stay' handbook which describes~~

~~the Patient Rights and process for handling a complaint/grievance. This handbook provides the contact name and information of how to file a complaint/grievance with the hospital. For outpatients, information about filing patient complaints are contained in The Patient Rights posted in the department or on the hospital's website.~~informed of these rights through various modes:

a. Patient Rights information available in the Inpatient handbook which describes how to file a complaint/grievance. This handbook provides the contact name and information of how to file a complaint/grievance with the hospital.

b. For outpatient, information about filing patient complaints and greivances are contained in The Patient Rights posted in the registration area, the department and on the hospital's website. Some areas have brochures available.

2. There are Patient Rights posters posted throughout the facility with the contact information on how to file a complaint within the facility and with external agencies such as CDPH and the Joint Commission directly.
3. For Medicare beneficiaries who raise a complaint regarding quality of care, disagree with a coverage decision or wish to appeal a premature discharge, the patient will be informed that they have a right to file a complaint with the appropriate Quality Improvement Organization (QIO). If the beneficiary requests that ECH forward his/her complaint to the QIO, the hospital will forward the complaint.

B. Patients ~~and families~~(or patient's representative) and visitors may file a complaint or grievance as follows:

1. Calling the Patient Experience Department directly at 650-962-5836

   ~~Completing a patient comment card~~
2. Letter or email to the Patient Experience Department and/or management staff
3. Direct communication to ECH ~~employees~~employee(s)

C. Management of complaints~~/~~ and grievances filed by persons other than a patient:

1. ECH supports interested third parties such as patient representatives, family members, or friends' ability to raise concerns about a patient's care. To protect patient privacy, it is the policy of ECH to notify the patient of the concern(s) raised and have the patient confirm they want to move forward with the complaint/grievance.
2. Patient Experience will let the third party know that their concerns will be documented and investigated but that the patient will be contacted to ask if they are seeking further resolution to the ~~concerns~~concern(s).The patient will be notified that a party has informed ECH of a concern regarding their care and that we will direct communication to the patient directly. The patient may indicate that communication may occur with the third party. If the patient states they do not wish the complaint/grievance to move forward, the matter will be documented and closed.

   ~~The patient will be notified that a party has informed ECH of a concern regarding their care and that we will direct communication to the patient directly. The patient~~

~~may direct that communication may occur with the third party. If the patient states they do not wish the complaint/grievance to move forward, the matter will be documented in the QRR and closed.~~

3. If the patient is incapacitated, or deceased, the appropriate surrogate decision-maker shall be contacted and the process above followed.
4. If patient is deceased, to confirm authority reference estate/probate law as followed by Health Information Management Systems. If the deceased has left no documentation to indicate beneficiaries then under HIPAA the hospital can provide records to a spouse or any child without any legal documents if the hospital is able to verify they are a decedent of the deceased. Under the laws of intestate succession, the order of priority is 1) spouse 2) children 3) sibling (if decedent has no spouse or children). Note, you must be able to verify the relationship through either documentation in the chart or supporting documentation (if needed) such as a birth or marriage certificate.

D. Complaint Resolution:

Upon recognition of customer dissatisfaction, the employee, volunteer or ~~Medical~~medical staff member will do the following:

1. Identify the area of ~~customer~~ dissatisfaction.
    i. ~~Billing complaints are referred to Patient Accounts for resolution~~
    ii. ~~Privacy complaints are referred to the Compliance Office for resolution~~
    a. Billing complaints are referred to Patient Accounts for resolution
    b. Privacy complaints are referred to the Compliance Office for resolution
2. Discuss possible solutions with the ~~customer~~person. Involve other individuals/ departments if needed to resolve ~~customer~~person's ~~concerns~~concern(s).
3. Take responsibility to rectify problem within your scope of authority.
4. ~~Complete an on-line Quality Review Report (QRR) for centralized tracking. Once matter is resolved, note this in QRR.~~Document concern(s) for tracking using incident reporting system. Any follow up or actions taken shall also be documented, once matter is resolved this shall be noted and file closed out.
5. Grievances Resolution Process: Any complaint that cannot be resolved by staff present or meet the definition above as a grievance will be handled as follows:
    i. ~~Complaints received by Administration, Patient Care units and departments will be referred to the Patient Experience Department if unable to resolve by staff present.~~
    ii. ~~The Patient Experience Department will enter an online QRR and enter on the grievance log for tracking. A copy of the complaint letter will also be maintained.~~
    iii. ~~The expectation is that all grievances will be resolved within seven (7) business days. If the investigation and resolution of the grievance cannot be resolved within this timeframe, a letter of acknowledgement shall be~~

sent to the patient or the patient's authorized representative. For those cases for which resolution cannot be reached in seven (7) business days, a final written response regarding the hospital's investigation and resolution of the grievance shall be sent to the patient within thirty (30) business days of receipt of the formal grievance.

iv. If the patient files a written grievance regarding concerns with physician care/management, the hospital shall notify the patient in writing that the Medical Board of California or the California Board of Podiatric Medicine, as the case may be, is the only authority in the state that may take disciplinary action against the license of the name licensee, and shall provide to the complainant the address and toll-free telephone number of the applicable state board. Patient Experience shall also notify the involved medical staff member of the complaint.

v. The manager for the responsible area or designee will be notified to investigate and provide a written response to the patient within the appropriate timeframe. The written response must include the name of the person investigating the complaint, the steps taken to investigate the grievance and the resolution. An interim letter will be sent to patients if the Grievance Committee decides that there needs to be further investigation into the grievance and therefore more time is needed.

vi. The Grievance Committee, consisting of multidisciplinary team members, also reviews all patient grievances and coordinates responses back to patients.

vii. Risk Management shall approve all resolution letters.

viii. Medical staff issues will be reviewed in accordance with medical staff by laws.

ix. A copy of the signed response will be sent to the Patient Experience Department for tracking.

x. The manager/designee will add their follow-up action to the QRR.

xi. There may be situations where the hospital has taken appropriate and reasonable actions on the patient's behalf to resolve the patient's grievance and the patient or the patient's authorized representative remains unsatisfied with the hospital's actions. In these situations, if there are no new issues identified, the patient/patient representative will be notified that the grievance has been resolved and considers the grievance closed.

xii. The hospital may use additional tools to investigate a grievance, such as meeting with the patient and/or authorized representative. In its written response, the hospital is not required to include statements that could be used in a legal action against the hospital, or to provide an exhaustive explanation of every action taken to investigate or resolve the grievance, or any other actions taken by the hospital.

xiii. All letters will be sent via certified mail for tracking purposes.

a. Complaints received by Administration, Patient Care units and departments will be referred to the Patient Experience Department if unable to resolve by staff present.

b. Patient Experience Department will document concern(s) in incident reporting system and add to grievance log. If applicable, copy of the complaint letter will also be maintained.

c. CMS expectation is that grievances be resolved within seven (7) days, but no later than thirty (30) days.

d. An acknowledgment letter shall be sent out to the patient, or patient's representative, immediately but no later than within seven (7) days of notification.

e. A final written response regarding the hospital's investigation and resolution of the grievance shall be sent to the patient (or patient representative) within thirty (30) days of notification of the formal grievance.

f. An interim, or extension, letter will be sent to patients if the Grievance Committee decides that there needs to be further investigation into the grievance and therefore more time is needed.

g. If the patient files a written grievance regarding concerns with physician care/management, the hospital shall notify the patient in writing that the Medical Board of California or the California Board of Podiatric Medicine, as the case may be, is the only authority in the state that may take disciplinary action against the license of the name licensee, and shall provide to the complainant the address and toll-free telephone number of the applicable state board. Patient Experience shall also notify the involved medical staff member of the complaint.

h. The manager for the responsible area or designee will be notified to investigate concern(s) and with assistance from Patient Experience formulate a written response to the patient within the appropriate time-frame. The written response must include the name of the person investigating the complaint, the steps taken to investigate the grievance and the resolution.

i. The Grievance Committee, consisting of multidisciplinary team members, also reviews all patient grievances and coordinates response back to patient or authorized representative.

j. Medical staff issues will be reviewed in accordance with medical staff by laws.

k. A copy of the signed response will be sent to the Patient Experience Department for tracking and documenting in file.

l. The manager/designee will add their follow-up action to incident reporting system

m. There may be situations where the hospital has taken appropriate and reasonable actions on the patient's behalf to resolve the patient's

grievance and the patient or the patient's authorized representative remains unsatisfied with the hospital's actions. In these situations, if there are no new issues or information presented, the patient/patient representative will be notified that the grievance has been resolved and considers the grievance closed.

n. The hospital may use additional tools to investigate a grievance, such as meeting with the patient and/or authorized representative. In its written response, the hospital is not required to include statements that could be used in a legal action against the hospital, or to provide an exhaustive explanation of every action taken to investigate or resolve the grievance, or any other actions taken by the hospital.

o. All letters will be saved and attached to file in the incident reporting system.

E. Breast Mammography Complaints. Pursuant to American College of Radiology accreditation requirements for mammography, if a patient reports a "serious adverse event" defined as an event which significantly compromises clinical outcomes or one for which a facility fails to take appropriate corrective action in a timely manner, the patient must be provided directions for filing a serious complaint with ACR if the facility is unable to resolve the serious complaint to the patient's satisfaction.



American College of Radiology,
Mammography Accreditation Director
Breast Imaging Accreditation Programs
1891 Preston White ~~Dr.~~Drive
Reston, VA 20191
~~or~~
OR

CDPH, Mammography Program
PO Box ~~97414~~997414, MS-7610
Sacramento, CA ~~95899-74714~~95899-7414

In addition, the hospital must forward the unresolved serious complaint to the ACR as well. Any unresolved serious complaints should be forwarded to the accrediting body, the American College of Radiology, at the address above.

F. At least annually, the Grievance Committee will provide a report to Quality Council on the number and type of grievances, their resolution and compliance with the response time frames.

An annual report will also be presented to the Quality Council, Medical Executive committee and Board of directors as part of the hospital's Quality Assessment and Performance Improvement program. All discussions ~~and~~, including meeting minutes, of the Grievance Committee are considered privileged under California Evidence Code 1157.

## ~~VI. REFERENCE:~~

~~Comprehensive Accreditation Manual for Hosptials, Standards RI.01.07.01, EP 1 & 18, CMS Conditions of Particiapiton §482.13(a) (2) (iii)~~

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2022 |
| | Christine Cunningham: Chief Experience and Performance Improvement Offic [PS] | 03/2022 |

Status **Pending** PolicyStat ID **10260115**

El Camino Health

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| Last Revised | 01/2022 | | |
| Next Review | 3 years after approval | | |

# Scope of Service - Palliative Care Services



## Types and Ages of Patient Served

~~Patients living with a life limiting illness~~

Any adult over the age of 18 years living with a serious or life-threatening illness at any stage of illness. Palliative Care supports patients across the treatment spectrum, including curative, selective and comfort focused care.

## Assessment Methods

Palliative Care services are provided by an interdisciplinary team (IDT): physician, nurse practitioner, nurse, social ~~worker, and chaplain~~workers and chaplains. Patients are referred, if desired, to outpatient services that align with their physical needs and goals of care.

## Scope and Complexity

Palliative Care is consulted by the primary team at any stage of patient illness trajectory. The National Consensus Project defines palliative care as: "Palliative Care means patient-and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs to facilitate patient autonomy, access to information and choice". Patient populations include anyone diagnosed with serious illness, ~~but~~which includes and is not limited to those diagnosed with ~~diagnosis of Cancer~~cancer, ~~Congestive Heart Failure~~congestive heart failure, ~~Respiratory Failure~~respiratory failure, ~~Renal Failure~~renal failure, and ~~Stroke~~stroke. Palliative care also collaborates in management of patients admitted to the hospice General Inpatient level of care (GIP) with El Camino Health's contracted hospice

agency. Palliative Care services are provided to all patients in the acute care setting, which also includes those in the emergency department who have not yet been admitted to the inpatient setting.

# Appropriateness, Necessity and Timeliness of Services

The primary team consults the palliative care team when additional support is needed in providing care to the patient and family. The referred cases are reviewed by ~~the~~palliative care team~~, and assigned to a member of the~~ and members of the IDT. The members of the IDT collaborate with the primary care team to ~~reach out to physicians to determine how our team may be of~~ support patients and families coping with serious and life threatening illness. A collaborative approach is utilized in working with the physicians, the patients and their families. The goal is to initiate contact with patient and families within twenty-four hours of consult order (M-F).

# Staffing

Palliative Care is provided to patients in Mountain View and Los Gatos, Monday through Friday except holidays in the inpatient acute care setting and emergency department. The Palliative Care Team is an IDT comprised of a medical director, ~~to inpatients~~clinical physicians, nurses, nurse practitioners, social workers, pharmacists, and chaplains. ~~The Palliative Care Team is comprised a physician, nurse practitioner, pharmacist, nurse, social worker and chaplain.~~

# Level of Service Provided

The level of service provides is determined by the patient's goals, physical needs and the plan of care moving forward. This is an inpatient service though recommendations for outpatient referrals are a component of advanced illness care planning.

# Standard of Practice

Palliative Care is aligned with standards of the American Academy of Hospice and Palliative Medicine. Practice ~~manual~~manuals for team ~~is~~are: Primer of Palliative Care, published through AAHPM and current literature including evidence based journals and publications.

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|

| | | |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2022 |
| Medicine Department Executive Committee | Nathalie Garcia: Medical Staff Coord | 03/2022 |
| Medicine Department Executive Committee | Annette Cruz: Medical Staff Coord | 03/2022 |
| | Gretchen Suess: Manager Palliative Care | 01/2022 |

Status **Pending** PolicyStat ID **10993166**

| | | | |
|---|---|---|---|
| Origination | 01/2015 | Owner | Beth Willy |
| Last Approved | N/A | Area | Patient Care Services |
| Effective | Upon Approval | Document Types | Plan |
| Last Revised | 01/2022 | | |
| Next Review | 1 year after approval | | |

# Musculoskeletal Injury Prevention Plan and Policy (MIPP)



## COVERAGE:

All El Camino Hospital staff, physicians and contracted staff who are present during patient handling

## PURPOSE:

To describe El Camino Hospital's policy and procedure to comply with the intent of Cal/OSHA's Safe Patient Handling Regulation for "patient protection and health care worker back and musculoskeletal injury prevention plan (MIPP) as required by Title 8, California Code of Regulations, Section 5120" (Cal/OSHA, 2014).

## POLICY STATEMENT:

El Camino Hospital will comply with the intent of California Law to protect the health care worker with the replacement of manual lifting of patients with appropriate safety policies/procedures, equipment, professional judgment and clinical assessment of the registered nurse. According to this law, the RN is the coordinator of care in relation to mobility assessment and mobility tasks.

## DEFINITIONS:

Awareness Training: Training for employees, other than those who regularly participate in patient handling (i.e. nurses, CNAs, rehabilitation therapists) whose job assignment includes being present on patient care units

# POLICY:

A. Plan implementation methods and coordination of MIPP

1. MIPP implementation is the responsibility of the Chief Human Resource Officer.
2. Responsibility for oversight, operationalization and evaluation of the MIPP is the Safe Patient Handling and Mobility Committee. The Safe Patient Handling and Mobility Committee includes direct care staff and reports activities to the Central Safety Committee. The MIPP includes:
    a. Plan for employers whose employees have work assignments that include being present on patient care units (e.g. Registry and Traveler agencies):
        i. Plan for awareness training: designed by Education Department.
        ii. Procedure for reporting, investigation and recording of injuries: commensurate with Central Safety and Employee Wellness and Health Services Policies.
        iii. Training plan: designed by the Education Department.
    b. Plan to ensure El Camino Hospital employees (supervisor and non-supervisor) comply with the MIPP, specified procedures, and recommended equipment: designed and updated as necessary by the Education Department/Human Resources

B. Correction of hazards relating to patient handling:

1. All staff, physicians and contracted staff are encouraged to bring any recognized hazard to the attention of their supervisor, manager or hospital supervisor as soon as feasible after discovery without fear of reprisal.
2. No patient handling will occur without sufficient number of staff and sufficient equipment to safely handle patient and comply with this policy and procedure.



# PROCEDURE:

A. Identification and Evaluation of Patient Handling Hazards

1. Patient Handling Equipment
    a. The Safe Patient Handling and Mobility Committee is responsible for determining types, quantities and locations of patient handling equipment and where the equipment is located by unit/department (See Attachments)
    b. Safe Patient Handling and Mobility Committee uses methods such as demonstrations, vendor fairs, interviews and/or surveys to solicit input into evaluation of equipment.
    c. Evaluation of Patient Handling Equipment is managed by the Safe Patient Handling Committee annually and as needed for new equipment or if an unrecognized hazard is discovered.
    d. Procurement of equipment is commensurate with hospital procedures for

minor and capital equipment requests.

e. Regular use and care of equipment is at the unit level and the ultimate responsibility of the manager. All unit staff is expected to use and care for equipment as per manufacturer guidelines.

f. Maintenance/Repair of equipment will be commensurate with Clinical Engineering and Facilities procedures.

2. Registered Nurse (RN) assessment of Mobility Needs

    a. El Camino Hospital RNs use the "Patient Mobility Assessment Tool" (PMAT) to assess patient mobility and determine appropriate interventions (See Attachments)

    b. CNAs and Ancillary Healthcare Workers (e.g. Physical Therapy) shall verbally communicate to the patient's primary RN input regarding mobility

B. Investigation of musculoskeletal injuries related to patient handling

1. Injury investigation is the responsibility of the manager of the employee and Employee Wellness and Health Services in accordance with ~~1.11~~ Accident, Incident, and Exposure Investigation (AIER).

2. Guidelines for investigation of patient handling injuries includes:

    a. Patient specific risk factors,

    b. RN safe patient handling instructions,

    c. Review if MIPP was effectively implemented (i.e. correct equipment used),

    d. Feedback from injured person and others involved in the incident regarding any measure on how the injury could have been prevented.

3. Injury data and trends are used to evaluate and make adjustments to the MIPP on an annual basis. Adjustments to the MIPP will be made as needed annually or more often should a trend dictate.

C. Correcting patient handling hazards:

1. Whenever possible, patient's primary RN will complete PMAT prior to first mobility attempt during acute care hospitalization, and whenever major change in condition has occurred. If unable to do PMAT before first mobility attempt, RN to do PMAT as soon as possible. For the outpatient setting, RN will observe mobility ability at initial intake into service, and then prn RN will communicate results of PMAT, and thereby directions for mobility, via the EHR, signage and/or patient communication board (inpatient only). Signage and/or patient communication board information will also serve to communicate mobility assessment findings to patient's family/significant others. Any changes in the plan shall be updated in the EHR, signage and communication board.

2. Special circumstances:

    a. Emergency Situations: primary nurse or physician will evaluate benefits/ risks of patient handling and current emergency to best protect both the patient and the staff. For example, evacuation due to fire or earthquake

may supersede use of equipment that would happen under normal circumstances.

b. No RN present: Other healthcare workers are expected to follow the contents of this policy/procedure.

c. Patient not cooperative with handling instructions: Utilize extra staff or alter plan for handling.

d. Unique situations that are not currently covered by the plan: Consult with patient's RN and/or other resource such as Rehabilitation Services or Employee Wellness and Health Services.

D. Employee Communication

1. Any employee may communicate concerns regarding patient handling via direct communication with supervisor, manager, hospital supervisor or via incident reporting. Concerns may be filed anonymously.

    a. Follow up on reports will be commensurate with the Incident Reporting procedure.

E. Training

1. The Education Department is responsible for design and execution of all training related to safe patient handling. Design of materials will take into account literacy, educational level and vocabulary of the employees.
2. All employees, with regard to safe patient handling, receive training:

    a. Initially upon hire or transfer, includes:

        i. Type of injury/area of body most at risk most likely from patient handling with: vertical movement, lateral movement, bariatric patients, repositioning and ambulation

            1. How patient risk factors affect the above,

        ii. Importance of early recognition and management of an injury,

        iii. Communication with patient and family/significant other regarding safe patient handling practices,

        iv. Appropriate use and procedures for using various patient handling equipment,

        v. Importance of reporting any concern related to patient handling/ patient handling equipment,

        vi. The MIPP Policy and Procedure is available on the Toolbox,

        vii. Right of refusal of any employee to lift, reposition, mobilize or transfer a patient if concerned about patient or staff safety or lack of training, and how to communicate reasons for refusal to supervisor,

        viii. Role of the RN in safe patient handling,

        ix. Additional training is available by calling the Education

Department,

x. Opportunity for practice and inter-active questions/answers regarding safe patient handling. The practice will include using the types and models of equipment that they are expected to use in the health care setting.

b. Refresher training coordinated by the Education Department is conducted every 12 months includes:

i. Use of powered and non-powered equipment to handle patients safely,

ii. Procedures of safe patient handling,

iii. Review of items in initial training,

iv. Opportunity for inter-active questions/answers regarding safe patient handling equipment and procedures.

c. Whenever new equipment or procedures dictate.

d. Awareness training is provided for any other staff member present on patient care units and not part of aforementioned training. This includes: recognition of safe patient handling situation, how to get assistance if needed, and emergency procedures related to safe patient handling.

3. RN Training:

a. In addition to above, RNs is trained on the Mobility Assessment and the role of the RN in safe patient handling.

4. Supervisor/Management Training includes:

a. Staff may not be disciplined for refusal to lift, reposition, or transfer a patient due to concerns about patient/staff safety or lack of training or lack of equipment.

F. Record-keeping

1. Records of inspections including hazard identification and evaluation will be maintained by Employee Wellness and Health Services and reviewed by the Central Safety Committee.
2. Training records are maintained by the Education Department and reported to the Central Safety Committee.
3. Injury investigations are maintained by Employee Wellness and Health Services and reported in aggregate/trend format to the Central Safety and Safe Patient Handling and Mobility Committees.

# REFERENCES:

Cal/OSHA, (2014). The Cal/OSHA safe patient handling regulation. California Hospital Association, 1st ed. Retrieved from: www.calhospital.org/publications.

Unusual Occurrence Policy

ECH Policy and Procedures: Safety - Accident, Incident, and Exposure Investigation Guidelines, Administrative - Patient Safety/Unusua Occurrence Incident Reporting

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Attachments

Patient Mobility Assessment Tool.pdf

Unit Lifting Equipment Assessment

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2022 |
| HR Leaders including CHRO | Tamara Stafford: Dir Talent Development & EWHS | 03/2022 |
| Safe Patient Handling | Beth Willy: Director Clinical Education [PS] | 03/2022 |
| | Beth Willy: Director Clinical Education | 01/2022 |

Status **Pending** PolicyStat ID **11226745**

El Camino Health

| | | | |
|---|---|---|---|
| Origination | N/A | Owner | Margarita Guizar |
| Last Approved | N/A | Area | Corporate Compliance |
| Effective | Upon Approval | Document Types | Procedure |
| Last Revised | N/A | | |
| Next Review | 3 years after approval | | |

# Privacy Breach Notification



## COVERAGE:

All El Camino Hospital employees, contractors, volunteers, affiliates, clinics and business partners, collectively referred to as "ECH".

## PURPOSE:

To assure ECH complies with privacy breach notification requirements as required under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the California Confidential Medical Information Act ("CMIA"), the Compliance Department ("Compliance") investigates and completes a breach risk of harm assessment in collaboration with the stakeholders involved with the incident and upon discovery of a potential breach or when an unauthorized acquisition, access, use or disclosure of protected health information ("PHI") has occurred.

## DEFINITIONS:

A. **Breach:** the impermissible acquisition, access, use, or disclosure of protected health information. This does NOT include:

   1. Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or business associate if such acquisition, access, or use was made in good faith and within the scope of of work and does not result in further use or disclosure in a manner not permitted under HIPAA or the CMIA.
   2. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized

to access protected health information at the same covered entity or business associate, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA or CMIA.

3. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonable be retained.

B. **Discovery Date:** the first day the breach is known to ECH, or, by exercising reasonable diligence would have been known to any person other than the person committing the breach who is a workforce member or agent of ECH (45 C.F.R. § 164.404(a)(2)).

C. **Medical Information:** any individually identifiable information, in electronic or physical form, that is combined with the individual's health information in possession of or derived from ECH .

D. **Personal Information:** a user name or email address in combination with a password security question/answer that would permit access to an online account; or an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data element(s) are not encrypted:

1. Social Security Number;
2. Driver's License Number or California Identification Card Number;
3. Account Number, Credit or Debit Care NUmber in combination with any required security code, access code, or password that would permit access to an individual's financial account;
4. Medical Information which includes any information regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional;
5. Health insurance information that includes health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records
6. Information collected through use of an automated license plate recognition system

E. **Protected Health Information ("PHI"):** a direct-identifier in combination with health information from an individual's past, present, or future physical or mental health condition, also known under HIPAA as individually identifiable health information. This does not include protected health information within employment records, which is separately protected under the Family Educational Rights and Privacy Act, Americans with Disabilities Act, and the California Medical Information Act.

F. **Workforce Member:** Employees, volunteers, trainees, and other persons whose conduct, in performance of work for a covered entity or business associate, is under the direct control of ECH.

# REFERENCES:

- 45 C.F.R. § 164.400 - 164.414

- 45 C.F.R. § 164.103

# PROCEDURE:

Employees aware of a potential breach of PHI must report to Compliance immediately. All employees are expected to support and assist management and Compliance in the investigation, as requested.

**In the event of a suspected breach of protected health information or medical information:**

1. Submit an iSafe report or email Compliance at compliance@elcaminohealth.org.
2. Compliance enters the incident in the compliance incident system, sets the discovery date to the date incident was reported to Compliance, and begins the investigation.
3. Upon collection of all facts, Compliance completes a HIPAA Breach Risk of Harm Assessment in collaboration with the stakeholders involved with the incident
    - The risk of harm assessment is completed by Compliance using a HIPAA Breach Risk of Harm Assessment Tool in order to determine the probability that the PHI was compromised based on the following four factors:
      The nature and extent of the protected health information involved
      Whether the information was secured/encrypted
      Whether the protected information was viewed
      Whether the risk of exposure was mitigated and could not be reasonable retained, ie. destroyed or returned, preventing further disclosure
4. If deemed a reportable Breach, Compliance begins the notification process to CDPH, the Patient, and HHS where appropriate.
    - CDPH Notice is sent electronically through CalHEART, or by Fax and Mailed with a copy of the patient's letter attached
    - Patient's notice is sent by mail
    - HHS notice is submitted electronically within the time-frame established in the HIPAA Breach Risk of Harm Assessment and in compliance with HIPAA Breach Notification Requirements.

Compliance issues notifications to individuals in the event of a confirmed impermissible acquisition, access, use, or disclosure of protected health information, medical information, or personal information as defined under HIPAA and CMIA respectively. Business Associates are also required to issue notice(s) in the event of a breach and is equally responsible for complying with the breach notification laws, rules, and regulations. *NOTE: In the event of unauthorized access jeopardizing the cyber security of ECH network or systems, Employess must immediately notify the Information Security Department.*

## Notice to Affected Patient

Notice is provided by Compliance via first-class mail at the last known address or by e-mail (if the patient has agreed to electronic communication). In the event that the patient is deceased and a next of kin or personal representative of the patient is listed in the medical record, notice will be sent to the deceased next of kin or personal representative. *NOTE: If Social Security and/or Driver's License numbers are involved, also refer to the Identity Theft Detection and Prevention procedure.*

**Notification to the Affected Patient must include the following elements:**

- Name of Affected Patient
- Discovery Date
- Date of Breach/Incident
- Facility Name, Address, and Contact
- Name of Violator
- Description of Incident
- Corrective/Mitigating Action

## CDPH Breach Notice

Notification is provided to the patient and California Department of Public Health ("CDPH") by Compliance within 15 business days from the date of discovery of a breach.

**Notification to CDPH must include the following elements:**

- Name of Affected Patient
- Discovery Date
- Date of Breach/Incident
- Date Patient Notified
- Breach Type
- Facility Name, Address, and Contact
- Name of Violator
- Type of Breached Information
- Likelihood of re-identifying the individual
- Description of Incident
- (if applicable) Audit Reports
- (if applicable) Witness Statements
- (if applicable) 6-year look back of breach with same patient
- Correct/Mitigating Action



Notice to CDPH is submitted by fax to (408) 277-1032 and by first-class mail to the local District Office:

**California Department of Public Health**
**Licensing and Certification District Office**
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113

**Upon receipt of the CDPH Determination Letter, Compliance will proceed as followed:**

| CDPH DETERMINATION | ACTION |
|---|---|
| Substantiated with No Deficiencies | File with closed case file |
| Substantiated with Deficienciencies | Follow instructions/corrective actions provided by CDPH on the determination letter, and re-open the case file. Close the file once deficiencies have been completely addressed. |
| Unsubstantiated | File with closed case file. |

## HHS Breach Notice

Notification to the Department of Health and Human Services ("HHS") is sent by Compliance and is dependent on a risk of harm assessment completed by Compliance and in collaboration with stakeholders involved with the incident. This will determine if notice to HHS is due no later than 60 calendar days from discovery of the breach, or no later than 60 days after the close of the calendar year. There are specific elements required in each notification.

A. For notices required 60 days after the calendar year:
    1. Run a report from the compliance incident reporting system of Reportable Privacy Incidents for the calendar year.
    2. Validate all hard-copy files align with the Reportable Privacy Incident report.
    3. Go to the HHS Breach Portal at https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf
    4. Complete the electronic form following the online prompts. *NOTE: An individual entry is needed for each HHS reportable incident.*
    5. Save a copy of the online submission to the case file in the compliance incident reporting system.

B. For notices required within 60 days from discovery of a breach:
    1. Go to the HHS Breach Portal at https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf
    2. Complete the electronic form following the online prompts. *NOTE: An individual entry is needed for each HHS reportable incident.*
    3. Save a copy of the online submission to the case file in the compliance incident reporting system.

**Notification to HHS must include the following elements:**

- Discovery Date
- Date of Breach/Incident
- Date Patient Notified
- Breach type
- Facility Name, Address, Contact

- Type of Breached Information
- Description of Incident
- Corrective/Mitigating Action Taken

If 500 or more individuals are affected, notice to HHS is submitted electronically through the OCR Breach Portal and posted in a prominent media outlet, such as the ECH website. However, if less than 500 individuals are affected, then only an electronic notice to HHS through the OCR Breach Portal within 60 days after the close of the calendar year is necessary.

## Delay of Notification for Law Enforcement Reasons

In the event that law enforcement provides notice in writing that notice to an individual, HHS, or business associate of the breach may interfere with a criminal investigation and a delay in notice is necessary, the notice must include the delay time required. Compliance and Legal will confirm that the notice is valid.

Verbal notice may be accepted subject to proper validation of the law enforcement officer's identity and will only be granted a 30-day delay.

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2022 |
| Director of Corporate Compliance | Diane Wigglesworth: Sr Dir Corporate Compliance | 03/2022 |
| | Margarita Guizar: Manager Privacy | 03/2022 |

Status **Pending** PolicyStat ID **11051624**

| | | | |
|---|---|---|---|
| Origination | 03/2012 | Owner | Dan Pipal |
| Last Approved | N/A | Area | Scopes of Service |
| Effective | Upon Approval | | |
| Last Revised | 03/2022 | | |
| Next Review | 3 years after approval | | |

# Scope of Service: Rehabilitation Services



## Type and Ages of Patients Served

Rehabilitation Services serves young adult, adult and geriatric in-patients and out-patients. Neonates and pediatric patients up to two years of age are treated in our NICU by an ECH provider.

## Assessment Methods

Therapeutic exercises/activities and modalities are provided to patients after assessment by licensed/ registered physical, occupational and speech therapists, as appropriate per departmental policies and procedures, who monitor patients' responses to therapy. All therapeutic activities follow an established plan of care documented in the evaluation or re-evaluation of the patient's status.

## Scope and Complexity of Services Offered

Rehabilitation Services provides comprehensive specialty rehabilitation services for El Camino Hospital including inpatient and outpatient care. These services include Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Pathology (speech therapy (ST). The inpatient services cover all areas of the hospital. The highest volumes of patients seen are orthopedic patients including joint replacements; neurosurgical patients; neurological patients (especially post CVA); and medical-surgical patients. Neonatal patients are also regularly treated. Pediatric and psychiatric patients are occasionally treated

The outpatient clinics at Mountain View and Los Gatos provide Occupational Therapy, Physical Therapy, and Speech and Language Pathology. All clinical areas of the patient population are served. The highest volume seen are orthopedic patients, especially those with lumbar and cervical injuries and joint

replacements; industrial injuries; neurological patients, especially those post-CVA; general medicine patients; arthritis patients; post-surgical patients and those with cumulative trauma.

All specialty services are provided by skilled and licensed/certified professionals. Services are provided on a referral basis only. All staff works actively to promote and support the mission, vision, and values of El Camino Hospital.

# Rehabilitation Services Provides:

| | |
|---|---|
| **PT** | Back care training, gait training/ambulation, transfer training, manual therapy, therapeutic exercise programs, neuromuscular re-education, pelvic floor interventions, prosthetic training, modalities, neonatal massage therapy, neonatal voice therapy, and developmental interventions & programs as appropriate. |
| **OT** | Evaluation and treatment of daily living, social, educational, play/leisure skills, work adjustment, sensorimotor evaluation and therapy, self-management, therapeutic adaptations, preventive techniques, cognitive evaluation and therapy, UE evaluation and treatment, neuromuscular re-education, splinting and therapeutic activities, neonatal massage therapy, neonatal voice therapy, and developmental interventions & programs as appropriate. |
| **ST** | Evaluation and treatment of speech and language disorders or dysphagia evaluation and treatment, including Vital Stimulation, evaluations and treatment of cognition impairments, assisting the radiologist with videofluoroscopic examinations, neonatal massage therapy, neonatal voice therapy, and developmental interventions & programs as appropriate. |



# Appropriateness, Necessity and Timeliness of Services

Rehabilitation Services assesses the appropriateness and necessity of therapeutic exercises/ activities and modalities by evaluating the patient's clinical history and current condition for pertinence to the therapy ordered. Criteria for the termination of rehabilitation services are described in the departmental policies and procedures.

The timeliness of services is addressed in departmental policies and procedures that describe the hours of operation, criteria for prioritization of patients/treatments, as well as performance of routine procedures.

# Staffing/Staff Mix

Rehabilitation Services hours of service for in-patient rehab therapy are daily, 8:30 a.m. to 5:00 p.m.; regular NICU days of service are Monday-Friday. Diminished staffing levels are scheduled during weekends and holidays.

| | |
|---|---|
| **IN-PATIENT** | El Camino Hospital **Mountain View** (main building)<br>2500 Grant Road<br>Mountain View, CA 94039-7025<br>Mail Stop: 4A 4AREH<br>Phone: (650) 940-7269 |

| | |
|---|---|
| | El Camino Hospital **Los Gatos**<br>815 Pollard<br>Mail Stop: LGH117<br>Los Gatos. CA 95032<br>Hours:<br>Sunday - Saturday, 8:30 a.m. - 5:00 p.m.<br>Legal holidays, except as listed:<br>8:30 am – 5:00 pm |

Outpatient rehabilitation services are provided Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of all legal holidays, or by special appointment.

| | |
|---|---|
| **OUT-PATIENT** | **Mountain View**<br>Park Pavilion Building, 2nd Floor<br>2400 Grant Road<br>Mountain View, CA 94040-4378<br>Mail Stop: PAR 210<br>Phone: (650) 940-7285<br>Fax: (650) 965-2992 |
| | **Los Gatos**<br>555 Knowles Drive, Suite 100<br>M/S: KNO101<br>Los Gatos. CA 95032<br>Phone: (408) 866-4059<br>Fax: (408) 871-2347<br><br>Hours:<br>Monday - Friday, 8:00 a.m. - 5:00 p.m.<br>Closed on legal holidays |



The types of staff providing care and services include licensed/registered physical, occupational and speech therapists; licensed/registered physical and occupational therapy assistants; therapy aides and front desk staff.

# Levels of Service Provided

The levels of services provided by the department are consistent with the therapeutic needs of the patients as determined by the medical staff.

Services are designed to meet patient needs by accurately performing procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which Rehabilitation Services meet patient needs.

# Standards of Practice

Rehabilitation Services is governed by state regulations as outlined in Title 22, Physical Therapy Practice Act, Occupational Therapy Practice Act and Speech Therapy Practice Act. The department also follows

guidelines set forth by the American Occupational Therapy Association, American Physical Therapy Association and the American Speech, Hearing and Language Association. Additional practices are described in department policies and procedures (see below):

1. Physical Therapy:

   Physical Therapy assists in the prevention, correction or alleviation of pain, disability or deformity caused by injury or disease. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Physical Therapy provides, but is not limited to, the following services:

   a. Functional evaluations and goal setting.
   b. Medical, neurological and orthopedic rehabilitation.
   c. Therapeutic exercise, including strengthening, flexibility training, and developmental interventions.
   d. Modalities: traction, moist heat, cold, electrotherapy, and ultrasound.
   e. Manual therapy: myofascial release, peripheral and spinal joint mobilization, soft tissue mobilization, manual traction, and neonatal touch and massage.
   f. Gait, transfer training, and neonatal 4-handed care for positioning.
   g. LE Prosthetic training.
   h. Use of exercise equipment.
   i. Balance training, coordination training, and neonatal neuromuscular reeducation.
   j. Patient, family and caregiver education and training.
   k. Ergonomic assessments, injury prevention training, and neonatal positioning programs to preserve musculoskeletal integrity.
   l. Advancement of physical therapy rehabilitation programs
   m. Aquatic therapy.
   n. Evaluation and treatment of pelvic floor dysfunction

      Advanced Practice Physical Therapy: Additional and separate current certification is required for any Physical Therapist performing procedures involving Electromyography or Electroneuromyography.

2. Occupational Therapy:

   Occupational Therapy provides for goal-directed, purposeful activity to aid in the development of adaptive skills and performance capacities by individuals of all ages who have physical disabilities and related psychological impairment(s). Such therapy is designed to maximize independence, prevent further disability, and maintain health. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Occupational Therapy provides, but is not limited to, the following services:

   a. Functional evaluations and goal setting.
   b. Medical, neurological, orthopedic, and developmental interventions for rehabilitation.

c. Sensorimotor, cognitive and perceptual evaluation and rehabilitation; neonatal touch and massage.
d. Balance and coordination training; neonatal neuromuscular reeducation, neonatal positioning programs to preserve musculoskeletal integrity..
e. Energy conservation training.
f. Bed mobility and transfer training; neonatal 4-handed care for positioning.
g. Wheelchair fitting and mobility training.
h. Activities of daily living (ADL) training.
i. Advancement of Occupational Therapy rehabilitation programs.
j. Feeding training.
k. Patient, family and caregiver education and training.
l. Recommendations for static and dynamic splinting.
m. Therapeutic exercises.

Advanced Practice Occupational Therapy: Additional and separate current certification is required for any Occupational Therapist treating patients in the areas of:

a. Hand Therapy – including, but not limited to, fabrication of static and dynamic splints, manual peripheral joint mobilization, soft tissue mobilization, UE prosthetic training
b. Use of physical agent modalities
c. Swallowing Assessment, Evaluation or Intervention

3. Speech and Language Pathology:

Speech and Language Pathology services include screening, assessing and interpreting disorders of speech and language, oral-pharyngeal function, and cognitive/communicative disorders. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Speech and Language Pathology provides, but is not limited to, the following services:

a. Diagnostic speech and language evaluation and goal setting.
b. Videofluoroscopy.
c. Cognitive evaluation and treatment.
d. Prosthetic assessment and training.
e. Dysphagia evaluation and treatment.
f. Advancement of Speech Therapy rehabilitation programs.
g. Patient, family and caregiver training.
h. Assessment and interventions for neonates including: developmental interventions, neonatal touch and massage, neonatal 4-handed care for positioning, neonatal neuromuscular reeducation, and neonatal positioning programs to preserve musculoskeletal integrity.

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Stephanie Iljin: Manager Administration | Pending |
| MEC | Franz Encisa: Director Quality and Public Reporting [PS] | 05/2022 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2022 |
| Department Medical Director or Director for non-clinical Departments | Dan Pipal: Dir Rehabilitation Svcs | 03/2022 |
| | Dan Pipal: Dir Rehabilitation Svcs | 03/2022 |

# PLACEHOLDER

**This document is in process and will be available on Tuesday, June 7, 2022.**

# Proposed Fiscal Year 2023 Organizational Performance Goals – Draft 05/26/2022

**(highlights indicate variance from ECC presentation)**

| True North Pillar | Weight | GOAL | OBJECTIVES/ OUTCOMES | Benchmark | | Measurement Defined | | | Measurement Period |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Internal Benchmarks | External Benchmark | Minimum | Target | Stretch | |
| **Threshold** | | Operating EBIDA Margin | Maintain positive EBIDA Margin | FY2020: 11.6%; FY2021: 15.8%<br>FY2022 through March: 19.6%<br>Budget FY2023: 16.7% | Moody's: Median for 'A1': 9.7% Median for 'Aa3': 8.9% | ≥ 13.4% Operating EBIDA Margin (80% of budget) | | | FY2023 |
| **Quality and Safety** | 30% | Zero Preventable Harm | HAC Index | FY2022 composite score | Internal Calculation; limited external benchmarks | 5% improvement from FY2022 baseline | 7.5% improvement from FY2022 baseline | 10% improvement from FY2022 baseline | FY2023 |
| **Service** | 15% | Exceptional Personalized Experience, Always | Likelihood to Recommend (LTR) – Inpatient | FY2021: 79.6 (80th %ile)<br>FY2022 through April:81.1<br>(88th % ile) | Press Ganey | Maintain FY2022 baseline | Top 50% of improvers | Top 30% of improvers | FY2023 |
| | 15% | | LTR – El Camino Health Medical Network | FY2021: 76.0 (26st% ile)(NRC)<br>FY2022 through April : 75.0 (21st%ile) (NRC)<br>*FY2022 Jan – Apr (PG) 81.0*<br>*(20th %ile)* | Press Ganey | Maintain FY2022 baseline | Top 50% of improvers | Top 30% of improvers | FY2023 |
| **People** | 20% (Managers) | Teams Aligned & Empowered With Trust and Purpose | Culture of Safety | FY2018: 4.04<br>FY2021: 3.96 | 2021 Nat. Avg. - 4.01<br>Targets based on statistically significant improvement | 3.99 | 4.02 | 4.04 | FY2023 |
| **People** | 20% (Employees) | | | Participation in Culture of Safety Survey | Press Ganey average participation-75% | 80% | 85% | 90% | FY2023 |
| **Finance** | 20% | Sustainable Strength and Vitality | Operating EBIDA Margin | Actual FY2020-22: 11.6%; 15.8%; 18.0%<br>Actual FY2022 through April: 19.6%<br>Budget FY2023: 16.6% | Moody's: Median for 'A1': 9.7%<br>Median for 'Aa3': 8.9% | 100% of budget (16.6%) | 105% of budget (17.4%) | 110% of budget (18.3%) | FY2023 |

# OPEN SESSION CEO Report
# June 8, 2022
# Dan Woods, Chief Executive Officer

**Operations**

El Camino Health's Los Gatos and Mountain View hospitals earned a Centers for Medicare & Medicaid Services (CMS) 5-Star Overall Hospital Quality Rating. The overall hospital rating summarizes a variety of measures on Hospital Compare reflecting common conditions that hospitals treat.

CMS uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system — the Star Rating Program. The overall hospital rating shows how well each hospital performed, on average, compared to other hospitals in the U.S. and is meant to enhance the ability of patients to choose the healthcare that is best for them. The overall hospital rating ranges from 1 to 5 stars. The more stars, the better a hospital performed on the available quality measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care and efficient use of medical imaging.

Last week, Newsweek recognized ECH Mountain View for 5-ribbon performance (top performance) and as one of America's Top Maternity Hospitals for 2022. The evaluation is based on three data sources: a nationwide online survey in which hospital managers and maternity healthcare professionals (e.g., neonatal care providers and OB/GYNs) were asked to recommend leading maternity hospitals; medical key performance indicator data relevant to maternity care (e.g., a hospital's rate of cesarean births); and patient satisfaction data (e.g., how patients rated a hospital's medical staff for responsiveness and communication).

El Camino Health has earned a distinguished three-star rating from The Society of Thoracic Surgeons (STS) for its patient care and outcomes in aortic valve replacement (AVR), coronary artery bypass grafting (CABG) and Mitral Valve Repair/Replacement (MVRR). The three-star rating, which denotes the highest category of quality, places El Camino Health among the only hospitals in the Bay Area with these reults. The STS star rating system is one of the most sophisticated and highly regarded overall measures of quality in health care, rating the benchmarked outcomes of cardiothoracic surgery programs in the United States and Canada. The star rating is calculated using a combination of quality measures for specific procedures performed by an STS Adult Cardiac Surgery Database participant.

**Marketing and Communications**

All creative assets of the "Accept Nothing Less" brand advertising campaign have launched including 3 additional TV spots (primary care, cardio, and cancer ), digital, social, OOH (flagpoles) and print. The campaign runs for 10 months (March-December).

The team supported all Hospital Week planning and communications activities and produced numerous training materials for El Camino Health's Safety First/Mission Zero HRO initiative.

**Human Resources**

During the month of May Human Resources continued to provide key support to the Safety First/Mission Zero journey by recruiting and training 40 leaders from across the organization to become Universal Skills Trainers. These individuals will responsible for training nearly 5,000 employees and medical staff members over the next seven months in tools that will support highly reliable and safe processes. Building on the success of our first RN Bridge Program, Recruiting and Clinical Education partnered to open up a second cohort, hiring 16 RNs who will begin in July. Talent Development launched an Employee Engagement/Culture of Safety Pulse survey with the results to be available in July.

**Finance**

In the past couple of months, we completed our annual updates with the credit rating agencies. I'm pleased to share that Moody's affirmed our 'A1' rating and revised our outlook from 'Stable' to 'Positive'. This is significant given the instability in our industry and acknowledgment of the initiatives we've implemented to mitigate the impact of Covid, workforce challenges and inflation have yielded the intended results.

The month ending April 30, 2022, produced net operating revenue, after expenses, of $10.0 million. Net income was unfavorable to budget by $61.0 million and $82.8 million lower than the same period last year. This is attributed the instability in the capital markets which resulted in unrealized losses of $52.5 million in the month of April. Please note these results were presented and approved at the May 26th Finance Committee meeting.

**Information Services**

The Distributed Antennae System (DAS) was recently upgraded to provide enhanced cellular signal coverage for the main three service providers (AT&T, Verizon, T-Mobile) on the Mountain View campus. In addition, a recent upgrade to the Wireless Network has enabled an improved mobile and digital connected experience for clinicians, patients and visitors when moving within and externally to campus buildings. The new wireless network provides the foundation for the next generation of communication tools and devices while supporting security requirements to keep data and patients safe.

A new automated enterprise daily huddle dashboard combines EMR data and operational metrics such as census information, COVID volumes and patient through-put to support the daily Enterprise Huddles. The new dashboard eliminates manual entry of the information saving staff time while reducing potential errors in data entry highlighting the value of analytics and data to our organization.

**Philanthropy**

More than 100 friends and supporters of El Camino Health and the foundation gathered at Los Altos Golf & Country Club on May 14, 2022 for Taking Wing, a gala benefiting the renovation and expansion of the Orchard Pavilion for Maternal and Child Health. Attendees heard from three grateful patient families, including a video message from San Francisco 49ers punter Mitch Wishnowsky and his wife Maddie Wishnowsky, whose baby was born in the Orchard Pavilion last fall. CEO Dan Woods described the construction plans and process, and the impact it would have on patient care. Chief Administrative Services Officer Ken King took guests on a video hard hat tour of the construction site and Dr. Anna Anderson, medical director of obstetric services spoke briefly about what the renovation means for clinicians and patients. The guests enthusiastically participated in the evening's fundraising activities, including a raffle, silent auction, and fund-in-need appeal.

**Corporate & Community Health Services**

The Chinese Health Initiative (CHI) welcomed a patent attorney as a new advisory board member. The 10th anniversary event was a great success. CHI participated in a senior resource fair in Mountain View.

The South Asian Heart Center engaged 490 new and prior participants in screening, education and coaching that included 635 consultations and coaching sessions. The center hosted lifestyle workshops and health information events attended by 200 community members.

**Auxiliary**

The Auxiliary donated 2,942 volunteer hours for the month of April.

**Revised 5/30/2022**

| FY22 Hospital Board Pacing Plan – Q1 | | |
|---|---|---|
| **JULY - NO MEETING** | **August 18, 2021** | **September 22, 2021 (Rescheduled)** |
| | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (GC, FC, ECC)<br>• Quality Committee Report (Board Quality Dashboard)<br>• Medical Staff Report (Closed) With Q4 Appt. and Resignation Summary)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (IC, CAC) – Written Memo as needed<br>• Quality Committee Report<br>• Executive Session<br>• Public Communication |
| | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Medical Staff Report (Open)<br>• FY 21 Period 11 Financials<br>• Credentialing and Privileges Report | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Credentials and Privileges Report |
| | **Informational Items:**<br>• CEO Report w/Auxiliary, Foundation Reports | **Informational Items:**<br>• CEO Report<br>• FY22 Period 1 Financials |
| | **Specific Items:**<br><u>Approvals</u>:<br>• FY21 Period 12 Financials<br>• FY22 Organizational Performance Goals<br>• Board Action Plan | **Specific Items:**<br><u>Approvals</u>:<br>• FY21 Patient Safety Claims Report (Annual) |
| | <u>Discussion</u>:<br>• Enterprise Risk Management<br>• Strategic Plan | <u>Discussion</u>:<br>• FY21 Strategic Plan Metrics (Final) |

**Revised 5/30/2022**

| FY22 Hospital Board Pacing Plan – Q2 | | |
|---|---|---|
| **October 13, 2021** | **November 10, 2021** | **December 8, 2021** |
| **Regular Items:**<br>• Board Recognition<br>• Committee Reports (FC, ECC, CAC,)<br>• Quality Committee Report (Open Consent)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (GC meeting, ECC)<br>• Quality Committee Report (Open Session Discussion Board Quality Dashboard)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports<br>• Quality Committee Report (Open Consent)<br>• Executive Session<br>• Public Communication |
| **Consent Calendar Approvals:**<br>• Board Minutes (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Annual 403(b) Audit<br>• Participant Cash Balance Plan Audit<br>• Closed Session QC Report (C&P, QC Minutes)<br>• FY21 CB Plan Report | **Consent Calendar Approvals:**<br>• Board Minutes (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Medical Staff Report (Open)<br>• Annual Safety Report for the Environment of Care<br>• Closed Session QC Report (C&P, QC Minutes)<br>• Reappoint Carlos Bohorquez to PHHH Board (term expires) | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Letters of Rebuttable Presumption<br>• FY22 P3 Financials<br>• Closed Session QC Report (C&P, QC Minutes) |
| **Informational Items:**<br>• CEO Report Incl. Auxiliary and Foundation Reports (Foundation Report in Person) | **Informational Items:**<br>• CEO Report Incl. Auxiliary Foundation Reports<br>• FY22 Period 3 Financials | **Informational Items:**<br>• CEO Report Incl. Auxiliary, Foundation Reports<br>• MV Site Plan Status (From Nov. FC) |
| **Specific Items:**<br><u>Approvals</u>:<br>• FY22 Period 2 Financials<br>• FY21 Audit<br>• FY21 Organizational Performance Goal Score<br>• FY21 Organizational Performance (Incentive) Goal Achievement (Score)<br>• FY22 Executive Base Salaries, Salary Ranges<br>• FY21 CEO Incentive Comp. Individual Score and Payment<br>• Capital Purchase – 2660 Grant Road | **Specific Items:**<br><u>Approvals</u>:<br>• Board Action Plan<br>• FY21 Compliance Summary<br>• FY22 Period 4 Financials (Quarterly Financial Report) | **Specific Items:**<br><u>Approvals</u>:<br>• |
| <u>Discussion</u>:<br>• Governance Best Practices | <u>Discussion</u>:<br>• FY22 Strategic Plan Metrics Update (Q1 Results)<br>• ECHMN (SVMD) Semi-annual Report | <u>Discussion</u>:<br>• Strategic Planning Update<br>• ERM – Follow Up Discussion<br>• Board Assessment |

**Revised 5/30/2022**

| FY22 Hospital Board Pacing Plan – Q3 | | |
|---|---|---|
| **January 2022 – NO MEETING** | **February 9, 2022** | **March 9, 2022** |
| | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (FC, CAC, GC)??<br>• Quality Committee Report (Open Discussion Board Quality Dashboard)<br>• Medical Staff Report (Closed) (With Q2 Appt. and Resignation Summary)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (GC, CAC)<br>• Quality Committee Report (Exception Report/Underperforming Metrics)<br>• Executive Session<br>• Public Communication |
| | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Medical Staff Report (Open)<br>• Period 5 Financials<br>• Closed Session QC Report (C&P, QC Minutes) | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations<br>• Closed Session QC Report (C&P, QC Minutes) |
| | **Informational Items:**<br>• CEO Report Incl. Auxiliary, Foundation Report, ERM | **Informational Items:**<br>• CEO Report Incl. Auxiliary, Foundation Reports<br>• FY 21 Period 7 Financials |
| | **Specific Items:**<br><u>Approvals</u>:<br>• FY 22 Period 6 Financials (Quarterly Financial Report)<br>• Board Member Benefits<br>• ~~Proposed Revised Community Benefits Policy (Delegation to FC)~~ | **Specific Items:**<br><u>Approvals</u>:<br>• Draft Revised Long-Term Operating and Capital Financial Plan<br>• ~~PBX Call Center Scope of Service~~<br>• Strategic Plan Approval (Open Session) |
| | <u>Discussion</u>:<br>• Strategic Planning Update<br>• Strategic Plan Implementation - Q2 FY22 Metrics<br><br>*** February 23, 2022: Board Retreat - Understanding Systemness and System Alignment & Building an Outpatient Strategy* | <u>Discussion</u>:<br>• ~~MSO Education~~<br>• Enterprise Risk Management (Follow-up Discussion) |

**Revised 5/30/2022**

| FY22 Hospital Board Pacing Plan – Q4 | | |
|---|---|---|
| **April 13, 2022** | **May 11, 2022** | **June 8, 2022** |
| **Regular Items:**<br>• Board Recognition<br>• Committee Reports (GC, CAC, FC, ECC)<br>• Quality Committee Report (Open Consent)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports<br>• Quality Committee Report (Open Discussion Board Quality Dashboard)<br>• Executive Session<br>• Public Communication | **Regular Items:**<br>• Board Recognition<br>• Committee Reports (IC, GC, ECC, FC, CCC)<br>• Quality Committee Report (Open Consent)<br>• Executive Session<br>• Public Communication |
| **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Committee Recommendations (GC, CAC, ECC, FC)<br>• Medical Staff Report (Open)<br>• FY21 Period 7 and 8 Financials<br>• Closed Session QC Report (C&P, QC Minutes) | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Approval of Auxiliary Officers<br>• Closed Session QC Report (C&P, QC Minutes) | **Consent Calendar Approvals:**<br>• Board (Open and Closed)<br>• Policies<br>• Physician Agreements<br>• Med Staff Report (Open) w/Clinical Contracts<br>• **FY23 Master Calendar**<br>• **FY23 Committee Goals**<br>• **FY23 Committee and Liaisons Appointments**<br>• Closed Session QC Report (C&P, QC Minutes) |
| **Informational Items:**<br>• CEO Report w/Auxiliary, Foundation Reports<br>• MV Site Plan Status (From March FC) | **Informational Items:**<br>• CEO Report w/Auxiliary, Foundation Reports | **Informational Items:**<br>• CEO Report w/Auxiliary, Foundation Reports<br>• Individual Goals<br>• Executive Performance Incentive Plan<br>• MV Site Plan Status (from June FC) |
| **Specific Items:**<br>Approvals:<br>• Value Proposition Statement | **Specific Items:**<br>Approvals:<br>• Board Quality Dashboard<br>• FY21 Period 9 Financials | **Specific Items:**<br>Approvals:<br>• **FY22 CEO Salary and Contract**<br>• FY22 Community Benefit Plan<br>• **Board Officer Elections** |
| Discussion:<br>• Diversity<br>• ERM | Discussion:<br>• Strategic Plan Implementation FY22 Q3 Metrics and Review,<br>• FY22 Q3 Financial – Quarterly Update<br>• Board Officer Elections Procedure<br>• ~~ECHMN Semi-Annual Report~~<br><br>*** May 26: Joint Meeting with Finance Committee* | Discussion:<br>• FY22 Strategic Plan Goals and Metrics<br>• FY22 Capital and Operating Budget<br>• CQO Salary<br>• Diversity<br>• ~~ECHMN Semi-Annual Report~~ |