Meeting the health needs of our neighbors

GOOD HEALTH IS THE BASIS FOR AN ENGAGED, PRODUCTIVE LIFE. Despite the prosperity in Silicon Valley, many people don’t have access to the tools they need to stay healthy. The high cost of housing is making it difficult for many to find an affordable place to live, purchase nutritious food, and secure medical insurance. These and other factors impact the health of low-income and vulnerable communities. El Camino Healthcare District and El Camino Hospital together invested $10 million in grants and sponsorships in fiscal year 2018 to open the doors to better health.

Investing in Our Community’s Health FY 2018

$6.9M Community Benefit
El Camino Healthcare District

$63.5M Community Benefit
El Camino Hospital

From Our Leadership

DEAR COMMUNITY MEMBERS,

We are pleased to share with you the FY 2018 Community Benefit Report for El Camino Healthcare District and El Camino Hospital, “Improving Health, Changing Lives.” To make the report more accessible, we are introducing a new web version at www.elcaminohealth.org/communitybenefit2018. The report highlights how our Community Benefit programs are addressing the unmet health needs of many of our neighbors.

The District and the Hospital together support local efforts to provide access to quality health and wellness services through partnerships with the nonprofits, school districts, clinics, and community service agencies highlighted in this report. These investments have made a difference in the lives of thousands of our neighbors, young and old, and from diverse backgrounds. In FY 2018, we contributed:

- $63.5 million in total El Camino Hospital Community Benefit, including $5.1 million for community health grants and sponsorships
- $69.9 million in community health grants and sponsorships from the El Camino Healthcare District
- 100 grants and 41 sponsorships for a combined total of $10 million

Although the District and the Hospitals have separate, individually funded Community Benefit programs, they share the same goals:

- Make meaningful investments that help individuals in our community — especially the economically disadvantaged — get the healthcare they need
- Fund local programs and activities that contribute to the health and well-being of the entire community

We invite you to read how our Community Benefit commitment is helping our neighbors through vital support services, such as primary care and dental care for low-income and homeless individuals, school-based health programs, mental health counseling, diabetes and hypertension prevention, food pantries, and support for at-risk youth and victims of domestic violence. Together, we can meet the challenges of preventing disease, supporting good health at every stage of life, and helping all members of our community access healthcare that meets the highest standards of excellence.

Read our report online at www.elcaminohealth.org/communitybenefit2018
COMMUNITY BENEFIT AT A GLANCE

Social Determinants of Health

Our health is influenced by a complex set of conditions based on where we live, work, and age, as well as our race, ethnicity, and socioeconomic status. These are called social determinants of health. Factors that impact health such as diet, exercise, stress, and access to healthcare are affected by these conditions. If we are born into a family with enough resources to buy nutritious food, live in a safe neighborhood, afford healthcare, and pay for education, our chances of living a healthy life are much greater. On the other hand, if we are born into a family struggling to make ends meet and healthy food is scarce, doctor visits are few and far between, and there is little chance of a solid education or job training, our health prospects are much worse.

El Camino Healthcare District and El Camino Hospital support local efforts to address these social determinants of health through our Community Benefit grant programs. We conduct a Community Health Needs Assessment with other healthcare leaders to determine the most pressing health issues in our region.

Caring for Vulnerable Neighbors

When people struggle just to make ends meet, their health can suffer. Low-income communities face higher rates of diseases like diabetes and hypertension. Many don’t have access to regular healthcare, making it difficult to get preventive health screenings and other medical services. Healthy food is often too expensive to buy on a regular basis, if at all. Cultural and language barriers can make it even harder to get care. Through Community Benefit grants, many of our partners provided free culturally appropriate health and wellness services in multiple languages.

Vital health services provided to vulnerable community members include:

- Primary care access
- Dental services
- Health screenings
- Social work case management
- Psychiatric and counseling services
- Falls prevention for older adults
- Food pantries and healthy food access programs

Grant Cycle and Timeline

El Camino Healthcare District and El Camino Hospital provide annual grants to community-based organizations, clinics, and schools to address local unmet health needs. This annual Community Benefit Report provides an overview of these funded programs and the critical services they deliver.

The Community Health Needs Assessment (CHNA) is conducted every three years to identify the top unmet health needs in partnership with six other local hospitals, the Santa Clara County Public Health Department, the Hospital Council of Northern and Central California, and the Palo Alto Medical Foundation. This process includes collecting data on key health conditions, capturing input from a wide spectrum of community members through surveys and focus groups, and prioritizing the unmet needs to be addressed.

El Camino Healthcare District and El Camino Hospital use the most recent 2016 CHNA to guide the Community Benefit grant programs with the following priority area framework: Healthy Body, Healthy Mind, and Healthy Community. These include programs that serve the health needs of our most vulnerable community members.

The annual grant cycle opens in January. For more information visit: www.elcaminohospital.org/communitybenefit, or www.elcaminohealthcaredistrict.org/communitybenefit

See the list of our grant partners for FY 2018 on pages 9 through 11 of this report.
Cultivating Health in Schools

SCHOOLS OFFER KEY OPPORTUNITIES FOR INSTILLING HEALTHY CHOICES AND PROVIDING SERVICES WHERE THEY ARE LACKING. Many families in our community don’t have enough resources to ensure their children eat a healthy diet and get the care they need to stay healthy. Poor health can lead to school absences and other issues that keep children and teens from succeeding at school. Without treatment, physical and mental health conditions can spiral out of control.

School is a great place to reach children and teens, and their families, with programs that can improve physical, emotional, and mental health. Community Benefit grants helped our partners give those in preschool through high school a healthier start in life.

The provision of two school nurses to support our families in ensuring access to healthcare is a tremendous benefit. Other benefits are getting much needed glasses to our students through our Vision To Learn partnership, increasing students’ health with 5-2-1-0, and enhancing their physical fitness awareness through PlayWorks. None of this would have been possible without El Camino Hospital.”

Dr. Shelly Varascon, Superintendent, Campbell Union School District

Health Programs at Our Schools

35 GRANTS
24 DISTRICTS
176 SCHOOLS
463 PROGRAM SITES
1,385 PEOPLE SERVED
$2.9M INVESTED

Improving Mental Health

GOOD MENTAL HEALTH IS CRITICAL FOR A FULL AND SATISFYING LIFE. Mental health conditions can take a toll on relationships, get in the way of job and school success, and impact other health issues. Getting help can be difficult, especially for people with limited resources. Those who go untreated are at higher risk for addiction, self-destructive behavior, and suicide. With our funding, Community Benefit partners were able to address issues such as anxiety, depression, dementia, domestic violence, substance abuse, and bullying.

Services provided to people of all ages include:

- Counseling and psychiatric care
- Crisis intervention
- Case management
- Group support
- Peer counseling
- Addiction services
- Substance abuse

15,410 HOURS
Mental Health Counseling in Local Schools

“We’re so grateful for having the clinic around. It really is the only spot here. The psychiatrist here, he’s the only hookup we’ve got to mental health services. He’s helped to get a lot of us leveled out.”

Pretoria Healthcare Connection patient and formerly homeless community member

“We’re so grateful for having the clinic around. It really is the only spot here. The psychiatrist here, he’s the only hookup we’ve got to mental health services. He’s helped to get a lot of us leveled out.”

Pretoria Healthcare Connection patient and formerly homeless community member

“My healing began when I started coming to support groups at Next Door Solutions. I remember crying the whole time, listening to women telling their stories. At that moment, I realized I’m not alone.”

Participant, Next Door Solutions to Domestic Violence

Mental Health Services

25 GRANTS
$1.9M FUNDED
9,030 PEOPLE SERVED
El Camino Healthcare District
$6,902,005 GRANTS & SPONSORSHIPS

El Camino Hospital
$3,096,213 GRANTS & SPONSORSHIPS

$63.5M El Camino Hospital
TOTAL COMMUNITY BENEFIT

$30,555,812 Government-sponsored healthcare
(Unreimbursed Medi-Cal)

$20,518,753 Subsidized health services

$5,989,544 Financial assistance (charity care)

$3,096,213 Grants and sponsorships

$2,159,576 Health professions education

$727,512 Clinical research

$329,601 Community Benefit operations

$110,844 Community health improvement services

$63,487,855 TOTAL

+$105M in Uncompensated Medicare
(Not included in Community Benefit total)

Healthy Body
PARTNERS

These grants support efforts to prevent the onset of disease and improve access to primary care, chronic disease management, health and wellness education, and oral health.

5210 Health Awareness Program Partnership — School-based nutrition and health programs at Cambrian, Campbell, Cupertino Union, Fremont and Sunnyvale School Districts. Funding: El Camino Healthcare District (ECHD), El Camino Hospital (ECH).

Bay Area Women’s Sports Initiative (BAWSI) — Physical activity and self-esteem program for girls at Cambrian and Sunnyvale School Districts. ECHD, ECH.

Breathe California — Screenings, education, and home assessment for families of children with asthma and seniors with respiratory conditions. ECHD, ECH.

Cambrian School District — School Nurse Program: Filling the gap in care for students. ECH.

Campbell Union School District — School Nurse Program: Filling the gap in care for students. ECH.

Challenge Diabetes Program — Prediabetes screening and education for community service agencies. ECH.

Community Service Agency, Mountain View — Intensive case management for seniors with chronic disease. ECHD.

Cristo Rey Network — School health and wellness programs. ECH.

Cupertino Union School District — School Nurse Program: Filling the gap in care for students. ECHD, ECH.

Day Worker Center — Health programming and nutritious meals for the underserved. ECHD.

Fresh Approach — Mobile Farmers Market and nutrition education. ECHD.

Gardner Family Health Network — Clinical and healthy behavior change program for pediatric and diabetic patients. ECH.

GoFloodLe — Brain breaks, activities designed to help students focus at 183 schools in 20 districts. ECHD, ECH.

Health Mobile — Mobile dental services for homeless and low income community members. ECHD.

Hope’s Corner — Nutritious meals for the homeless and food insecure. ECHD.

Indian Health Center — Clinical and healthy behavior change program for at-risk and diabetic youth. ECH.

Living Classroom — Garden-based school nutrition program at Mountain View Whisman and Sunnyvale School Districts. ECHD.

Lucile Packard Foundation for Children’s Health — Teen Health Van at Mountain View Las Altas High School focused on at-risk youth. ECHD.

MayView Community Health Center — Medical preventive care for the uninsured. ECHD.

Medical Respite — Medical care and social services for homeless patients. ECHD, ECH.

Mountain View Whisman School District — School Nurse Program: Filling the gap in care for students. ECHD.

New Directions — Coordination of care and connection to safety-net services for homeless and at-risk community members. ECHD.

Pathways Home Health and Hospice — Compassionate care for the uninsured and underinsured. ECHD.

Planned Parenthood Mar Monte — Medical care for the underserved. ECHD.

Pre-diabetes Initiative — Awareness, screening, and management resources for pre-diabetes. ECHD.

Playworks — Physical activity and school climate program in Campbell Union, Mountain View-Whisman and Sunnyvale School Districts. ECHD, ECH.

Santa Clara County Office of Education — Early Head Start Advocacy Program. ECHD.

Santa Clara Valley Medical Center — Primary and behavioral mobile healthcare for the homeless, and dental services for low-income and homeless adults. ECHD.

Sunnyvale School District — School Nurse Program: Filling the gap in care for students. ECH.

Vision to Learn — Mobile clinic providing vision screening and delivering eye glasses to low-income students at schools. ECHD, ECH.

Grow with Healthy Kids Foundation — Dental and hearing screenings, and healthy lifestyle education for parents. ECHD, ECH.

Read our report online at www.elcaminohospital.org/communitybenefit2018

2018 GRANT FUNDING PROGRAM PARTNERS

$10M Combined Investments for 151 Grants & Sponsorships
to Address Unmet Health Needs in Our Community
Healthy Mind

PARTNERS

These grants provide access to mental health services for youth and adults. Issues addressed include depression, anxiety, dementia, domestic violence, and substance abuse.

- Acknowledge Alliance — Resilience and social emotional learning lessons for students - ECHD
- Almaden Valley Counseling Service — School-based social emotional skill building - ECHD
- Alum Rock Counseling Center — Mentoring for at-risk youth - ECHD
- Alzheimer’s Association — Asian Dementia Initiative culturally based services for patients and caregivers - ECHD
- Asian Americans for Community Involvement (AAIC) — Senior isolation and depression program - ECHD
- Avenues — Adult day health program - ECHD
- Bill Wilson Center — Therapy for abused children - ECHD
- Cambrian School District — Mental health counseling - ECHD
- CHAC — Mental health counseling at Sunnyvale School District - ECHD
- Child Advocates of Silicon Valley — Advocacy and support services for foster teens - ECHD
- Cupertino Union School District — Mental health counseling - ECHD
- Eating Disorders Resource Center — Support for recovery - ECHD
- Hope Services — Peer to peer counseling/advisory for adults with developmental disabilities - ECHD
- Law Foundation of Silicon Valley — Removing legal barriers to mental health services - ECHD
- Los Altos School District — Mental health counseling - ECHD
- Momentum for Mental Health — Psychiatric services and medication management for the underserved and uninsured - ECHD, ECHD
- Mountain View Los Altos Union High School District — Mental health counseling - ECHD
- National Alliance on Mental Illness (NAMI) Santa Clara County — Peer support for mental health conditions - ECHD
- Peninsula HealthCare Connection — Psychiatric services and medication management for homeless and at-risk community members - ECHD
- Prevention Partnership, Inc. — Culturally based family education for substance use and mental health disorders - ECHD
- Uplift Family Services — Mental health counseling and addiction prevention services for Cambell Union High School District - ECHD

Healthy Community

PARTNERS

These grants promote the improvement of overall health in the community. Programs focus on issues such as access to transportation, fall prevention, and health screenings and education.

- American Heart Association — Hypertension initiative: blood pressure awareness, screening and blood pressure management - ECHD
- Cancer CAREpoint — Nutrition education and support - ECHD
- Chinese Health Initiative — Screenings and education - ECHD
- Family & Children Services (a division of Caminar) — Domestic violence survivor services - ECHD
- Farewell to Falls — In-home assessment, education, and exercise recommendations - ECHD
- Friends for Youth — Connecting at-risk youth with supportive mentors - ECHD
- Great Nonprofits — Hypertension initiative test-based awareness program - ECHD
- Health Library & Resource Center Mountain View and Los Gatos — Evidence-based: health information and medical searches - ECHD
- The Health Trust — Meals on Wheels Program for older adults - ECHD
- KnowYourBloodPressure — Hypertension initiative public awareness campaign - ECHD
- Latinas Contra Cancer — Breast cancer awareness and resources for Latinas - ECHD
- Maitri — Culturally focused crisis counseling and legal representation for domestic violence victims - ECHD
- Matter of Balance — Falls prevention classes for seniors - ECHD
- Mountain View Police Department, Youth Services Unit — Camps for at-risk youth - ECHD
- Next Door Solutions — Crisis counseling, shelter services, and support for victims of domestic violence - ECHD
- Racing Hearts — Automated External Defibrillator (AED) Program: placing nearly 800 devices throughout Santa Clara County, including all public schools - ECHD
- Reach Potential Movement — Physical activity and health programs for low-income youth in Sunnyvale - ECHD
- Rebuilding Together — Home repair program for seniors at risk for falls - ECHD
- RoadRunners — Patient transportation program - ECHD
- Second Harvest Food Bank — Nutrition education - ECHD
- Silicon Valley Bicycle Coalition — Promoting safe physical activity in affordable housing communities - ECHD
- South Asian Heart Center — Screenings and education: for heart disease and diabetes - ECHD, ECHD
- Sunnyvale Community Services — Emergency assistance and social work case management - ECHD
- Teen Successes, Inc. — Promoting self-sufficiency and health education for teen mothers - ECHD
- Valley Verde — Home garden and nutrition education for low-income households - ECHD
- West Valley Community Services — Social work case management, benefits assistance, and nutrition workshops; case management for at-risk seniors - ECHD
- Working Partnerships, USA — Coverage initiative for the remaining uninsured — ECHD
- YWCA Silicon Valley — Summer camp for low-income youth - ECHD
- YWCA of Silicon Valley — Support for at-risk women - ECHD

SPONSORSHIP RECIPIENTS

El Camino Healthcare District
- American Red Cross
- Avenues Housing Conference
- BAWI (Bay Area Women’s Sports Initiative)
- CHAC (Community Health Awareness Council)
- Child Advocates of Silicon Valley
- City of Mountain View Senior Center
- City of Sunnyvale Senior Center
- Community Services Agency Mountain View
- Downtown Streets Team
- Healthier Kids Foundation
- Healthiest
- Hope's Corner
- Mentor Tutor Connection
- Momentum for Mental Health
- Our Kids, Our Community Summer Meals Foundation (Silicon Valley Community Foundation)
- Sunnyvale School District/Sunnyvale Community Services
- Out2L, a Program of Adolescent Counseling Services
- Pacific Stroke Association
- Pathways Home Health and Hospice
- Project WorkIt
- Sunnyvale PAL (Police Athletic League) — Kick, Lead and Dream Soccer Camp
- Valley Medical Foundation

El Camino Hospital
- AAC (Asian Americans for Community Involvement)
- Abilities United
- Aging Services Collaborative
- Alzheimer’s Association
- American Kidney Fund
- Bay Area Older Adults
- Cancer CAREpoint
- Chinese American Coalition for Compassionate Care
- City of San Jose Senior Center
- Walk and Resource Fair
- Congregation Shir Hadash
- Heart Health Fair
- Cystic Fibrosis Foundation
- Heart of Hope American Hospice Care
- Hunger at Home
- Jenny’s Light Run
- Joint Venture Silicon Valley — Self-Sufficiency Standard Report for California
- Los Gatos Lions Club Youth Mental Health Event
- National Alliance on Mental Illness (NAMI)
- San Jose City College
- Next Door Solutions
- People Acting in Community Together (PACT)

 Planned Parenthood Mer Monte
 Kids in Common Children’s Summit
 Precampaña Foundation
 Project Cornerstone
 Services for Brain Injuries
 Silicon Valley Leadership Group
 Turkey Trot and Heart & Sole Run
 Standup for Kids
 Stides for Life Colon Cancer
 Uplift Family Services
 West Valley Services
 YWCA Silicon Valley

 "Thank you for helping us. We never thought we would be in this situation. You were very kind and patient. I would be homeless without your assistance and appreciate your compassion and help." 
 84-year-old senior client with 24-year-old disabled son, Sunnyvale Community Services
El Camino Healthcare District
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

See this report online:
www.elcaminohospital.org/communitybenefit2018

El Camino Healthcare District was formed pursuant to the California Local Health Care District Law (California Health and Safety Code Sections 32000 et seq.) to provide healthcare services that foster good physical and mental health. The District boundaries, set in the late 1950s, encompass Mountain View and Los Altos, large portions of Sunnyvale and Los Altos Hills, and small sections of Cupertino, Santa Clara, and Palo Alto. The District is governed by a five-member publicly elected Board and provides oversight of El Camino Hospital, a nonprofit community hospital. The District also administers a Community Benefit Program, which addresses unmet health needs through grants and collaborations with local schools, nonprofits, and social and health service providers.

El Camino Hospital is an acute-care, 443-bed, nonprofit and locally governed organization with campuses in Mountain View and Los Gatos, California. Key medical specialties include cancer, heart and vascular, men’s health, mental health, neuroscience, orthopedic and spine, senior health, urology, and the first Women’s Hospital in Northern California. The hospital is recognized as a national leader in the use of health information technology and wireless communications, and has been awarded the Gold Seal of Approval from The Joint Commission as a Primary Stroke Center as well as three consecutive ANCC Magnet Recognitions for Nursing Care.
El Camino Hospital

Executive Summary Including Non Community Benefit (Medicare and Bad Debt)

For period from 7/1/2017 through 6/30/2018

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Financial Assistance
### Executive Summary Including Non Community Benefit (Medicare and Bad Debt)

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El Camino Hospital

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</tr>
<tr>
<td>Financial Assistance</td>
<td></td>
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**El Camino Hospital**

**Executive Summary Excluding Non Community Benefit (Medicare and Bad Debt)**

**For period from 7/1/2017 through 6/30/2018**

<table>
<thead>
<tr>
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<tr>
<td>**** Government Sponsored Health Care</td>
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<td>30,555,812</td>
</tr>
</tbody>
</table>

| Totals - Community Benefit   | 131,396 | 63,487,855 |

| Totals - Overall   | 131,396 | 63,487,855 |
Acknowledgments

El Camino Hospital gratefully acknowledges the contributions of the Santa Clara County Community Benefit Coalition for its work on this project. The Coalition members include:

- **El Camino Hospital**, Barbara Avery, Director of Community Benefit
- **Hospital Council of Northern & Central California**, Jeanette Murphy, Regional Office Coordinator
- **Hospital Council of Northern & Central California**, Jo Coffaro, Regional Vice President
- **Kaiser Permanente**, Amy Aken, Sr. Public Affairs Specialist
- **Kaiser Permanente**, Stephan Wahl, Community Health and Benefit Manager
- **Lucile Packard Children’s Hospital Stanford**, Joseph Vaughan, Manager of Community Benefits
- **O’Connor Hospital & Saint Louise Regional Hospital**, Kel Kanady, Community Relations, Marketing Manager, Public Relations
- **Saint Louise Regional Hospital**, Sister Rachela Silvestri, D.C., R.N., Director of Community Health
- **Santa Clara County Public Health Department**, Anandi Sujeer, Manager Epidemiology and Vital Records
- **Stanford Health Care**, Sharon Keating Beauregard, Executive Director, Community Partnership Program
- **Sutter Health**, Janet Lederer, Vice President, Education Division, Sutter Health Regional Community Benefit

**Applied Survey Research** is a social research firm dedicated to helping people build better communities.

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El Camino Hospital would also like to recognize the following individuals for their tremendous effort on this project:

- **Applied Survey Research** - Lisa Colvig-Niclai
- **Applied Survey Research** - Melanie Espino
- **Applied Survey Research** - Jennifer van Stelle, Ph.D.
- **Applied Survey Research** - Angie Aguirre

El Camino Hospital especially recognizes the critical contribution of the Community Benefit Advisory Council for its guidance with this project:

**Community Benefit Advisory Council Members:**

- Barbara Avery (Chair), Director of Community Benefit, El Camino Hospital Mountain View and El Camino Hospital Los Gatos
- Bonnie Broderick, Director of Chronic Disease and Injury Prevention, Santa Clara County Public Health Department
- Cecile Currier, President, CONCERN-EAP; Vice President, Corporate & Community Health Services, El Camino Hospital
- Dr. Rhonda Farber, Past Superintendent, Campbell Union High School District
- Laura Macias, Past Councilmember and Mayor, City of Mountain View
- Dr. Cesar Molina, M.D., Physician and Medical Director of South Asian Heart Center, El Camino Hospital
- Naomi Nakano-Matsumoto, Past Executive Director, Community Health Awareness Council
- Dr. Anil Singhal, M.D., Physician, RotaCare Clinic Volunteer Physician and El Camino Hospital Foundation Board of Directors
- Marilyn Winkleby, Ph.D., M.P.H., Professor of Medicine and Director of the Office of Community Health, Stanford University School of Medicine

**Community Benefit Advisory Council Board Liaisons:**

- Peter Fung, M.D., F.A.C.P., F.A.A.N., F.A.H.A., El Camino Hospital Board Liaison, El Camino Hospital Board of Directors; El Camino Healthcare District Board of Directors
- Julia E. Miller, El Camino Healthcare District Board Liaison, El Camino Hospital Board of Directors; El Camino Healthcare District Board of Directors
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EXECUTIVE SUMMARY

Overview of the Community Health Needs Assessment (CHNA)

The Santa Clara County Community Benefit Coalition ("the Coalition") is a group of organizations that includes seven nonprofit hospitals, the Hospital Council of Northern and Central California, a nonprofit multispecialty medical group, and the Santa Clara County Public Health Department. It was formed in 1995 for the purpose of identifying and addressing critical health needs of the community. Every three years since 1995, the Coalition has worked together to conduct an extensive Community Health Needs Assessment (CHNA). This 2016 CHNA builds upon those earlier assessments.

Through this process, the Coalition uses data to identify health trends and to continue to address critical health needs. With this assessment, Coalition members, individually and collectively, will develop strategies to tackle these needs and improve the health and well-being of community members. As with prior CHNAs, this assessment highlights Santa Clara County’s strengths, assets, and resources.

The 2016 CHNA should serve as a tool for guiding policy and program planning efforts and is available to the public. For Coalition member hospitals, it serves to assist in developing Community Benefit Plans pursuant to California State Senate Bill 697, as well as assist in meeting Internal Revenue Service (IRS) requirements for Community Health Needs Assessment and Implementation Strategies pursuant to the Affordable Care Act of 2010.¹

About El Camino Hospital & Its Community

El Camino Hospital (ECH) is an independent, nonprofit hospital with two campuses located in Mountain View and Los Gatos, California. El Camino Hospital’s patients come from most of the cities in Santa Clara County, but primarily, Mountain View, Sunnyvale, Los Altos, Los Altos Hills, Santa Clara, Los Gatos, Cupertino, Campbell, Saratoga, and San Jose.

How Was El Camino Hospital’s Assessment Conducted?

The Coalition began the 2016 CHNA planning process in Fall 2014. The Coalition’s goal for the CHNA was to collectively gather community feedback and existing data about health status to inform the member hospitals’ respective needs prioritization and selection. The Coalition obtained community input during the winter and spring of 2015 via key informant interviews with local health experts, focus groups with community leaders and representatives, and resident focus groups. The Coalition obtained secondary data from a variety of sources, including the public Community Commons data platform and the Santa Clara County Public Health Department. (See Attachment 3 for a complete list.)

¹ For a copy of the full CHNA, see www.elcaminohospital.org/CommunityBenefit.
The health needs described in this report fall into one or more of the four categories described below:

- Health conditions: Diseases, impairments, or other states of ill health (physical or mental) that contribute to a poor health outcome.
- Health drivers: Behavioral, environmental, or clinical care factors that impact health. May be social determinants of health.
- Health outcomes: A snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality.
- Social determinants of health: Conditions in which people are born, grow, live, work, and age. The distribution of money, power, and resources at global, national, and local levels shape these circumstances.

In September 2015, the Coalition identified health needs by synthesizing primary qualitative research and secondary data, and then filtering those needs against the following progressive criteria:

1. The issue fits the definition of a health need: A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
2. More than one source of secondary and/or primary data suggests or confirms the issue.
3. It meets either qualitative or quantitative data criteria:
   - At least one related indicator performed poorly against the Healthy People 2020 (“HP2020”) benchmark or, if there was no HP2020 benchmark, against the state average.
   - The community prioritized it in three of the ten focus groups or it was mentioned by a key informant. To obtain information on community priorities for this assessment, the Coalition asked professionals and residents who participated in focus groups and key informant interviews to identify the top health needs of their clients and/or communities drawing on their own perceptions and experiences.

Based on community input and secondary data, the Coalition generated a list of health needs that reflect the community’s priorities.

**What Are the Priority Health Needs?**

1. **Access to Healthcare & Healthcare Delivery** is a health need in Santa Clara County as demonstrated by the proportion of Latinos who are less likely to be insured, less likely to see a primary care physician, and more likely to go without healthcare due to cost. For example, 68% of Latinos are insured compared to 85% of residents countywide. The need is a top priority for the community because of persistent barriers, such as lack of affordability (of insurance and services), linguistic isolation, and a perceived lack of both medical providers and culturally competent care.

<table>
<thead>
<tr>
<th>HEALThCARE ACCESS INDICATORS, 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured (Under 65)</strong></td>
</tr>
<tr>
<td>Overall: 85%</td>
</tr>
<tr>
<td>Latino: 68%</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey.
Alzheimer’s Disease & Dementia impact older adults, and the rates of these conditions are expected to rise along with the aging population. The age-adjusted death rate of Alzheimer’s disease in Santa Clara County in 2011 was 35.9 per 100,000, which was higher than the state overall in 2010 (30.1 per 100,000).

Behavioral Health includes mental health, well-being, and substance use/abuse. Close to four in ten (38%) Santa Clara County residents report poor mental health on at least one day in the last 30 days. Six in ten county residents report being somewhat or very stressed about financial concerns. The community discussed the stigma that persists for those who experience mental illness. With regard to alcohol and substance abuse, the community expressed concern with the documented high rates of youth marijuana use and rising youth methamphetamine use.

Birth Outcomes are a health need in Santa Clara County as evidenced by stark racial and ethnic disparities. For instance, the mortality rate of Black infants (7.8 per 1,000) is higher than the HP2020 target (6.0 per 1,000). Moreover, over a quarter of Blacks (29%) and Latinos (26%) experience inadequate prenatal care.

Cancer was the leading cause of death in Santa Clara County in 2013, accounting for 2,372 deaths. Data show that colorectal and prostate cancer prevalence rates are higher than both the HP2020 target and the state average. Breast and cervical cancers disproportionately affect Whites; lung cancer disproportionately affects Blacks, and a high proportion of Vietnamese residents have liver cancer as shown in the figure below.

![Adult Liver Cancer Incidence Rate by Ethnicity and Gender, 2007-2009](image)


---

2 Centers for Disease Control and Prevention (CDC), Community Health Status Indicators (CHSI)/National Center for Health Statistics, County Profile, 2011; CDC, National Center for Health Statistics (NCHS) Data Brief, 2010; CDC, Health Data Interactive for National Data, 2011.
3 California Department of Public Health, Birth Profiles by Zip Code, 2011.
4 Ibid.
6. **Cardiovascular (Heart) and Cerebrovascular (Stroke) Diseases** are responsible for 26% of all deaths in the county. In addition, ethnic disparities exist in mortality rates of heart disease and stroke. Poor nutrition is a driver of cardiovascular diseases. Youth consumption of fruits and vegetables is worse in Santa Clara County compared with California. Compared with California overall, Santa Clara County has more fast food restaurants, fewer grocery stores, and fewer WIC-authorized stores per capita.

7. **Communicable Diseases** are a health need in Santa Clara County as evidenced by high rates of tuberculosis (TB) and hepatitis B, which greatly exceed HP2020 targets, and the fact that influenza was the eighth leading cause of death in the county in 2013 accounting for 244 or 3% of deaths.

8. **Economic Security** is a need in Santa Clara County because of the ethnic disparities seen in rates of poverty, unemployment, and lack of a high school education. As seen in the graph below, in 2014, 32% of Latinos did not graduate from high school, compared to 18% of residents countywide. In terms of poverty, the graph shows that 10% of Santa Clara County residents live below the Federal Poverty Level. However, the percentage living below the self-sufficiency standard, which is a more comprehensive measure of poverty, is higher (23%). The community expressed concern that income inequality and the wage gap contribute to poor health outcomes.

9. **Housing** is a health need because Santa Clara County is one of the most expensive places to live in California, and a lack of safe, stable housing contributes to poor physical and mental health outcomes. Rents increased significantly in the past five years in the San Jose-Sunnyvale-Santa Clara metropolitan area. Rents for a two-bedroom residence averaged $1,994 in 2015, a 21% increase when compared to rents from 2013. Of mortgage-holders, a higher proportion of Blacks and Latinos spend 30% or more of household income on housing (52% and 59% respectively) compared to Santa Clara County overall (45%) and California (46%). Community focus group participants expressed housing and homelessness as a top concern.
10. **Hypertension** (abnormally high blood pressure) can lead to heart disease and stroke, which are the leading causes of death in the United States. More than a quarter (27%) of Santa Clara County residents have been diagnosed with high blood pressure. Blacks, men, and older adults are more likely to be diagnosed with high blood pressure than county residents overall.

11. **Learning Disabilities** are a health need because of the increasing proportion of county public school children who receive special education services, which is slightly greater than the state proportion. The percentage of Santa Clara County children enrolled in special education classes increased slightly between 2011 and 2015 from 9% to 10%.

12. **Obesity & Diabetes** and related health conditions are health needs because of the proportion of children and adolescents who are overweight and/or obese. Moreover, one in five adults are obese and the proportion is higher in the LGBTQ, Latino, and Black populations. As illustrated in the figure below, racial and ethnic disparities exist across all age groups in rates of overweight and obesity. Rates among Latinos and Blacks more often fail Healthy People 2020 targets.

---

**PERCENT WHO ARE OBESE BY AGE, 2014**

![Bar chart showing percent who are obese by age and ethnicity]

Source: CA Department of Health Care Services, Child Health and Disability Prevention Program, Pediatric Nutrition Surveillance 2010 Data (Kids); BRFS (5th, 7th, 9th graders) Santa Clara County Public Health Department, Community Health Assessment (2014; Adults).
13 **Oral & Dental Health** is a need in Santa Clara County illustrated by nearly two thirds (64%) of adults lacking dental insurance.5 One in three adults have had tooth loss, and the statistics are worse for Black adults (49%).6 Additionally, youth dental care utilization rates (15%) are worse than the state (19%).7 The community expressed concern about the proportion of adults who lack dental insurance, the lack of providers who accept Denti-Cal, and the costs of dental care for those who do not have it.

14 **Respiratory Conditions** are a health need in Santa Clara County as marked by racial and ethnic, economic, and geographic disparities in asthma prevalence and hospitalization rates. For example, those with household incomes of $50,000-$74,999 (25%), multiracial adults (22%), and Blacks (19%) have a higher prevalence of asthma than the county overall (14%).8 The health need is likely impacted by health behaviors such as youth smoking (8%) and by issues in the physical environment such as air quality levels.

15 **Sexual Health (including sexually transmitted infections [STIs] and teen births)** data in Santa Clara County show ethnic disparities, especially for HIV incidence and births to teen mothers. Also, women are twice as likely to contract chlamydia as men, at a rate of 422.3 per 100,000 compared to 203.7.

16 **Tobacco Use** is a driver of cancer and respiratory conditions. One in ten Santa Clara County residents are current smokers, which is lower than the HP2020 target of 12%. However, as illustrated in the figure below, men are more likely to smoke than women (13% compared to 7%), and Filipinos have the highest smoking prevalence (21%) of all racial and ethnic groups. Moreover, smoking among non-White youth rose in the previous five years.

---

6 Ibid.
Unintentional Injuries are a concern in Santa Clara County because rates of deaths due to falls and adult drownings in the overall population are higher than Healthy People 2020 targets. In addition, we see that rates for some ethnic/racial groups exceed Healthy People 2020 targets in various injury categories. For example, death rates from pedestrian accidents among Latinos (2.2) and Asians (1.6) exceed the HP 2020 objective of 1.3 per 100,000.

Violence & Abuse in the county is a problem that disproportionately affects people of color, including adult homicide and domestic violence deaths. Also, a majority of youth report having been victims of physical, psychological, and/or cyber bullying. The community indicated that the health need is also affected by the following factors: the cost and/or lack of activity options for youth, financial stress, poor family models, unaddressed mental and/or behavioral health issues among perpetrators, cultural/societal acceptance of violence, linguistic isolation, and lack of awareness of support and services for victims.

For further details, including statistical data and citations, please consult the full health needs descriptions in the Identification & Prioritization of Health Needs Section, and the Health Needs Profiles appended to this report as Attachment 8. For details on community assets and resources that address the health needs, please refer to Attachment 7.

Next Steps

After making this CHNA report publicly available in 2016, our hospital will solicit feedback and comments about the report for a period of three years. Our hospital will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by November 15, 2016.

From Assessment to Implementation

After reviewing the findings of the community health needs assessment, El Camino Hospital’s Community Benefit Advisory Council (CBAC) selected 12 health needs to be addressed in fiscal years 2017-2019 with community benefit grant-funding. The graphic on the next page shows the health needs mapped to three health priority areas:
The Coalition selected health needs based on the following criteria:

1. A needs assessment process identified the issue as significant and important to a diverse group of community stakeholders.
2. The issue affects a relatively large number of individuals.
3. The issue has serious impact at the individual, family, or community level.
4. If left unaddressed, the issue is liable to become more serious.
5. The issue offers potential for program intervention that can result in measurable impact.
6. El Camino Hospital has the required expertise and/or human and financial resources to make an impact.

Furthermore, addressing the CBAC’s health priority areas has the potential of impacting several of the other identified health needs based on the connection between many related health conditions and the preventative nature of the strategies funded to address them.

Detailed strategies and partners funded to address these needs are explained in further detail in the El Camino Hospital Community Benefit Plan & Implementation Strategy, upon Board approval. This CHNA will inform plans for the next three years.
INTRODUCTION/BACKGROUND

The CHNA Effort

The Santa Clara County Community Benefit Coalition (“the Coalition”) is a group of organizations that includes seven nonprofit hospitals, the Hospital Council of Northern & Central California, a nonprofit multispecialty medical group, and the Santa Clara County Public Health Department. It formed in 1995 to identify and address critical health needs of the community. Every three years since 1995, the Coalition has worked together to conduct an extensive Community Health Needs Assessment (CHNA). This 2016 CHNA builds upon those earlier assessments. Through this process, the Coalition uses data to identify health trends to continue addressing critical health needs. With this assessment, Coalition members, individually and collectively, develop strategies to tackle these needs and improve the health and well-being of community members. Note that for the purposes of this assessment, “community health” is not limited to traditional health measures. This definition, in addition to the physical health of community members, includes indicators relating to the quality of life (e.g., access to healthcare, impact of new technology, affordable housing, child care, education, and employment), the physical, environmental, and social factors that influence the health of the county’s residents. This reflects the Coalition’s philosophy that community health is affected by many factors and cannot be adequately understood without consideration of trends outside the realm of healthcare. As with prior CHNAs, this assessment also highlights Santa Clara County’s strengths, assets, and resources.

The 2016 CHNA is designed to serve as a tool for guiding policy and program planning efforts and is available to the public. For Coalition member hospitals, it serves to assist in developing Community Benefit Plans pursuant to California State Senate Bill 697, as well as assist in meeting Internal Revenue Service (IRS) requirements for Community Health Needs Assessment and Implementation Strategies pursuant to the Affordable Care Act of 2010.
ABOUT EL CAMINO HOSPITAL

El Camino Hospital is an acute-care, 443-bed, nonprofit and locally governed organization with campuses in Mountain View and Los Gatos, California. Key medical specialties include cancer, heart and vascular, men’s health, mental health, neuroscience, orthopedic and spine, senior health, urology, and the first Women’s Hospital in Northern California. In fiscal year 2015, El Camino Hospital had 19,081 outpatient visits and 201,508 inpatient visits, and delivered 5,090 babies.

Our Mission

It is the mission of El Camino Hospital to be an innovative, publicly accountable and locally controlled comprehensive healthcare organization that cares for the sick, relieves suffering, and provides quality, cost-competitive services to improve the health and well-being of the community.

Brief History

Local voters approved the formation of a 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 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 the Board 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, 1961.

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 senior resource center. During the hospital’s third decade in the community, the Board established the El Camino Hospital 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, after a festive ribbon cutting and community day with more than 8,000 people taking tours of the new facilities, the new 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 El Camino Hospital Los Gatos reopened within 90 days of the closure in July 2009. 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 first opened in 1962.
**Specialty Care and Innovation**

El Camino Hospital provides specialty programs and clinical areas of distinction that are highly regarded throughout the Bay Area. Some programs and accomplishments unique to the hospital are:

- Regional leader in performing robotic-assisted surgery
- Cardiovascular specialists who were among the researchers to introduce CoreValve and MitraClip, two minimally invasive valve treatments
- Highest volume program on the West Coast in performing bronchial thermoplasty, a novel procedure to treat severe asthma
- One of the first comprehensive Men’s Health Programs in California and the U.S.
- The Cancer Center’s five-year survival rates for breast, colon, prostate and lung cancers exceed national benchmarks
- A nationally certified cardiac and pulmonary rehabilitation program – the first in the region – offering comprehensive recovery services
- One of the few Bay Area hospitals to offer neurointervention, a minimally invasive way to treat brain conditions
- Founding sponsor of the PulsePoint app, a life-saving smartphone app that alerts CPR-trained citizens of nearby cardiac arrests
- South Asian Heart Center, a heart health education and lifestyle modification program for the South Asian community
- Chinese Health Initiative, a health education and support program tailored to the health disparities and cultural preferences of the Chinese community

El Camino Hospital is also recognized as a national leader in the use of health information technology and wireless communications, and has been awarded the Gold Seal of Approval from The Joint Commission as a Primary Stroke Center as well as three consecutive American Nurses Credentialing Center (ANCC) Magnet Recognitions for Nursing Care.

**About El Camino Hospital’s Community Benefit Program**

For more than 50 years, El Camino Hospital 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 Hospital to collaborate with community members who have a special understanding of health disparities in local cities, as well as organizations with missions similar to ours. Working together has vastly multiplied El Camino Hospital’s ability to make a difference.

El Camino Hospital, in partnership with El Camino Healthcare District, provides funding through the Community Benefit Program in the form of grants and sponsorships that demonstrate an ability to impact the health needs of underserved and at-risk community members.
Integral to the process is the valuable guidance the Hospital receives from the Community Benefit Advisory Council (CBAC). The CBAC is comprised of Board members, physicians, and representatives from the community who have knowledge about local disparate health needs.

The CBAC’s recommendations for grant funding are included in the annual Community Benefit Plan and Implementation Strategy, which is presented to the El Camino Hospital Board of Directors for review and approval.

Every year, the Hospital publishes a Community Benefit Report to inform the community about the partnerships created to improve the health of vulnerable populations both through direct services and expansive prevention initiatives.

**Demographic Profile of Community Served**

The IRS defines the "community served" by a hospital as those individuals residing within its geographic service area and that this community is inclusive of low-income or underserved populations. El Camino Hospital’s community includes most of the cities of Santa Clara County. These cities are listed in the following table:

<table>
<thead>
<tr>
<th>Regions, Cities, and Towns Served by El Camino Hospital</th>
<th>North County</th>
<th>West County</th>
<th>Mid-County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunnyvale</td>
<td>Cupertino</td>
<td>Santa Clara</td>
<td></td>
</tr>
<tr>
<td>Mountain View</td>
<td>Monte Sereno</td>
<td>Campbell</td>
<td></td>
</tr>
<tr>
<td>Los Altos</td>
<td>Saratoga</td>
<td>San Jose</td>
<td></td>
</tr>
<tr>
<td>Los Altos Hills</td>
<td>Los Gatos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loyola</td>
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</tbody>
</table>
El Camino Hospital's primary market area is the area in which the majority of its inpatients reside. The El Camino Healthcare District sits within El Camino Hospital Mountain View’s primary service area. El Camino Hospital also provides care to residents in the secondary market with primarily specialized care such as cardiovascular surgery, high-risk obstetrics, and/or cancer care.
Santa Clara County

El Camino Hospital is located in Santa Clara County. The 2014 estimated Santa Clara County population is 1.8 million people, making it the sixth-largest county in California by population. The total population for the El Camino Hospital community is 1.5 million people. Approximately 11\% of the population is linguistically isolated in the county overall and in the El Camino Hospital community. These areas have a similar age distribution, with one quarter (24\%) of the population under the age of 18, 12\% are 65 years or older, and 64\% are 18 to 64. As illustrated in the table below, these geographic areas are also very diverse. Notably, less than half (48\%) of the population in the El Camino Hospital community is White and 39\% are foreign-born, making it slightly more racially and ethnically diverse than Santa Clara County overall.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Santa Clara County</th>
<th>ECH Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>54</td>
<td>48</td>
</tr>
<tr>
<td>Black</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Asian</td>
<td>35</td>
<td>34</td>
</tr>
<tr>
<td>Pacific Islander/Native Hawaiian</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Latino (of Any Race)</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

*Note: Percents do not add to 100\% because they overlap. ECH Community data are averages of cities served by ECH.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>SCC Foreign-Born %</th>
<th>ECH Community Foreign-Born %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any race</td>
<td>37</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, American Community Survey (2010-2014 5-Year Estimates).
Retrieved from factfinder.census.gov, April 2016.
Social Determinants of Health

Two key social determinants, income and education, have a significant impact on health outcomes. As the following chart illustrates, Monte Sereno, which has the highest median household income in Santa Clara County, has an average life expectancy three years greater than San Jose, which has the lowest median household income in the county.

<table>
<thead>
<tr>
<th>Income in Life Expectancy of SCC Cities with the Highest and Lowest Median Household Incomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median Household Income</strong></td>
</tr>
<tr>
<td>$0</td>
</tr>
<tr>
<td>$50,000</td>
</tr>
<tr>
<td>$100,000</td>
</tr>
<tr>
<td>$150,000</td>
</tr>
<tr>
<td>$200,000</td>
</tr>
<tr>
<td>$250,000</td>
</tr>
<tr>
<td><strong>Monte Sereno</strong></td>
</tr>
<tr>
<td><strong>San Jose</strong></td>
</tr>
<tr>
<td><strong>Source:</strong> Santa Clara County Public Health Department, Monte Sereno Profile 2015 and San Jose Profile 2015.</td>
</tr>
</tbody>
</table>

Santa Clara County has one of the highest annual median incomes in the country and one of the highest costs of living. The median household income is $91,201, which is far higher than California ($59,645) and higher than neighboring San Mateo County ($86,245).\(^9\) As displayed in the following chart, about half of the population lives in households with incomes of $100,000 or more, about one-fourth live in households with incomes between $50,000 and $100,000, and another fourth live below $50,000. The data are similar for households residing in the El Camino Hospital community.

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Despite the fact that half of households in the county earn more than $100k per year, approximately 23% of residents in Santa Clara County and the El Camino Hospital community live below 200% of the Federal Poverty Level. In addition, 38% of the children in Santa Clara County are eligible for free or reduced-price lunch, and the percentage is slightly higher for the El Camino Hospital community (39%). Santa Clara County housing costs are high; the 2015 median home price is $900,000\(^{10}\) and average rents are more than $2,000 in Santa Clara County.\(^{11}\) The following map identifies where high concentrations of the population are living in poverty and where populations living without a high school diploma overlap. One in ten people in the County and El Camino Hospital community are uninsured and 13% have less than a high school diploma.\(^{12}\)

\(^{10}\) Avalos, G. “Home Prices Soar to Records in Santa Clara and Alameda Counties.” San Jose Mercury News.


Santa Clara County Vulnerability Footprint

- Population (25% or more) living at or below 100% of FPL
- Population (25% or more) aged 25 and older and lacking high school diploma
- Population (25% or more) both lacking high school diploma and living at or below 100% of FPL
- Population (top 20% of earners) has a mean income that is at least double the county mean income.

The Affordable Care Act in California and Santa Clara County

Following the institution of the ACA in January 2014, Medi-Cal expanded in California to low-income adults who were not previously eligible for coverage. Specifically, non-disabled adults now qualify if they earn less than 138% of the Federal Poverty Level ($15,856 annually for an individual).\(^\text{13}\) In 2014, “Covered California,” a State Health Benefit Exchange, was created to provide a marketplace for healthcare coverage for any Californian. Americans and legal residents with incomes between 138% and 400% of the federal poverty level can benefit from subsidized premiums through the exchange.\(^\text{14}\)

Between 2013 and 2014, there was a 12% drop in the number of uninsured Californians aged 18-64 years old (from 16% to 12%), according to data cited by the California Healthcare Foundation.\(^\text{15}\) In a March 2015 memo to the Secretary of the California Health and Human Services Agency in support of the Medi-Cal 2020 Waiver Renewal, the County of Santa Clara Board of Supervisors reported that approximately 150,000 Santa Clara County residents remained uninsured, and that over 20,000 people had been enrolled in the Low-Income Health Program under the “Bridge to Reform” Waiver (who were subsequently enrolled in Medi-Cal upon expansion).\(^\text{16}\)

Although many thousands of county residents have obtained health insurance for the first time, concern remains about health insurance costs and the cost of care, as well as access to timely appointments. As discussed later in this report, residents (including those whose insurance plans did not change since ACA) are experiencing difficulties with getting timely appointments for care, which they attribute to the lack of healthcare professionals. This is supported by evidence that there was a significant decrease in the proportion of Californians who were able to get an appointment in a timely manner (from 91% in 2013 to 87% in 2014) and the increase in the proportion of Californians who said they had gone without care because they could not get an appointment (from 5% in 2013 to 8% in 2014).\(^\text{17}\) In addition, professionals who participated in this assessment expressed specific concern about the lack of sufficient doctors and clinics that accept Medi-Cal and/or Denti-Cal insurance.

While 2014 survey data are informative in understanding initial changes in healthcare access, a clearer picture on what healthcare access looks like will be forthcoming in future CHNA reports.

\(^\text{13}\) In addition to disabled adults, non-disabled adults who qualified before ACA included those who qualified for CalWORKS; Supplemental Security Income and State Supplemental Program (SSI/SSP); Entrant or Refugee Cash Assistance (ECA or RCA); In-Home Supportive Services (IHSS); or Foster Care or Adoption Assistance Program.


ASSESSMENT TEAM

Hospitals & Other Partner Organizations

- El Camino Hospital (Mountain View and Los Gatos Hospitals)
- Hospital Council of Northern & Central California
- Kaiser Permanente South Bay (Santa Clara and San Jose Kaiser Foundation Hospitals)
- Lucile Packard Children’s Hospital Stanford
- O’Connor Hospital
- Stanford Health Care
- Saint Louise Regional Hospital
- Santa Clara County Public Health Department
- Sutter Health

Identity & Qualifications of Consultants

Applied Survey Research (ASR), a nonprofit social research firm, completed this CHNA. For this assessment, ASR conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identification of community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

ASR’s expertise in community assessments is well-recognized nationally. It accomplishes successful assessments by using mixed research methods to help understand the needs in question, and by putting the research into action through designing and facilitating strategic planning efforts with stakeholders. The project leaders for this assessment were Lisa Colvig-Niclai, M.A., Jennifer van Stelle, Ph.D., and Melanie Espino, who bring complementary skill sets and various schools of thought. More information about ASR can be found at www.appliedsurveyresearch.org.
CHNA 2013 NEEDS & EVALUATION FINDINGS

In 2012-13, the Hospital participated in a collaborative process to identify community health needs and meet the IRS requirements of the CHNA. The Hospital posted the 2013 CHNA on its public website, and solicited feedback (written comments) by email (CommunityBenefit_ECH@elcaminohospital.org), accessible where the report is available (www.elcaminohospital.org/chna) and an electronic “Message” form accessible at www.elcaminohospital.org/contact-us. Feedback is monitored and responded to by staff of the El Camino Hospital Community Benefit Program. (At the time of this CHNA report development, the Hospital had received one written comment about the 2013 CHNA report inquiring if the report would be updated in 2014.)

During this first federally-mandated CHNA study, the research focused on identifying health conditions and secondarily the drivers of those conditions (including healthcare access). As a member of the Santa Clara County Community Benefit Coalition, the Hospital helped to identify the health needs found in the list below. For the 2016 CHNA, the Coalition built upon this work by using the list of identified needs below and delving deeper into questions about healthcare access, delivery, barriers to care, and solutions. The Coalition also specifically sought to understand how the full implementation of the Affordable Care Act in 2014 impacted residents’ access to healthcare, including affordability of care.

Santa Clara County 2013 Countywide Prioritized Health Needs

<table>
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<tr>
<th>IDENTIFIED COUNTYWIDE HEALTH NEED</th>
<th>HEALTH NEED CHOSEN BY THE HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s Disease</td>
<td>YES</td>
</tr>
<tr>
<td>Birth Outcomes</td>
<td>NO</td>
</tr>
<tr>
<td>Cancer</td>
<td>YES</td>
</tr>
<tr>
<td>Cardiovascular &amp; Heart Disease, Stroke</td>
<td>YES</td>
</tr>
<tr>
<td>Diabetes</td>
<td>YES</td>
</tr>
<tr>
<td>Poor Mental Health</td>
<td>YES</td>
</tr>
<tr>
<td>Obesity</td>
<td>YES</td>
</tr>
<tr>
<td>Poor Oral/Dental Health</td>
<td>YES</td>
</tr>
<tr>
<td>Respiratory Conditions</td>
<td>YES</td>
</tr>
<tr>
<td>STDs/HIV-AIDS</td>
<td>NO</td>
</tr>
<tr>
<td>Substance Use (ATOD)</td>
<td>NO</td>
</tr>
<tr>
<td>Unintentional Injuries (Falls)</td>
<td>YES</td>
</tr>
<tr>
<td>Violence</td>
<td>NO</td>
</tr>
</tbody>
</table>

Note: The countywide CHNA process in 2013 lacked statistical data on unintentional injuries. El Camino Hospital requested that the consultants include additional data on this topic, and based on these additional statistical data along with the primary (qualitative) data from the CHNA process, El Camino Hospital identified Unintentional Injuries as a health need.

While the Community Benefit Coalition prioritized health-related drivers in 2013, the cross-cutting driver, Access to Healthcare Services, was not scored during the prioritization process. The Coalition classified Access to Healthcare as a separate health need after prioritization took place.
Evaluation Findings of 2013-2016 Implemented Strategies

Implementation of strategies identified in El Camino Hospital’s 2013 CHNA began in July 2013. In December 2014, the IRS published its final regulations that require hospitals to report on the impact of implemented strategies. The following tables describe the evaluation of community benefit programs funded through June 30, 2015, for the period of FY 2014 – FY 2015. In FY14, El Camino Hospital’s Community Benefit investment totaled $53,412,629, while in FY15 the amount was $52,084,189. For grants and sponsorship funding, the FY14 investment amounted to $1,304,751, and in FY15 it was $2,713,079.

El Camino Hospital Community Benefit Dashboard FY14

<table>
<thead>
<tr>
<th>Category</th>
<th>Partner</th>
<th>Goals/Metrics</th>
<th>Annual Target</th>
<th>Annual Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Access (Primary, Oral, and Chronic Conditions Care)</td>
<td>School District 1&lt;br&gt;School nurse program</td>
<td>- Students served&lt;br&gt;- Uninsured students who have applied for insurance&lt;br&gt;- Students with failed health screening at schools with improved attendance&lt;br&gt;- Students identified as needing urgent dental care through on-site screenings who saw a dentist&lt;br&gt;- Schools with at least 25% of staff CPR certified</td>
<td>3,903&lt;br&gt;60%&lt;br&gt;80%&lt;br&gt;80%&lt;br&gt;83%</td>
<td>3,963&lt;br&gt;62%&lt;br&gt;82%&lt;br&gt;74%&lt;br&gt;83%</td>
</tr>
<tr>
<td></td>
<td>School District 2&lt;br&gt;School nurse program</td>
<td>- Students served&lt;br&gt;- Uninsured students who have applied for insurance&lt;br&gt;- Students who failed vision or hearing screening and saw a healthcare provider&lt;br&gt;- Students identified as needing urgent dental care through on-site screenings who saw a dentist&lt;br&gt;- Students absent 10% or more and who improved their attendance by 2 days or more over a 2-month period&lt;br&gt;- Kindergartners who received a well-care exam by the end of school year as measured by the receipt of a completed CHPD (Child Health &amp; Disability Prevention) “Health Exam for School Entry” form</td>
<td>1,850&lt;br&gt;80%&lt;br&gt;69%&lt;br&gt;75%&lt;br&gt;60%&lt;br&gt;60%</td>
<td>1,857&lt;br&gt;88%&lt;br&gt;76%&lt;br&gt;76%&lt;br&gt;60%&lt;br&gt;50%</td>
</tr>
<tr>
<td></td>
<td>School District 3&lt;br&gt;School nurse program</td>
<td>- Students served- 3 schools&lt;br&gt;- Students who failed health screening who received healthcare provider visits&lt;br&gt;- Students identified as needing urgent dental care through on-site screenings who saw a dentist&lt;br&gt;- Incoming 7th-grade students compliant with Tdap</td>
<td>2,600&lt;br&gt;67%&lt;br&gt;50%&lt;br&gt;90%</td>
<td>3,112&lt;br&gt;70%&lt;br&gt;63%&lt;br&gt;92%</td>
</tr>
<tr>
<td>Program 1&lt;br&gt;Advocacy for low-income families and teen parents</td>
<td></td>
<td>- Children served&lt;br&gt;- Services provided&lt;br&gt;- Children meeting the CHDP periodicity schedule&lt;br&gt;- Children identified with developmental delays linked to mental health and/or Program 1 services within 30 days of identification&lt;br&gt;- Children flagged for non-attendance (4 consecutive days for other than minor medical reasons) receiving referrals for support services&lt;br&gt;- Families with an identified need (per Family Needs Assessment) receiving services within 60 days with follow up conducted every 60 days</td>
<td>72&lt;br&gt;95%&lt;br&gt;95%&lt;br&gt;95%&lt;br&gt;25%&lt;br&gt;90%</td>
<td>88&lt;br&gt;95%&lt;br&gt;100%&lt;br&gt;100%&lt;br&gt;26%&lt;br&gt;95%</td>
</tr>
<tr>
<td>Category</td>
<td>Partner</td>
<td>Goals/Metrics</td>
<td>Annual Target</td>
<td>Annual Total</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Healthcare and Mental Access</strong></td>
<td><strong>Program 2</strong></td>
<td>- Number of youth receiving orthodontic services</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td><strong>Oral, Community Based Organization (CBO)</strong></td>
<td><strong>Program 3</strong></td>
<td>- Orthodontic services provided</td>
<td>400</td>
<td>421</td>
</tr>
<tr>
<td><strong>Primary, and Chronic Conditions Care</strong></td>
<td><strong>Community Based Organization (CBO) 1</strong></td>
<td>- Social workers who report &quot;Yes Absolutely&quot; to the survey question, &quot;Orthodontic treatment had a positive impact on their client’s wellbeing and self-esteem&quot;</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Medical care and shelter for homeless patients</strong></td>
<td><strong>Medical Training program for Golden Seniors</strong></td>
<td>- Patients served (full program)</td>
<td>120</td>
<td>131</td>
</tr>
<tr>
<td><strong>Mental Health Access</strong></td>
<td><strong>CBO 2</strong></td>
<td>- Patients served from El Camino Hospital Los Gatos (ECH LG)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Psychiatric services and medication management</strong></td>
<td><strong>CBO 3</strong></td>
<td>- Linkage to Primary Care Home</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td><strong>Senior Wellness Program</strong></td>
<td><strong>CBO 4</strong></td>
<td>- Discharged to interim or permanent housing</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Daybreak Care and Home Care and Golden Gateway Programs</strong></td>
<td><strong>CBO 5</strong></td>
<td>- Avoided hospital days (full program)</td>
<td>480</td>
<td>484</td>
</tr>
<tr>
<td><strong>Foundation 1</strong></td>
<td><strong>Training in the Principles of Recovery</strong></td>
<td>- Avoided hospital days (ECH LG)</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td><strong>Counseling and medication management for uninsured</strong></td>
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<td>Partner</td>
<td>Goals/Metrics</td>
<td>Annual Target</td>
<td>Annual Total</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Healthy Eating, Physical Activity and Obesity</td>
<td>CBO 6 School-based physical activities program for students</td>
<td>- Students served - 3 schools</td>
<td>1,500</td>
<td>1,791</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers reporting moderate to significant increase in physical activity</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers reporting moderate to significant decrease in bullying</td>
<td>45%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers reporting increase in students’ healthy play</td>
<td>85%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers reporting increases in “positive impact on reduction in disciplinary action” and “positive impact on school climate”</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Initiative 1 School-based physical activities program for low-income students</td>
<td>- Students served</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Initiative 1 “Focus Girls” who are observed to have improved behavior and attitudes toward physical activity, healthy eating, and life skills taught each week</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Initiative 1 “Focus Girls” who self-report two or more positive effects of program participation</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Average weekly attendance</td>
<td>80%</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>Program 4 School-based nutrition and physical activity program</td>
<td>- Students served</td>
<td>800</td>
<td>850</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase in students who are physically active one or more hours per day (weekdays; pre-/post survey)</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase in students who limit sweetened beverages to 0-1 per day (pre/post survey)</td>
<td>50%</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase in students reporting that a balanced diet includes eating 5 fruits/vegetables per day</td>
<td>40%</td>
<td>39%</td>
</tr>
<tr>
<td>Community Health Education and Health Literacy</td>
<td>CBO 7 Case-management and referrals for low-income families</td>
<td>- Clients served</td>
<td>100</td>
<td>118</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients participating in Benefit Clinics</td>
<td>120</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Contacts made by case manager offering information and referrals</td>
<td>2,700</td>
<td>2,722</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who sign-up for public benefits</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Households moved out of food insecurity and out of poverty</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Case managed clients who increase in 3 of the 18 domains measured by Self Sufficiency Index</td>
<td>10 households</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Library 1 Health Information and Eldercare consultations</td>
<td>- Community members served</td>
<td>1,400</td>
<td>1,399</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who strongly agree or agree with the question, eldercare referrals appropriate to my needs</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who strongly agree or agree with the question, increase my knowledge of care options</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who strongly agree or agree with the question, the library has proven valuable in helping me manage my health or a friend or family member</td>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who strongly agree or agree with the question library information appropriate to my needs</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Program 5 On-line health education curriculum</td>
<td>- Schools served</td>
<td>198</td>
<td>143</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers who report improvement in students’ health knowledge</td>
<td>70%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers who report satisfaction with program</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Initiative 2 Health education and support for Chinese community</td>
<td>- Individuals served</td>
<td>150</td>
<td>220</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Services (including education/training, screening and referrals)</td>
<td>375</td>
<td>460</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Screened participants who are vaccinated or monitored through their physicians</td>
<td>50%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Participants who strongly agree or agree with the statement, program education and screening events help me better manage my health</td>
<td>80%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>CBO 8 Health education and lifestyle modification for South Asian Community</td>
<td>- Participants screened</td>
<td>100</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of assessment, lifestyle intervention, and coaching touch-points</td>
<td>700</td>
<td>733</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reduction in triglycerides in rest test follow-up of participants</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improvement in number of participants consuming 3+ vegetable servings per day</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>CBO 9 Countywide campaign for Hepatitis B prevention</td>
<td>- Individuals receiving information regarding hepatitis B at community events</td>
<td>1,000</td>
<td>1,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Individuals screened and tested for hepatitis B at Hep B Free events</td>
<td>400</td>
<td>348</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clinicians who sign the Clinicians Honor Roll to pledge that they will follow CDC testing guidelines</td>
<td>100</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>CBO 10</td>
<td>- Individuals served</td>
<td>2,500</td>
<td>2,594</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Emergency Medical Services (EMS)/ first responders trained in falls prevention</td>
<td>100</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Emergency Medical Services (EMS) workers who report increased knowledge after training</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Community members who report confidence they will engage in falls prevention behavior learned at presentations</td>
<td>85%</td>
<td>93%</td>
</tr>
</tbody>
</table>
### El Camino Hospital Community Benefit Dashboard FY15

<table>
<thead>
<tr>
<th>Category</th>
<th>Partner</th>
<th>Goals/Metrics</th>
<th>Annual Target</th>
<th>Annual Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Access (Primary, Oral, and Chronic Conditions Care)</strong></td>
<td><strong>School District 1</strong>&lt;br&gt;School nurse program</td>
<td>· Students served&lt;br&gt;· Uninsured students who have applied for insurance&lt;br&gt;· Students with failed health screening who saw a healthcare provider&lt;br&gt;· Students identified as needing urgent dental care through on-site screenings who saw a dentist&lt;br&gt;· Schools with at least 25% of staff CPR certified</td>
<td>3,902&lt;br&gt;62%&lt;br&gt;70%&lt;br&gt;80%&lt;br&gt;85%</td>
<td>4,102&lt;br&gt;79%&lt;br&gt;77%&lt;br&gt;77%&lt;br&gt;85%</td>
</tr>
<tr>
<td></td>
<td><strong>School District 2</strong>&lt;br&gt;School nurse program</td>
<td>· Students served - 3 schools&lt;br&gt;· Students who failed health screening and saw a healthcare provider&lt;br&gt;· Teachers who accessed HealthTeacher materials&lt;br&gt;· Kindergarten and second-grade students identified with urgent dental care needs screenings who saw a dentist&lt;br&gt;· Incoming 7th-grade students compliant with Tdap</td>
<td>3,100&lt;br&gt;70%&lt;br&gt;50%&lt;br&gt;50%&lt;br&gt;83%</td>
<td>3,075&lt;br&gt;88%&lt;br&gt;49%&lt;br&gt;51.9%&lt;br&gt;74%</td>
</tr>
<tr>
<td></td>
<td><strong>Program 1</strong>&lt;br&gt;Advocacy for low income families and teen parents</td>
<td>· Children served&lt;br&gt;· Services provided&lt;br&gt;· Children meeting the CHDP periodicity schedule&lt;br&gt;· Children identified as not having received all recommended procedures for an earlier age brought up to date&lt;br&gt;· Children with a dental home, receiving oral health exams and treatment&lt;br&gt;· Parents participating in educational opportunities&lt;br&gt;· Families with an identified need (per Family Needs Assessment) receiving services within 60 days with follow up conducted every 60 days</td>
<td>88&lt;br&gt;500&lt;br&gt;95%&lt;br&gt;90%&lt;br&gt;95%&lt;br&gt;25%&lt;br&gt;90%</td>
<td>88&lt;br&gt;523&lt;br&gt;96%&lt;br&gt;92%&lt;br&gt;95%&lt;br&gt;27%&lt;br&gt;95%</td>
</tr>
<tr>
<td></td>
<td><strong>Program 2</strong></td>
<td>· Clients served&lt;br&gt;· Services (rides)&lt;br&gt;· Strongly agree or “agree” with the statement, having RoadRunners (RR) services helped in maintaining my independence&lt;br&gt;· Strongly agree or “agree” with the statement, having RoadRunners (RR) made it possible to get to my medical appointments</td>
<td>100&lt;br&gt;480&lt;br&gt;90%&lt;br&gt;94%&lt;br&gt;95%</td>
<td>48&lt;br&gt;567&lt;br&gt;94%&lt;br&gt;95%&lt;br&gt;95%</td>
</tr>
<tr>
<td></td>
<td><strong>Program 3</strong>&lt;br&gt;Orthodontic services</td>
<td>· Children served&lt;br&gt;· Services provided&lt;br&gt;· Youth at mid-treatment and completing orthodontic services who report being satisfied with their orthodontic care&lt;br&gt;· Social workers of youth at mid-treatment and completing orthodontic services who indicate that orthodontic care has had a positive impact on clients’ well-being and self-esteem</td>
<td>51&lt;br&gt;1,046&lt;br&gt;75%&lt;br&gt;75%</td>
<td>52&lt;br&gt;1,083&lt;br&gt;97%&lt;br&gt;94%</td>
</tr>
<tr>
<td></td>
<td><strong>Program 4</strong>&lt;br&gt;Medical care and shelter for homeless patients</td>
<td>· Patients served (nine hospitals in collaborative) / ECH&lt;br&gt;· Linked to primary care physician&lt;br&gt;· Discharged to interim or permanent housing&lt;br&gt;· Avoided hospital days</td>
<td>140/2&lt;br&gt;92%&lt;br&gt;75%&lt;br&gt;50%</td>
<td>183/2&lt;br&gt;91%&lt;br&gt;70%&lt;br&gt;584</td>
</tr>
<tr>
<td><strong>Mental Health Access</strong></td>
<td><strong>Community Based Organization (CBO) 1</strong></td>
<td>· Services provided by APS&lt;br&gt;· Youth served by Child and Adolescent Mobile Crisis Program (CACP)&lt;br&gt;· Youth participating in individual and group counseling showing a 50% improvement in positive behavior and attitude&lt;br&gt;· Youth participating in the Holistic Intervention Prevention Partnership who show a 50% or greater improvement in change&lt;br&gt;· Parents/caregivers who demonstrate an increase in knowledge of the topics presented and a better understanding of how to access services for their child&lt;br&gt;· Non-recidivist youths served by CACP hospital diversion rate&lt;br&gt;· Non-recidivist youths served by CACP who are able to stay with their families</td>
<td>2,775&lt;br&gt;40&lt;br&gt;75%&lt;br&gt;81%&lt;br&gt;95%&lt;br&gt;70%&lt;br&gt;71%</td>
<td>2,811&lt;br&gt;40&lt;br&gt;78%&lt;br&gt;86%&lt;br&gt;98%&lt;br&gt;70%&lt;br&gt;71%</td>
</tr>
<tr>
<td>Category</td>
<td>Partner</td>
<td>Goals/Metrics</td>
<td>Annual Target</td>
<td>Annual Total</td>
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<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Mental Health Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBO 2</td>
<td>Psychiatric services and medication management</td>
<td>- Patients served</td>
<td>125</td>
<td>165</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Psychiatry, therapy and/or case management visits</td>
<td>500</td>
<td>687</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Actively managed patients who obtain housing</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Psychiatric patients not hospitalized in a 12 month period</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>CBO 3</td>
<td></td>
<td>- Seniors screened for depression</td>
<td>150</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Seniors enrolled in Healthy IDEAS</td>
<td>46</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Healthy IDEAS encounters</td>
<td>400</td>
<td>322</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Healthy IDEAS clients with decrease in score on Geriatric Depression Scale-15</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Healthy IDEAS clients reporting new knowledge and skills to maintain mental health</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Foundation 1</td>
<td>Training in the Principles of Recovery</td>
<td>- Mental health professionals trained</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Training hours provided</td>
<td>504</td>
<td>504</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Respondents who &quot;strongly agree&quot; or &quot;agree&quot; that immersion training enhanced their knowledge and improved service delivery to clients</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>CBO 4</td>
<td>Counseling and medication management for uninsured</td>
<td>- Patients served</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Services provided</td>
<td>180</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients avoiding psychiatric hospitalization for 12 months after admission</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients who demonstrate a 10% improvement on the Global Functioning Scale (GAF)</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients who demonstrate improvement on the PHQ-9 from admission to discharge</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Hospital 1</td>
<td></td>
<td>- Older adults served</td>
<td>80</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Encounters provided by a Geriatric Psychiatrist</td>
<td>652</td>
<td>715</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Encounters provided by a Psychiatric Nurse Practitioner</td>
<td>490</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Older adults who received access to care with a Geriatric Psychiatrist or Psychiatric Nurse Practitioner within 10 days of initial contact</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Older adults who received care from a Geriatric Psychiatrist or Psychiatric Nurse Practitioner who saw at least a one category improvement (mild, moderate, or severe) of anxiety as measured by the GAD-7 assessment tool</td>
<td>80%</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Older adults who received care from a Geriatric Psychiatrist or Psychiatric Nurse Practitioner who saw a one category improvement (mild, moderate, moderately severe, or severe) of depression as measured by the PHQ-9 assessment tool</td>
<td>80%</td>
<td>82%</td>
</tr>
<tr>
<td>School District 3</td>
<td>School-based mental health services</td>
<td>- Students served through classroom intervention</td>
<td>500</td>
<td>877</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students served in individual/group counseling</td>
<td>30</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counseling sessions provided</td>
<td>400</td>
<td>241</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Case management interactions</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students (receiving counseling services) who increased days of attendance (at least 10% by 6 months and 25% by year end) compared to previous year</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students (receiving counseling services) earning a 2.0 GPA or higher in a 12 month period</td>
<td>15%</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reduction of incidences of high risk behavior that may result in suspension or discipline referrals for students receiving counseling services compared to previous year</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>School District 4</td>
<td>School-based mental health services</td>
<td>- Students served in individual/group counseling</td>
<td>110</td>
<td>134</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counseling sessions provided</td>
<td>1,800</td>
<td>2,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students who improved on treatment plan goals by 20% in 6 months and 50% by end of school year</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students who improved from pre-test to post-test on the Strength and Difficulties Questionnaire by 50%</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Category</td>
<td>Program</td>
<td>Goals/Metrics</td>
<td>Annual Target</td>
<td>Annual Total</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Library 1</td>
<td>Caregiver Program</td>
<td>- Number of Family Caregivers enrolled in program</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Caregivers who log on to linkAges system at least once a month</td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Percentage of caregivers who attend planned activities/events per program period</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Percentage of participants who increase number of steps per week from baseline to end of program period (6 months)</td>
<td>60%</td>
<td>74%</td>
</tr>
<tr>
<td>CBO 5</td>
<td>School-based physical activities program</td>
<td>- Students served - 3 schools</td>
<td>1,700</td>
<td>1,745</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting increase in students who are physically active and engaged in healthy play</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting decrease in time spent in class resolving conflicts</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting time spent in class resolving conflicts</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting decrease in number of bullying incidents</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting a reduction in disciplinary incidents</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Teachers/administrators reporting reduction in disciplinary action and a positive impact on school climate</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Initiative 1</td>
<td>School-based physical activities program for low-income students</td>
<td>- Students served</td>
<td>96</td>
<td>131</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group encounters</td>
<td>47</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- “Focus Girls” observed to have improved behavior or attitude</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Average weekly attendance</td>
<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td>Program 5</td>
<td>School-based nutrition and physical activity program</td>
<td>- Total individuals served (unduplicated)</td>
<td>2,500</td>
<td>2,946</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students who report being active one or more hours per day after 5210 engagement</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students who limit sweetened beverages to 0-1 per day after 5210 engagement</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Students who report the knowledge that a balanced diet includes eating 5 fruit/vegetables per day after program engagement</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>CBO 6</td>
<td>Challenge Diabetes Program</td>
<td>- Clients educated about Challenge Diabetes program</td>
<td>400</td>
<td>1,490</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Participants enrolled in program</td>
<td>200</td>
<td>282</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Completion of Pre-screening and Post-screening</td>
<td>200</td>
<td>245</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Participants with increased knowledge of risks and causes of diabetes</td>
<td>30%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Participants who have made at least one lifestyle improvement (increased consumption of fruits/vegetables, decreased consumption of high sugar/high fat foods, and/or increased physical activity)</td>
<td>30%</td>
<td>59.5%</td>
</tr>
<tr>
<td>CBO 7</td>
<td>Case-management and referrals for low-income families</td>
<td>- Case management clients</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients participating in Benefit Clinics</td>
<td>144</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients participating in nutritional and education workshops</td>
<td>36</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Contacts made by case manager offering information and referral</td>
<td>3,376</td>
<td>3,380</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who sign up for public benefits</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Households moved out of food insecurity and out of poverty</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Case managed clients who increase in 3 of the 18 domains measured by Self Sufficiency Index</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Library 2</td>
<td>Health Information and Eldercare consultations</td>
<td>- Community members served</td>
<td>1,400</td>
<td>1,314</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who “strongly agree” or “agree” with the question, eldercare referrals appropriate to my needs</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who “strongly agree” or “agree” with the question, increase my knowledge of care options</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clients who “strongly agree” or “agree” with the question, the library has proven valuable in helping me manage my health or health of a friend or family member</td>
<td>65%</td>
<td>78%</td>
</tr>
<tr>
<td>Category</td>
<td>Partner</td>
<td>Goals/Metrics</td>
<td>Annual Target</td>
<td>Annual Total</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>
| Community Health Education and Health Literacy | Program 6  
*Online health education curriculum* | - Schools served  
- Physical activity breaks played (GoNoodle)  
- GoNoodle monthly active users as % of total staff  
- Teachers who report improvement in students' health knowledge  
- Teachers who report they are satisfied with GoNoodle program  
- Teachers who report they believe in the benefit of GoNoodle for their students’ performance in the classroom  
- Teachers who report using HealthTeacher improved students’ health behaviors | 145 7,228 14% 90% 95% 90% 85% | 153 80,597 57% 91% 99% 90% 83% |
|                                           | Initiative 2  
*Health education and support for Chinese community* | - Individuals served  
- Services (including education/training, screening, and referrals  
- Develop and distribute a resource guide to 150 Chinese seniors  
- Participants who strongly agree or agree with the statement, program education and screening events help me better manage my health | 75 400 150 80% | 97 475 271 99% |
|                                           | CBO 8  
*Health education and lifestyle modification for South Asian community* | - Individuals receiving information regarding hepatitis B at community events  
- Individuals screened and tested for hepatitis B at Hep B Free events  
- Clinicians who sign the Clinicians Honor Roll to pledge that they will follow CDC testing guidelines | 1,000 6,700 80 | 860 7,222 89 |
|                                           | CBO 9  | - Community members served  
- Organizations receiving technical assistance  
- Presentations and health fairs delivered  
- Community members who report they will engage in falls prevention behavior learned at presentations  
- Hits on Website  
- Participants who report confidence in their ability to protect themselves, reduction in concerns about falling, and intention to exercise appropriate to their needs  
- Organizations reached through Falls Prevention Awareness Day activities | 2,500 14 35 85% 3,500 85% 30 | 2,638 14 38 90% 4,029 90% 30 |
|                                           | CBO 10  
*Systems Innovation* | - Participants enrolled  
- Participants 60+ years  
- Participants reporting a reduction in feelings of loneliness and isolation  
- Participating seniors reporting increased connections with surrounding communities  
- Number of TimeBank exchanges  
- Number of hours exchanged by participants | 600 180 600 1,200 | 531 254 88% 871 1,701 |
|                                           | CBO 11  
*Intensive geriatric case management and transitions assistance to older adults* | - Participants attending outreach events and educational presentations targeting Latino populations  
- Participants of outreach and educational who “agree” or “strongly agree” they increased their understanding of the signs and symptoms of Alzheimer’s disease  
- Staff and volunteers trained in best practices for working with Latino populations  
- Participants involved in the training will "agree” or "strongly agree” that they learned best practices in Latino outreach strategies and communication  
- Increased number of Helpline calls received from Latino families | 200 30 | 1,036 10 53 90% 92% 8% |
|                                           | CBO 12  
*Intensive geriatric case management and transitions assistance to older adults* | - Households served through case management  
- Clients participating in workshops and other socialization activities to build self-sufficiency  
- Encounters made by case manager offering information and referrals  
- Isolated households connected to community services and improving their self-sufficiency  
- Case managed clients who increased in 3 of the 18 domains measured by Self-Sufficiency Index | 20 160 10 | 20 61 180 10 66% |
The Coalition worked in collaboration on the primary and secondary data requirements of the 2016 CHNA. The CHNA data collection process took place over eight months and culminated in ASR writing a report for the Coalition in March of 2016.

The Community Benefit Coalition of Santa Clara County’s CHNA Process


The Coalition contracted with ASR to collect secondary quantitative (statistical) data, secondary qualitative data via Santa Clara County Public Health Department reports, and primary qualitative data via key informant interviews and focus groups.

Data Sources of CHNA Input
Secondary Quantitative & Qualitative Data Collection

ASR analyzed over 200 quantitative health indicators to assist the Coalition with understanding the health needs in Santa Clara County and assessing their priority in the community (See Attachment 4 for list). Data from existing sources were collected using the Community Commons data platform\(^{18}\) and other online sources. ASR collected sub-county data where available.

In addition, ASR collected quantitative and qualitative secondary data from multiple Santa Clara County Public Health Department sources:

- 2014 Santa Clara County Community Health Assessment
- Behavioral Risk Factors Survey (BRFS) Quick Facts 2014
- Status of African/African Ancestry Health: Santa Clara County, 2014
- Status of LGBTQ Health: Santa Clara County, 2013
- Status of Vietnamese Health: Santa Clara County, 2011

As a further framework for the assessment, the Coalition requested that ASR address the following questions in its analysis:

- How do these indicators perform against accepted benchmarks (Healthy People 2020 objectives and statewide averages)?
- Are there disparate outcomes and conditions for people in the community?

Healthy People is an endeavor of the U.S. Department of Health and Human Services, which has provided 10-year national objectives for improving the health of Americans based on scientific data for 30 years. Healthy People sets objectives or targets for improvement for the nation. The most recent set of objectives are for the year 2020 (HP2020), and were updated in 2012 to reflect the most accurate population data available.\(^{19}\)

Regarding secondary qualitative data, in 2013 the Santa Clara County Board of Supervisors funded studies that shed light on key health issues for the LGBTQ and African/African Ancestry communities. The Status of LGBTQ Health: Santa Clara County 2013 report studied key priority health issues for the diverse lesbian, gay, bisexual, transgender, and queer communities of Santa Clara County. The African/African Ancestry Health Assessment studied health issues for those of African ancestry, with attention to the different experiences and needs of those who are foreign-born and native-born. Both of these reports include findings from community conversations with these populations, and include a specific effort to understand the experiences of LGBTQ residents who are of African Ancestry (Black and African-American).

In 2013, the lack of information about these populations was cited as an information gap (due to lack of statistical data on these small populations). The inclusion of these two important reports fills that gap and contributes to the understanding of the health needs of LGBTQ residents and Black residents.

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\(^{18}\) Powered by University of Missouri’s Center for Applied Research and Environmental System (CARES) system, www.communitycommons.org.

\(^{19}\) http://www.healthypeople.gov
Primary Qualitative Data (Community Input)

ASR conducted primary research for this assessment. It used three strategies for collecting community input: key informant interviews with health experts, focus groups with professionals who represent and/or serve the community, and focus groups with community members (residents).

The assessment included input from various populations:

- Low-income
- Minorities (e.g., Latinos and Vietnamese)
- The medically underserved
- Linguistically isolated populations
- Youth
- Older adults
- Undocumented immigrants

ASR conducted three out of five resident focus groups in languages other than English and intentionally recruited people with low-incomes.

The Coalition also sought to build upon the 2013 CHNA by focusing the primary research on the community’s perception of health and experience with healthcare access. There was a particular focus on the impact of the Affordable Care Act (ACA) since the California healthcare exchange was not fully enacted until after the data were collected for the 2013 CHNA.

Each focus group and interview was recorded and summarized as a stand-alone piece of data. When all data had been collected, the team used NVivo, a qualitative research software tool, to analyze the information. ASR then 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. This tabulation was used in part to assess community health priorities.

Community Leader Input

In all, ASR solicited input from almost 100 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 the target populations. Multiple community leaders participated from each of these types of agencies:

- Santa Clara County Public Health Department and Behavioral Health Services
- Santa Clara Valley Medical Center (County) clinics
- Hospitals and healthcare systems
- Health insurance navigators
- Mental/behavioral health or violence prevention providers
- School systems

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20 The IRS requires that community input include low-income, minority, and the medically underserved populations.
Nonprofit community-based organizations serving children, youth, seniors, parents, immigrants, those experiencing homelessness, and those with dementia, mental health, and substance use disorders

Many of these leaders and representatives participated in key informant interviews or focus groups, and others participated in an online survey (described below). See Attachment 5 for the list of CHNA participants, along with their expertise and mode of consultation (focus group or key informant interview).

Community Leader Survey

ASR invited 65 community leaders with expertise in serving the community to participate in an online survey in July 2015. The survey asked participants to rank a list of health needs in Santa Clara County and invited them to add other needs to the list. There were 49 responses to the survey which reflected a range of expertise. Participants’ organizations included behavioral health agencies, agencies that help families with basic needs, school systems, and other nonprofits. The results of the survey were combined with input gathered through focus groups and key informant interviews to determine the community’s priorities. Participants also contributed information about the current assets and resources available to meet health needs, which was incorporated into the information found in Attachment 7.

Health Expert Key Informant Interviews

In April and May 2015, ASR conducted primary research via key informant interviews with five Santa Clara County experts from various organizations in the health sector. It interviewed experts in person or by telephone for approximately one hour. ASR asked informants to identify the top needs of their constituencies, to give their perceptions about how access to healthcare has changed in the post-Affordable Care Act environment, to explain which barriers to good health or addressing health needs exist, and to share which solutions may improve health (including existing resources and policy changes).

Details of Key Informant Interviews

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>EXPERTISE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Clara County Dental Society</td>
<td>Oral health</td>
<td>4/30/15</td>
</tr>
<tr>
<td>Community Health Partnership</td>
<td>Un/underinsured</td>
<td>5/8/15</td>
</tr>
<tr>
<td>Pediatric Healthy Lifestyle Center (Sunnyvale)</td>
<td>Pediatric diabetes</td>
<td>5/13/15</td>
</tr>
<tr>
<td>Santa Clara County Public Health</td>
<td>Public health</td>
<td>5/21/15</td>
</tr>
<tr>
<td>School Health Clinics of Santa Clara County</td>
<td>Child health including immigrants</td>
<td>6/5/15</td>
</tr>
</tbody>
</table>

Community Leader Focus Groups

ASR conducted five focus groups with community leaders between April and September 2015. Sixty-eight professionals participated in the focus groups. The discussion centered on the following four questions, which were modified appropriately for the audience. (See Attachment 6 for detailed focus group protocols.)

1. What are the unmet health needs that you see in Santa Clara County? Which are the most pressing among the people you serve/represent? How are the needs changing?
2. How has the Affordable Care Act impacted access to healthcare, including insurance and adequate healthcare services, of the people you serve/represent?
3. What drivers or barriers are impacting unmet health needs?
4. What policies or resources exist or are needed to impact the health needs?

Details of Focus Groups with Professionals

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>FOCUS GROUP HOST/PARTNER</th>
<th>DATE</th>
<th>NUMBER OF PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>Destination Home</td>
<td>4/28/15</td>
<td>24</td>
</tr>
<tr>
<td>Medically underserved</td>
<td>Community Health Partnership</td>
<td>5/15/15</td>
<td>8</td>
</tr>
<tr>
<td>Older adults</td>
<td>Alzheimer's Association</td>
<td>5/19/15</td>
<td>10</td>
</tr>
<tr>
<td>Mental health/Substance use</td>
<td>Behavioral Health Contractors’ Association of Santa Clara County</td>
<td>5/28/15</td>
<td>12</td>
</tr>
<tr>
<td>South County</td>
<td>Community Solutions</td>
<td>9/18/15</td>
<td>14</td>
</tr>
</tbody>
</table>

Please see Attachment 5 for a full list of community leaders/stakeholders consulted and their credentials.

Resident Input

ASR held five focus groups with community members. To provide a voice to the community it serves in Santa Clara County, the assessment team targeted participants who are medically underserved, low-income, minority (including the linguistically isolated), and those who were socially isolated (older adults). ASR planned these resident groups in various geographic locations around the county. Nonprofit hosts, such as the Community Health Partnership, which serves uninsured residents, recruited participants. ASR conducted resident focus groups between April and October 2015. The discussion centered on the following four questions, which were modified appropriately for the audience. (See Attachment 6 for detailed focus group protocols.)

1. What are the unmet health needs in this community, and which are the most pressing?
2. How has the Affordable Care Act impacted your access to healthcare, including insurance, adequate healthcare benefits, primary or preventative care, and ER use?
3. What drivers or barriers are impacting your access to healthcare?
4. What do you suggest to improve the health conditions we talked about?
Details of Focus Groups with Residents

<table>
<thead>
<tr>
<th>POPULATION FOCUS</th>
<th>FOCUS GROUP HOST/PARTNER</th>
<th>DATE</th>
<th>NUMBER OF PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family caregivers of older adults</td>
<td>Family Caregiver Alliance (Avenidas, Palo Alto)</td>
<td>4/16/15</td>
<td>4</td>
</tr>
<tr>
<td>New and pregnant mothers (conducted in Spanish)</td>
<td>Columbia Neighborhood Center (Sunnyvale)</td>
<td>5/5/15</td>
<td>6</td>
</tr>
<tr>
<td>High school youth</td>
<td>Los Altos High School (Los Altos)</td>
<td>5/12/15</td>
<td>12</td>
</tr>
<tr>
<td>Spanish-speaking medically underserved (conducted in Spanish)</td>
<td>Community Health Partnership (San Jose)</td>
<td>5/13/15</td>
<td>8</td>
</tr>
<tr>
<td>Vietnamese adults (conducted in Vietnamese)</td>
<td>Asian Americans for Community Involvement (San Jose)</td>
<td>10/4/15</td>
<td>10</td>
</tr>
</tbody>
</table>

2016 Resident Participant Demographics

Forty community members participated in the focus group discussions across the county. Most participants completed an anonymous demographic survey, the results of which are reflected below.

- 63% of participants were Hispanic/Latino. 25% were Vietnamese, 10% were White, and 3% reported an “other” race.
- Vietnamese participants’ ages ranged from 34 to 81 years, with the average being 59 years. 40% of other participants (12) were under 20 years old, and 13% were 65 years or older.
- 13% (5) were uninsured, while 82% had benefits through Medi-Cal, Medicare or Health Kids/Healthy Families public health insurance programs. 5% had private insurance.
- Residents lived in multiple areas of the county: Mountain View (12), San Jose (4), Sunnyvale (5), Palo Alto (3), and one each in Santa Clara and Menlo Park.21
- 68% of those who responded21 reported having an annual household income of under $45,000 per year, which is below the 2014 California Self-Sufficiency Standard22 for Santa Clara County for two adults with no children ($45,802). The majority (64%) earned under $25,000 per year, which is below Federal Poverty Level for a family of four. This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.22

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21 Demographic does not include Vietnamese residents due to missing data on this item.
Information Gaps & Limitations

ASR and the Coalition were limited in their ability to fully assess some of the identified community health needs due to a lack of secondary data. Such limitations included:

- Oral/dental health
- Adult use of illegal drugs and misuse/abuse of prescription medications
- E-cigarette use
- Alzheimer’s disease and dementia diagnoses
- Mental health disorders
- Bullying
- Suicide among LGBTQ youth
- Ethnic subgroups affected by hepatitis B
- Diabetes among children
- Breastfeeding practices at home
- Community violence (especially officer-involved shootings)
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)

Another limitation is related to the local and national Behavioral Risk Factor Surveillance System (BRFSS). In 2011 BRFSS data collection, structure, and weighting methodology changed to allow the addition of data collection by cellular telephones. Because the CDC changed the methods for the BRFSS, trend comparisons for both national and locally implemented BRFSS surveys (such as the 2014 Santa Clara County Public Health Department BRFS) are not feasible.\(^\text{23}\)

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IDENTIFICATION & PRIORITIZATION OF COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced. To identify the community’s prioritized health needs, the Coalition and/or its members followed these steps:

- Gathered data on 200+ health indicators using the Community Commons platform, Healthy People 2020 objectives and qualitative data. See Attachment 4 for a list of indicators on which data were gathered.
- Narrowed the list to “health needs” by applying criteria.
- Each hospital used criteria to prioritize the health needs.
Identification of Priority Community Health Needs

In 2014, final IRS regulations clarified the definition of a health need, which includes social determinants of health. Social determinants of health affect entire families and communities, and they explain in part why some individuals thrive and experience good health, while other individuals are not as healthy as they could be. In addition to health related behaviors such as eating nutritious foods, and avoiding health risks such as smoking, our health is determined in large part by our economic opportunities; by whether or not we receive a quality education; the availability of resources and support in our homes, neighborhoods, and communities; our workplaces; environmental factors such as access to clean water, nutritious food, and air; community safety; and the nature of our social interactions and relationships. In 2016, given this broader definition, the Coalition identified 18 health needs that fit all three criteria outlined below.

The 2016 prioritized health needs described in this report meet all three of the following progressive criteria:

1. The issue fits the definition of a “health need” above.
2. More than one source of secondary and/or primary data suggests or confirms the issue.
3. It meets one of the two criteria below:
   - At least one related indicator performs poorly against an associated Healthy People 2020 (“HP2020”) benchmark or, if there is no HP2020 benchmark, against the state average. For example, the proportion of children younger than six in Santa Clara County who are obese (18%) is higher than the state average and the Healthy People 2020 benchmark (17% and 10%, respectively).
   - The community prioritized it in three of the ten focus groups or it was identified by a key informant. To obtain information on community priorities for this assessment, professionals and residents who participated in focus groups and key informant interviews were asked to identify the top health needs of their clients and/or communities drawing on their own perceptions and experiences.

Eighteen health conditions or drivers fit all three criteria and were retained as community health needs. The list of needs, in alphabetical order, is found below.
Summarized Descriptions of Priority Santa Clara County Community Health Needs

1. **Access to Healthcare and Healthcare Delivery** are health needs in Santa Clara County as demonstrated by the proportion of Latinos who are less likely to be insured, less likely to see a primary care physician, and more likely to go without healthcare due to cost. For example, 68% of Latinos are insured compared to 85% of residents countywide. The community input indicates that healthcare access is a top priority; specifically, affordability of insurance is an issue for those who do not qualify for Covered California subsidies. The lack of general and specialty practitioners, especially in community clinics, results in long wait times for appointments. The community also lacks health system literacy and is in need of patient navigators and advocates (especially immigrants). Community respondents expressed concern about access to healthcare for those experiencing homelessness, especially behavioral health treatment and treatment for conditions that require rehabilitation and follow-up care. The LGBTQ and Black communities cited a lack of culturally competent providers as an access barrier. In addition, a considerable minority are linguistically isolated in the county, which also impacts healthcare access.

2. **Alzheimer’s Disease and Dementia** are health needs in Santa Clara County as evidenced by Alzheimer’s disease being the third leading cause of death in 2012, accounting for 8% of all deaths. In California, it was the fifth leading cause. The age-adjusted death rate of Alzheimer’s disease in Santa Clara County in 2011 was 35.9 per 100,000, which was higher than the state overall in 2010 (30.1 per 100,000). In the next 10 years, nearly one in five local residents will be 65 years or older, which puts the population at higher risk for dementia and Alzheimer’s disease. Also, the county population is slightly older than the state overall. Local professionals who serve seniors expressed concern over the lack of dementia and Alzheimer’s diagnoses. There are a lack of countywide data on the prevalence of these diseases, which is a concern given the increasing proportion of older adults.

3. **Behavioral Health** was prioritized as a top need of the community. This need includes mental health, well-being (such as depression and anxiety), and substance use/abuse. Close to four in ten (38%) Santa Clara County residents report poor mental health on at least one day in the last 30 days. Six in ten county residents report being somewhat or very stressed about financial concerns. Notably, nearly one quarter (23%) of LGBTQ respondents have seriously considered attempting suicide or physically harming themselves within the past 12 months. The community discussed the stigma that persists for those who experience mental illness. They also expressed concern about older adults, LGBTQ residents, and those of particular ethnic cultures. Community feedback indicates that there is a lack of health insurance benefits for those who do not have formal diagnoses and insufficient services for those who do. Providers of behavioral health services cited poor access to such services when funding does not address the co-occurring conditions of addiction and mental illness. The community expressed concern about the documented high rates of youth marijuana use and rising youth methamphetamine use. While binge drinking among adults and youth is relatively low, it is a contributor to liver disease/cirrhosis, which is the ninth leading cause of death in the county.

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24 California Department of Public Health, *Leading Causes of Death; California Counties and Selected City Health Department*, 2012. Note that 2013 death data show an anomaly for Alzheimer’s deaths, with 3% of deaths due to Alzheimer’s disease which may reflect a change in how deaths were reported.


Birth Outcomes are a health need in Santa Clara County as evidenced by stark racial and ethnic disparities. For instance, the mortality rate of Black infants (7.8 per 1,000) is higher than the HP2020 target (6.0 per 1,000). Moreover, over a quarter of Blacks (29%) and Latinos (26%) experience inadequate prenatal care. The health need is likely impacted by certain social determinants of health (such as food insecurity experienced by pregnant mothers) and by the percentage of women receiving early prenatal care.

Cancer was the leading cause of death in Santa Clara County in 2013, accounting for 2,372 deaths. Data show that colorectal and prostate cancer prevalence rates are higher than both the Healthy People 2020 target and the state average. Breast and cervical cancers disproportionately affect Whites; lung cancer disproportionately affects Blacks, and a high proportion of Vietnamese residents have liver cancer. Blacks have higher overall cancer mortality rates compared with other groups. Hepatitis B, a driver of liver cancer, is higher in Santa Clara County compared to the state. Asian and Pacific Islander residents are more likely to have hepatitis B and are therefore at higher risk of liver cancer. In addition, public health experts expressed concern about youth tobacco use (as smoking has an impact on various types of cancer).

Cardiovascular (Heart) and Cerebrovascular (Stroke) Diseases are responsible for 26% of deaths in Santa Clara County. Whites and Blacks have higher rates of heart disease deaths than the county overall, and Pacific Islanders have a higher rate of stroke death than the county overall. Youth consumption of fruits and vegetables is worse in Santa Clara County compared with California. Compared with California overall, there are more fast food restaurants, fewer grocery stores, and fewer WIC-authorized stores in Santa Clara County.

Communicable Diseases are a health need in Santa Clara County as evidenced by high rates of hepatitis B (which is worse than the state) and tuberculosis (which fails to meet the Healthy People 2020 target). Ethnic disparities are also seen in tuberculosis rates, with the rate for Asian and Pacific Islanders more than double that of the county overall. Specifically, Vietnamese residents comprise a large proportion of all tuberculosis cases. The community expressed concern about the lack of screenings for these diseases, especially among Asian immigrants who come from countries where TB is more common than in the U.S. In addition, professionals cited the lack of referrals and follow-up with patients who are diagnosed with TB and/or hepatitis B. Also, influenza is the eighth leading cause of death in Santa Clara County.

Economic Security is a need in Santa Clara County because of the ethnic disparities seen in rates of poverty, unemployment, and lack of a high school education. In 2014, 32% of Latinos did not graduate from high school, compared to 18% of residents countywide. In terms of poverty, 10% of Santa Clara County residents live below the Federal Poverty Level. However, the percentage living below the self-sufficiency standard, which is a more comprehensive measure of poverty, is higher (23%). The community expressed concern that income inequality and the wage gap contribute towards poor health outcomes. Residents and professionals alike stated that financial stress about the cost of housing, food, and healthcare is a driver of poor health.

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28 Ibid.
**Housing** is a health need because a lack of safe, stable housing is related to poor physical and mental health outcomes. Data on the cost of rent and median home values indicate that Santa Clara County is one of the most expensive places to live throughout California. Rents have increased significantly in the past five years in the San Jose-Sunnyvale-Santa Clara metropolitan area. Rents for a two-bedroom residence averaged $1,994 in the area in 2015, a 21% increase from 2013. Of mortgage-holders, a higher proportion of Blacks and Latinos spend 30% or more of household income on housing (52% and 59% respectively) compared to Santa Clara County overall (45%) and California (46%). Additionally, homelessness has increased in Gilroy, Mountain View, and Palo Alto. Community focus group participants indicated that housing and homelessness are top concerns.

**Hypertension**, which is abnormally high blood pressure, can lead to heart disease and stroke, which are the leading causes of death in the United States. About one of three U.S. adults have high blood pressure and only about half (52%) have their high blood pressure under control. More than a quarter (27%) of Santa Clara County residents have been diagnosed with high blood pressure. Blacks, men, and older adults are more likely to be diagnosed with high blood pressure than county residents overall.

**Learning Disabilities**, including attention deficit disorder (ADD), attention deficit-hyperactivity disorder (ADHD), and autism, are a health need because of the increasing proportion of county public school children who are receiving special education services, which is slightly greater than the state proportion. The percentage of Santa Clara County children enrolled in special education classes increased slightly between 2011 and 2015 from 9% to 10%. Learning disabilities are the most common type of disability among those receiving special education. Children with ADHD are at increased risk for antisocial disorders, drug abuse, and other risky behaviors. While data are lacking about the prevalence of specific learning disabilities, the community expressed concern about the lack of diagnoses of learning disabilities and special needs, specifically among those experiencing homelessness and immigrant children (especially those who enter the country unaccompanied).

**Obesity and Diabetes** are related health conditions that are a health need as marked by the proportion of obese children younger than six in the county (18%), which is higher than the state (17%) and Healthy People 2020 targets (10%, see also page 7 of this report). Santa Clara County’s Latino (26%) and Black (21%) youth are more likely to be overweight and obese, and these rates fail Healthy People 2020 targets for this population (16%). While overall adult obesity is less grave in the county than in the state, the Latino adult obesity rate (34%) fails Healthy People 2020 targets (31%). While adult diabetes rates in Santa Clara County are no worse than in California, there is a perception in the community that childhood diabetes diagnoses are increasing (this could not be confirmed with extant data). The health need is likely impacted by health behaviors such as low fruit and vegetable consumption and high soda consumption, as well as environmental factors of proximity of fast food establishments, a lack of grocery stores, and a lack of WIC-authorized food sources (all of which are worse in the county than in the state overall).

---

13 Oral and Dental Health is a need in Santa Clara County illustrated by nearly two thirds (64%) of adults lacking dental insurance. One in three adults has had tooth loss, and the statistics are worse for Black adults (49%). Additionally, youth dental care utilization rates (15%) are worse than the state (19%). The community expressed concern about the proportion of adults who lack dental insurance, the lack of providers who accept Denti-Cal, and the costs of dental care for those who do not have insurance. The community also reported that some dental insurance benefits are not sufficient for those who need services beyond cleaning and extraction.

14 Respiratory Conditions are a health need in Santa Clara County as marked by disproportionality among non-Whites who have been diagnosed with asthma. Specifically, those with household incomes of $50,000-$74,999 (25%), multiracial adults (22%), and Blacks (19%) have a higher prevalence of asthma than the county (14%). Although there are lower asthma hospitalization rates in Santa Clara County compared with California, there are ethnic and geographical disparities. Blacks are twice as likely as Whites to be hospitalized for asthma, as are those living in East San Jose and North San Jose (95134 zip code). The health need is likely being impacted by health behaviors such as percentage of youth smoking and by issues in the physical environment such as air quality levels. Also, asthma is associated with obesity, which is a problem for Santa Clara County children.

15 Sexual Health is a health need in Santa Clara County as demonstrated by high incidence rates of HIV among Black and Latino men, as well as male primary and secondary syphilis incidence rates, which are higher than those in California. Women are twice as likely to contract chlamydia as men, at a rate of 422.3 per 100,000 compared to 203.7. The health need is likely impacted by low screening rates for HIV (countywide, the percentage of teens and adults ever screened for HIV is lower than the state average). Community feedback suggests that the health need is perceived as primarily affecting youth, LGBTQ, and single people, which may drive low screening rates for those who think they are low risk. Data show that large proportions of LGBTQ residents have never been tested for sexually transmitted infections. In addition to the perception of low risk, the LGBTQ community also cited fear of finding out that they had HIV or AIDS and a lack of time as reasons they had not been tested. Regarding teen births, the rate (per 1,000 females aged 15-19) decreased from 24.6 in 2003 to 16.8 in 2012. However, the Latina teen birth rate (36.9 per 1,000 females aged 15-19) was more than twice as high as the Black teen birth rate (14.4) and six times higher than the White teen birth rate (6.3).

---

31 Ibid.
**Tobacco Use** is a driver of cancer and respiratory conditions. One in ten Santa Clara County residents are current smokers, which is lower than the Healthy People 2020 target of 12%. However, men are more likely to smoke than women (13% compared to 7%), and Filipinos have the highest smoking prevalence (21%) of all racial and ethnic groups. Among Latinos, those who are foreign-born are much more likely to smoke (16%) than those born in the U.S. (6%).\(^{36}\) Latino and Black adolescents are disproportionately more likely to smoke than teens overall. Smoking among both these groups as well as Asian and Pacific Islander youth rose in the past five years. Public health reports cite a lack of education about tobacco prevention in schools as a driver of tobacco use.

**Unintentional Injuries** includes falls, drownings, and pedestrian and motor vehicle accidents. The rate of 7.7 unintentional falls deaths in Santa Clara County per 100,000 people slightly exceeds the HP2020 objective of 7.0 per 100,000 people.\(^{37}\) The annual economic cost of falls among adults aged 65 and older includes medical costs and work loss due to emergency department visits, hospitalizations, and deaths. In 2013 these costs amounted to more than $265 million in Santa Clara County.\(^{38}\) Regarding pedestrian accidents, Santa Clara County’s rate of 1.5 deaths per 100,000 from pedestrian accidents slightly exceeds the Healthy People 2020 objective of 1.3, and the rates are higher among Latinos (2.2) and Asians (1.6).\(^{39}\)

**Violence** is a health need in Santa Clara County as marked by ethnic disparities in adult homicide mortality and domestic violence deaths. The rate of rape is no better than the state average. A majority of youth (of every race/ethnicity) report having been victims of bullying at school. 2013 CHNA community input indicated that the health need is also affected by the following factors: the cost and/or lack of activity options for youth, financial stress, poor family models, unaddressed mental and/or behavioral health issues among perpetrators, cultural/societal acceptance of violence, linguistic isolation, and lack of awareness of support and services for victims. These community members also suggested that violence is underreported by victims, possibly due to stigma and/or cultural norms.

For further details, including statistical data and sources, please consult the Health Needs Profiles appended to this report as Attachment 8. For details on community assets and resources that address the health needs, please refer to Attachment 7.

---

\(^{38}\) Santa Clara County Public Health Department. *Santa Clara County: Unintentional Falls Among Older Adults*, 2015.
\(^{39}\) University of Missouri, Center for Applied Research and Environmental Systems; California Department of Public Health. *Death Public Use Data*, 2010-12.
Prioritization of Health Needs

Before beginning the prioritization process, the El Camino Hospital Community Benefit Advisory Council chose a set of criteria to use in prioritizing the list of health needs:

- Magnitude/scale of the need: The number of people affected by the health need.
- Clear disparities or inequities: Differences in health outcomes by subgroups. Subgroups may be based on geography, languages, race/ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- Multiplier effect: A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

A survey was then created, listing each of the health needs in alphabetical order and offering the first three prioritization criteria for rating. Committee members rated each of the health needs on each of the first three prioritization criteria during an in-person meeting in October 2015.

The score levels for the prioritization criteria were:

3: Strongly meets criteria, or is of great concern
2: Meets criteria, or is of some concern
1: Does not meet criteria, or is not of concern

Combining the Scores: For the first three criteria, ASR combined group members’ ratings and averaged them to obtain a combined score.

List of Prioritized Needs

The need scores ranged between 1.4 and 3.0, with 3 being the highest score possible and 1 being the lowest score possible. The needs are ordered by prioritization score in the following table.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Health Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Economic Security</td>
</tr>
<tr>
<td>1</td>
<td>Obesity &amp; Diabetes</td>
</tr>
<tr>
<td>3</td>
<td>Housing</td>
</tr>
<tr>
<td>4</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>5</td>
<td>Access &amp; Delivery</td>
</tr>
<tr>
<td>6</td>
<td>Oral &amp; Dental Health</td>
</tr>
<tr>
<td>7</td>
<td>Cardiovascular (Heart) &amp; Cerebrovascular (Stroke) Diseases</td>
</tr>
<tr>
<td>7</td>
<td>Hypertension</td>
</tr>
<tr>
<td>9</td>
<td>Tobacco Use</td>
</tr>
<tr>
<td>10</td>
<td>Violence &amp; Abuse</td>
</tr>
<tr>
<td>11</td>
<td>Cancer</td>
</tr>
<tr>
<td>12</td>
<td>Birth Outcomes</td>
</tr>
<tr>
<td>13</td>
<td>Alzheimer's Disease &amp; Dementia</td>
</tr>
<tr>
<td>14</td>
<td>Communicable Diseases</td>
</tr>
<tr>
<td>14</td>
<td>Unintentional Injuries</td>
</tr>
<tr>
<td>16</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>17</td>
<td>Respiratory Conditions</td>
</tr>
<tr>
<td>18</td>
<td>Sexual Health</td>
</tr>
</tbody>
</table>
CONCLUSION

Our Hospital worked with its Coalition partners, between Fall 2014 and Spring 2016, to conduct the 2016 Community Health Needs Assessment (CHNA). The 2016 CHNA builds upon years of health assessments dating back to 1995. It exceeds the new federally-mandated requirements as well as California state regulations. Through pooled expertise and resources to conduct a shared assessment, the Coalition was able to identify health needs that are a priority in the community and understand how each compare against Healthy People 2020 and/or state benchmarks. This was accomplished by collecting updated secondary data and conducting new primary research (community input).

After reviewing the findings of the community health needs assessment, El Camino Hospital’s Community Benefit Advisory Council (CBAC) identified 12 health needs to be addressed in FY17 and the subsequent two fiscal years with community benefit grant funding. The table below shows the health needs mapped to three health priority areas:

- Obesity & Diabetes
- Healthcare Access & Delivery
- Oral & Dental Health
- Cancer
- Hypertension
- Cardiovascular (Heart) and Cerebrovascular (Stroke) Diseases
- Respiratory Conditions
- Behavioral Health
- Alzheimer’s Disease & Dementia
- Violence & Abuse
- Unintentional Injuries
- Economic Security
The CBAC selected these health needs based on the following progressive criteria:

1. The issue fits the definition of a health need: A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
2. More than one source of secondary and/or primary data suggests or confirms the issue.
3. It meets either qualitative or quantitative data criteria:
   - At least one related indicator performs poorly against the Healthy People 2020 (“HP2020”) benchmark or, if there is no HP2020 benchmark, against the state average.
   - The community prioritized it in three of the ten focus groups or it was mentioned by a key informant.

Detailed strategies and partners funded to address these needs are explained in further detail in the FY17 El Camino Hospital Community Benefit Plan & Implementation Strategy, upon Board approval.
ATTACHMENTS

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## Federal Requirements Checklist

<table>
<thead>
<tr>
<th>A. Activities Since Previous CHNA(s)</th>
<th>Regulation Section Number</th>
<th>Report Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the written comments received on the hospital’s most recently conducted CHNA and most recently adopted implementation strategy.</td>
<td>(b)(5)(C)</td>
<td>Section pages 22-32</td>
</tr>
<tr>
<td>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).</td>
<td>(b)(6)(F)</td>
<td>Section pages 22-32</td>
</tr>
</tbody>
</table>

### B. Process & Methods

#### Background Information

- Identifies any parties with whom the facility collaborated in preparing the CHNA(s). (b)(6)(F)(ii) Section page 21
- Identifies any third parties contracted to assist in conducting a CHNA. (b)(6)(F)(ii) Section page 21
- Defines the community it serves, which:
  - Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance.
  - May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions.
  - May not exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients. (b)(i) (b)(3) (b)(6)(i)(A) Section pages 12-19
- Describes how the community was determined. (b)(6)(i)(A) Section pages 12-19
- Describes demographics and other descriptors of the hospital service area. Section pages 12-19

#### 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)(ii) Section pages 33-39
  - b. Describes methods of collecting and analyzing the data and information. (b)(6)(ii) Section pages 33-39
- CHNA describes how it “took into account input from persons who represent the broad interests of the community” in order to identify and prioritize health needs and identify resources potentially available to address those health needs. (b)(1)(iii) (b)(5)(I) (b)(6)(F)(III) Section pages 33-39
- Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.
  - 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 pages 33-39
### Federal Requirements Checklist

<table>
<thead>
<tr>
<th>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.)</th>
<th>(b)(5)(i)(B)</th>
<th>Section pages 33-39</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Medically underserved populations</td>
<td>(b)(5)(i)(B)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>II. Low-income populations</td>
<td>(b)(5)(i)(B)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>III. Minority populations</td>
<td>(b)(5)(i)(B)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).</td>
<td>(b)(5)(ii)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>Describes how such input was provided (e.g., through focus groups, interviews or surveys).</td>
<td>(b)(6)(F)(iii)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>Describes over what time period such input was provided and between what approximate dates.</td>
<td>(b)(6)(F)(iii)</td>
<td>Section pages 33-39</td>
</tr>
<tr>
<td>Summarizes the nature and extent of the organization’s input.</td>
<td>(b)(6)(F)(iii)</td>
<td>Section pages 33-39</td>
</tr>
</tbody>
</table>

### 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 pages 40-48 |
| Prioritized description of significant health needs identified. | (b)(6)(O)(O) | Section pages 40-48 |
| Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs. | (b)(6)(O)(D) | Section pages 40-48 |
| Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility). | (b)(4) (b)(6)(E) | Section pages 116-138 |

### D. Finalizing the CHNA

<p>| CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year. | (a)1 | Section pages 3-10 |
| 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 pages 3-10 |
| 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) | Section pages 3-10 and 22-32 |
| a. May not be a copy marked “Draft”. | (b)(7)(ii) | N/A |
| 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) | N/A |</p>
<table>
<thead>
<tr>
<th>Federal Requirements Checklist</th>
<th>Regulation Section Number</th>
<th>Report Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Instructions for accessing CHNA report are clear.</td>
<td>(b)(7)(i)(A)</td>
<td>N/A</td>
</tr>
<tr>
<td>d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.</td>
<td>(b)(7)(i)(A)</td>
<td>N/A</td>
</tr>
<tr>
<td>e. Individuals requesting a copy of the report(s) are provided the URL.</td>
<td>(b)(7)(i)(A)</td>
<td>N/A</td>
</tr>
<tr>
<td>f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.</td>
<td>(b)(7)(i)(B)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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 2: Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
<th>Description/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
<td>Syndrome caused by HIV; the last stage of HIV infection, when the immune system can no longer fight off infections.</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td>Survey implemented by CDC</td>
</tr>
<tr>
<td>CA</td>
<td>California (state)</td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
<td>A federal agency under the DHHS focused on health research, prevention, and intervention.</td>
</tr>
<tr>
<td>CDE</td>
<td>California Department of Education</td>
<td></td>
</tr>
<tr>
<td>CDHS</td>
<td>California Department of Health Services</td>
<td></td>
</tr>
<tr>
<td>CDPH</td>
<td>California Department of Public Health</td>
<td></td>
</tr>
<tr>
<td>CHNA</td>
<td>Community Health Needs Assessment</td>
<td></td>
</tr>
<tr>
<td>CNA</td>
<td>Community needs assessment</td>
<td></td>
</tr>
<tr>
<td>DHHS</td>
<td>United States Department of Health and Human Services</td>
<td>National, 10-year aspirational benchmarks set by federal agencies &amp; finalized by a federal interagency workgroup under the auspices of the U.S. Office of Disease Prevention and Health Promotion, managed by DHHS.</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal poverty level</td>
<td>An annual metric of income levels determined by DHHS.</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
<td>Sexually transmitted virus that can lead to AIDS.</td>
</tr>
<tr>
<td>HP2020</td>
<td>Healthy People 2020</td>
<td></td>
</tr>
<tr>
<td>HUD</td>
<td>United States Department of Housing and Urban Development</td>
<td>A cabinet department in the Executive branch of the United States federal government.</td>
</tr>
<tr>
<td>LGBTQI</td>
<td>Lesbian/ Gay/ Bisexual/ Transgender/ Questioning/ Intersex</td>
<td></td>
</tr>
<tr>
<td>PHD</td>
<td>Public health department</td>
<td></td>
</tr>
<tr>
<td>SCC</td>
<td>Santa Clara County</td>
<td></td>
</tr>
</tbody>
</table>
Attachment 3: Secondary Data Sources


Santa Clara County Public Health Department (SCC PHD). 2015. Santa Clara County: Unintentional Falls Among Older Adults.


## Attachment 4: Data Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator Variable</th>
<th>Description</th>
<th>Data Source</th>
<th>Year</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access - Usual Place of Care</strong></td>
<td>Percent of children (0-11) who have a usual place of care</td>
<td>Percent of children (0-11) who have a usual place of care</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Alcohol - Excessive Consumption</strong></td>
<td>Estimated adults drinking excessively (age-adjusted percentage)</td>
<td>Percentage of adults age 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women)</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the Health Indicators Warehouse; U.S. Department of Health &amp; Human Services, Health Indicators Warehouse</td>
<td>2006-12</td>
<td>Community Commons</td>
</tr>
<tr>
<td><strong>Alcohol Use</strong></td>
<td>Percent of adults who drank alcohol 1+ times in the past 30 days</td>
<td>Percent of adults who drank alcohol 1+ times in the past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Alcohol Use</strong></td>
<td>Percent of middle school and high school students who drank alcohol 1+ times in the past 30 days</td>
<td>Percent of middle school and high school students who drank alcohol 1+ times in the past 30 days</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Asthma - Hospitalizations</strong></td>
<td>Age-adjusted discharge rate (per 10,000 pop.)</td>
<td>Patient discharge rate (per 10,000 total population) for asthma and related complications</td>
<td>California Office of Statewide Health Planning and</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Indicator</td>
<td>Indicator Variable</td>
<td>Description</td>
<td>Data Source</td>
<td>Year</td>
<td>Data Source</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Asthma - Prevalence</strong></td>
<td>Percent of adults with asthma</td>
<td>Percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma</td>
<td>Development, OSHPD Patient Discharge Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asthma Children ER Visits</strong></td>
<td>Rate of asthma-related ER visits by children 0-17</td>
<td>Rate of asthma-related ER visits by children 0-17</td>
<td>SCC Patient Discharge Database, 2012</td>
<td>2011</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Asthma Prevalence (Adult)</strong></td>
<td>Percent of adults ever diagnosed with asthma</td>
<td>Percent of adults ever diagnosed with asthma</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Asthma Prevalence (Children)</strong></td>
<td>Percent of children (0-11) ever diagnosed with asthma</td>
<td>Percent of children (0-11) ever diagnosed with asthma</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td><strong>Binge Drinking (Adults)</strong></td>
<td>Percent of adults binge drinking in the last 30 days</td>
<td>Percent of adults binge drinking in the last 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Binge Drinking (Youth)</strong></td>
<td>Percent of adolescents binge drinking in the last 30 days</td>
<td>Percent of adolescents binge drinking in the last 30 days</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Breastfeeding (Any)</strong></td>
<td>Percentage of mothers breastfeeding (any)</td>
<td>Percentage of mothers who breastfeed their infants at birth. This indicator is relevant because breastfeeding has positive health benefits for both infants and mothers and may lower infant mortality</td>
<td>California Department of Public Health, CDPH - Breastfeeding</td>
<td>2012</td>
<td>Community Commons</td>
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<td>Indicator</td>
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<tr>
<td>Breastfeeding (Exclusive)</td>
<td>Percentage of mothers breastfeeding (exclusively)</td>
<td>Percentage of mothers who exclusively breastfeeding their infants during their post-partum hospital stay. This indicator is relevant because breastfeeding has positive health benefits for both infants and mothers and may lower infant mortality rates</td>
<td>CDPH - Breastfeeding Statistics</td>
<td>2012</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Cancer Incidence - Breast</td>
<td>Annual breast cancer incidence rate (per 100,000 pop.)</td>
<td>Age-adjusted incidence rate (cases per 100,000 population per year) of females with breast cancer adjusted to 2000 U.S. standard population age groups</td>
<td>National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, State Cancer Profiles</td>
<td>2007-11</td>
<td>Community Commons</td>
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<tr>
<td>Cancer Incidence - Cervical</td>
<td>Annual cervical cancer incidence rate (per 100,000 pop.)</td>
<td>This indicator reports the age-adjusted incidence rate (cases per 100,000 population per year) of females with cervical cancer adjusted to 2000 U.S. standard population age groups.</td>
<td>National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, State Cancer Profiles</td>
<td>2007-11</td>
<td>Community Commons</td>
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<tr>
<td>Cancer Incidence - Colon And</td>
<td>Annual colon and rectum cancer incidence rate (Per 100,000 Pop.)</td>
<td>Age-adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S.</td>
<td>National Institutes of Health,</td>
<td>2007-11</td>
<td>Community Commons</td>
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<td>Rectum</td>
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<td>standard population age groups</td>
<td>National Cancer Institute, Surveillance, Epidemiology, and End Results Program, State Cancer Profiles</td>
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<tr>
<td>Cancer Incidence - Liver</td>
<td>Age-adjusted cancer incidence rate (per 100,000 adults) by site, race/ethnicity and sex</td>
<td>Age-adjusted incidence rate (cases per 100,000 population per year) of liver cancer adjusted to 2000 U.S. standard population age groups</td>
<td>Greater Bay Area Cancer Registry; U.S. Census Bureau American Community Survey 3-Year Estimates</td>
<td>2007-2009</td>
<td>SCC PHD Vietnamese Report 2011</td>
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<tr>
<td>Cancer Incidence - Prostate</td>
<td>Annual prostate cancer incidence rate (per 100,000 pop.)</td>
<td>Age-adjusted incidence rate (cases per 100,000 population per year) of males with prostate cancer adjusted to 2000 U.S. standard population age groups</td>
<td>National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, State Cancer Profiles</td>
<td>2007-11</td>
<td>Community Commons</td>
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<tr>
<td>Cancer Incidence - Lung</td>
<td>Annual lung cancer incidence rate (per 100,000 pop.)</td>
<td>Age-adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S. standard population age groups</td>
<td>National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, State Cancer Profiles</td>
<td>2007-11</td>
<td>Community Commons</td>
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<tr>
<td>Cancer Mortality</td>
<td>Percent of deaths due to cancer</td>
<td>Cancer, age-adjusted mortality rate (per 100,000 Population) Rate of death due to malignant neoplasm (cancer) per 100,000 population, age-adjusted to year 2000 standard. This indicator is relevant because cancer is a leading cause of death in the U.S.</td>
<td>SCC PHD Death Statistical Master File; CA Vital Stats</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Cancer Mortality (All Types)</td>
<td>Age-adjusted mortality rate due to all cancers</td>
<td>Increase-adjusted mortality rate due to all cancers</td>
<td>SCC PHD Death Statistical Master File; CA Vital Stats</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Cancer Screening - Mammogram</td>
<td>Percent female Medicare enrollees with mammogram in past 2 years</td>
<td>Percentage of female Medicare enrollees, age 67-69 or older, who have received one or more mammograms in the past two years</td>
<td>Dartmouth College Institute for Health Policy &amp; Clinical Practice, Dartmouth Atlas of Health Care</td>
<td>2012</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Cancer Screening - Pap Test</td>
<td>Percent of adult females age 18+ with regular pap test (Age-Adjusted)</td>
<td>Percentage of women age 18 and older who self-report that they have had a Pap test in the past three years</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance</td>
<td>2006-12</td>
<td>Community Commons</td>
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<tr>
<td>Cancer Screening - Sigmoid/Colonoscopy</td>
<td>Percent of adults screened for colon cancer (age-adjusted)</td>
<td>Percentage of adults age 50 and older who self-report that they have ever had a sigmoidoscopy or colonoscopy</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; accessed via the Health Indicators Warehouse. U.S. Department of Health &amp; Human Services, Health Indicators Warehouse</td>
<td>2006-12</td>
<td>Community Commons</td>
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<tr>
<td>Child Abuse</td>
<td>Rate of substantiated allegations of child maltreatment</td>
<td>Rate of substantiated allegations of child maltreatment</td>
<td>UC Berkeley Child Welfare Indicators Project</td>
<td>2013</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<td>Chlamydia Incidence Rate</td>
<td>Chlamydia incidence rate</td>
<td>Chlamydia incidence rate</td>
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<td>SCC PHD CHA or BRFS Data Tables</td>
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<td>Chlamydia infection rate (per 100,000 pop.)</td>
<td>Incidence rate of chlamydia cases per 100,000 population</td>
<td>U.S. Department of Health &amp; Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</td>
<td>2012</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Cocaine Use</td>
<td>Percent of high school students who have ever used cocaine</td>
<td>Percent of high school students who have ever used cocaine</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>(Youth)</td>
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<tr>
<td>Commute To Work</td>
<td>Percentage of workers commuting by car, alone</td>
<td>Percentage of the population that commutes to work on a daily basis using a motor vehicle, and commutes as the only occupant of the vehicle; relevant because it conveys information about the efficiency of the public transportation network, potential impacts on the environment (e.g. air pollution), and can inform policy, system and environmental strategies to address potential climate and health impacts (e.g. active transportation and improving public transportation networks)</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<td>- Alone In Car</td>
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<tr>
<td>Commute To Work - Walking/Biking</td>
<td>Percentage Walking or Biking to Work</td>
<td>Percentage of the population that commutes to work by either walking or riding a bicycle; relevant because an active commute to work can reduce risk of cardiovascular disease, obesity, and hypertension. Active transportation is also a climate change mitigation strategy</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Dental Care - Lack of Affordability (Youth)</td>
<td>Percent Population Age 5-17 Unable to Afford Dental Care</td>
<td>Percentage of children and teens who self-report that during the past 12 months, there was any time when they needed dental care but could not afford it; relevant because it is a measure of access to dental health services; lack of healthcare access to regular primary care, specialty care, and other health services contributes to poor health status</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2009</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Dental Care - No Recent Exam (Adult)</td>
<td>Percent of adults without recent dental exam</td>
<td>Percentage of adults age 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System</td>
<td>2006-10</td>
<td>Community Commons</td>
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<tr>
<td>Dental Care - No Recent Exam (Youth)</td>
<td>Percent of youth without recent dental exam</td>
<td>Percentage of children age 2-13 who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2013-14</td>
<td>Community Commons</td>
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<tr>
<td>Dental Decay (Adult)</td>
<td>Percent of adults (45-64) who have had 1+ permanent teeth removed due to tooth decay or gum disease</td>
<td>Percent of adults (45-64) who have had 1+ permanent teeth removed due to tooth decay or gum disease</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Dental Decay (Adult)</td>
<td>Percent of adults with tooth loss due to gum problems or tooth decay</td>
<td>Percent of adults with tooth loss due to gum problems or tooth decay</td>
<td>SCC PHD BRFS, CDC BRFS</td>
<td>2009</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Dental Decay (Older Adults)</td>
<td>Percent of adults (65-74) who lost all teeth due to tooth decay or gum disease</td>
<td>Percent of adults (65-74) who lost all teeth due to tooth decay or gum disease</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Dental Health - Poor</td>
<td>Percent of adults with poor dental health</td>
<td>Percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; additional data analysis by CARES</td>
<td>2006-10</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Dental Health Professional Shortage Area -</td>
<td>Percentage of population living in a HPSA</td>
<td>Percentage of the population that is living in a geographic area designated as a &quot;Health Professional Shortage Area&quot; (HPSA), defined as having a shortage of dental health professionals; relevant because lack of access to health care, including regular primary care, dental care, and other specialty health services, contributes to poor health status</td>
<td>U.S. Department of Health &amp; Human Services, Health Resources and Services Administration, Health Resources and Services Administration</td>
<td>2015</td>
<td>Community Commons</td>
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<tr>
<td><strong>Dental Insurance</strong></td>
<td>Percent of adults with dental insurance</td>
<td>Percent of adults with dental insurance</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Dental Insurance - Absence of Coverage</strong></td>
<td>Percent of adults without dental insurance</td>
<td>Percentage of adults who self-report having no dental insurance for some or all of the past 12 months.</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2009</td>
<td>Community Commons</td>
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<tr>
<td><strong>Dentist Access</strong></td>
<td>Dentists, rate per 100,000 pop.</td>
<td>Rate of licensed, qualified dentists per 100,000 population (dental surgery or dental medicine)</td>
<td>U.S. Department of Health &amp; Human Services, Health Resources and Services Administration, Area Health Resource File</td>
<td>2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td><strong>Dentist Utilization (Adult)</strong></td>
<td>Percent of adults who went to the dentist in the last year</td>
<td>Percent of adults who went to the dentist in the last year</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Dentist Utilization (Children)</strong></td>
<td>Percent of children (1-11) who visited the dentist in the past 12 months</td>
<td>Percent of children (1-11) who visited the dentist in the past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Depression (Adults)</strong></td>
<td>Percent of adults who have ever been diagnosed with depression</td>
<td>Percent of adults who have ever been diagnosed with depression</td>
<td>SCC BRFS</td>
<td>2014</td>
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<tr>
<td>Diabetes Hospitalization (Adult)</td>
<td>Diabetes hospitalizations (adult)</td>
<td>Diabetes hospitalizations (adult)</td>
<td>SCC Patient Discharge Database, 2012</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Diabetes Hospitalizations</td>
<td>Age-adjusted discharge rate (per 10,000 pop.)</td>
<td>Patient discharge rate (per 10,000 total population) for diabetes-related complications; relevant because diabetes is a prevalent problem in the U.S. as it may indicate an unhealthy lifestyle, places individuals at risk for further health issues, and increases an individual’s vulnerability to climate change</td>
<td>California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Diabetes Prevalence</td>
<td>Percent of adults with diagnosed diabetes (age-adjusted)</td>
<td>Percentage of adults age 20 and older who have ever been told by a doctor that they have diabetes</td>
<td>Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
<td>2012</td>
<td>Community Commons</td>
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<tr>
<td>Diabetes Prevalence (Adult)</td>
<td>Percent of adults ever diagnosed with diabetes</td>
<td>Percent of adults ever diagnosed with diabetes</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Discrimination - Physical Symptoms</td>
<td>Percent of adults who had physical symptoms as a result of treatment based on their race in past 30 days</td>
<td>Percent of adults who had physical symptoms as a result of treatment based on their race in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Doctor Visit (Adults)</td>
<td>Percent of adults who saw a doctor for a routine checkup in the past 12 months</td>
<td>Percent of adults who saw a doctor for a routine checkup in the past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Doctor Visit (Children)</td>
<td>Percent of children (0-11) who saw a doctor for a routine checkup in the past 12 months</td>
<td>Percent of children (0-11) who saw a doctor for a routine checkup in the past 12 months</td>
<td>SCC BRFS</td>
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<tr>
<td>Domestic Violence Mortality</td>
<td>Rate of domestic violence-related deaths</td>
<td>Rate of domestic violence-related deaths</td>
<td>SCC Domestic Violence Council, Domestic Violence Death Review Committee</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Domestic Violence - Recent</td>
<td>Percent of adults who experienced physical violence or had unwanted sex in past 12 months with intimate partner</td>
<td>Percent of adults who experienced physical violence or had unwanted sex in past 12 months with intimate partner</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Economic Security - Commute Over 60 Minutes</td>
<td>Percentage of workers commuting more than 60 minutes</td>
<td>Percentage of the population that commutes to work for over 60 minutes each direction; relevant because the amount of time spent commuting impacts health-related activities such as sleeping, engaging in physical activity, and ability to prepare healthy meals</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Economic Security - Households With No Vehicle</td>
<td>Percentage of households with no motor vehicle</td>
<td>Percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates; relevant because individuals from households without access to a vehicle may lack access to health care, child care services, and employment opportunities</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Economic Security - Unemployment Rate</td>
<td>Unemployment rate</td>
<td>Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted); relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status</td>
<td>U.S. Department of Labor, Bureau of Labor Statistics</td>
<td>2015</td>
<td>Community Commons</td>
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<td>Ecstasy Use (Youth)</td>
<td>Percent of high school students who have ever used ecstasy</td>
<td>Percent of high school students who have ever used ecstasy</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Education - Head Start Program Facilities</td>
<td>Head start programs rate (per 10,000 children under age 5)</td>
<td>Number and rate of Head Start program facilities per 10,000 children under age 5; Head Start facility data are acquired from the U.S. Department of Health and Human Services (HHS) 2015 Head Start locator; Population data are from the 2010 U.S. Decennial Census; relevant because access to education is a primary social determinant of health, and is associated with increased economic opportunity, access to social resources (i.e. food access and spaces and facilities for physical activity), and positive health status and outcomes</td>
<td>U.S. Department of Health &amp; Human Services, Administration for Children and Families</td>
<td>2014</td>
<td>Community Commons</td>
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<tr>
<td>Education - High School Graduation Rate</td>
<td>Cohort graduation rate</td>
<td>Cohort high school graduation rate, which measures the percentage of students receiving their high school diploma within four years; relevant because low levels of education are often linked to poverty and poor health</td>
<td>California Department of Education</td>
<td>2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Education - Less Than High School Diploma (Or Equivalent)</td>
<td>Percent population age 25+ with no high school diploma</td>
<td>Percentage of the population age 25 and older without a high school diploma (or equivalency) or higher; relevant because educational attainment is a key driver of population health</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Emotional Support</td>
<td>Percent of adults who &quot;usually&quot; or &quot;always&quot; receive the emotional support they need</td>
<td>Percent of adults who &quot;usually&quot; or &quot;always&quot; receive the emotional support they need</td>
<td>SCC BRFS</td>
<td>2014</td>
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<tr>
<td>Falls</td>
<td>Percent of adults (45+) who have had a fall in the past 3 months</td>
<td>Percent of adults (45+) who have had a fall in the past 3 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Falls That Caused An Injury</td>
<td>Percent of adults (45+) who have had one or more falls that caused an injury in the past 3 months</td>
<td>Percent of adults (45+) who have had one or more falls that caused an injury in the past 3 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Fast Food Consumption (Adult)</td>
<td>Percent of adults who ate fast food at least weekly in past 30 days</td>
<td>Percent of adults who ate fast food at least weekly in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Fast Food Consumption (Children)</td>
<td>Percent of children (2-11) who ate fast food 1+ times in past week</td>
<td>Percent of children (2-11) who ate fast food 1+ times in past week</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Food Environment - Fast Food Restaurants</td>
<td>Fast food restaurants, rate (per 100,000 population)</td>
<td>Number of fast food restaurants per 100,000 population; fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating; relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors</td>
<td>U.S. Census Bureau, County Business Patterns; additional data analysis by CARES</td>
<td>2011</td>
<td>Community Commons</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Food Environment - Grocery Stores</td>
<td>Grocery stores, rate (per 100,000 population)</td>
<td>Number of grocery stores per 100,000 population; grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry; included are delicatessen-type establishments; relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors</td>
<td>U.S. Census Bureau, County Business Patterns; additional data analysis by CARES</td>
<td>2011</td>
<td>Community Commons</td>
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<tr>
<td>Food Environment - WIC-Authorized Food Stores</td>
<td>WIC-authorized food stores, rate (per 100,000 population)</td>
<td>Number of food stores and other retail establishments per 100,000 population that are authorized to accept WIC program benefits and that carry designated WIC foods and food categories; relevant because it provides a measure of food security and healthy food access for women and children in poverty as well as environmental influences on dietary behaviors</td>
<td>U.S. Department of Agriculture, Economic Research Service, U.S.D.A - Food Environment Atlas</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Food Security - Food Desert Population</td>
<td>Percent population with low food access</td>
<td>Percentage of the population living in areas designated as food deserts; a food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery store; relevant because it highlights populations and geographies facing food insecurity</td>
<td>U.S. Department of Agriculture, Economic Research Service, U.S.D.A - Food Access Research Atlas</td>
<td>2010</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Fresh Grocers</td>
<td>Percent of adults who shop for fresh fruits and vegetables within their community/neighborhood</td>
<td>Percent of adults who shop for fresh fruits and vegetables within their community/neighborhood</td>
<td>SCC BRFS</td>
<td>2014</td>
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<tr>
<td>Fruit And Vegetable Consumption (Adults)</td>
<td>Percent of adults who ate 2+ servings of fruits and 3+ servings of vegetables per day in past 30 days</td>
<td>Percent of adults who ate 2+ servings of fruits and 3+ servings of vegetables per day in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Fruit And Vegetable Consumption (Children)</td>
<td>Percent of children (2-11) who ate/drank 2+ servings of fruit/100 percent juice and ate 3+ servings of vegetables the previous day</td>
<td>Percent of children (2-11) who ate/drank 2+ servings of fruit/100 percent juice and ate 3+ servings of vegetables the previous day</td>
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<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Fruit And Vegetable Consumption (Teens)</td>
<td>Percent of teens who ate 5+ servings of fruits and vegetables yesterday</td>
<td>Percent of teens who ate 5+ servings of fruits and vegetables yesterday</td>
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<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Fruit Consumption (Adults)</td>
<td>Percent of adults who ate 2+ servings of fruit per day in past 30 days</td>
<td>Percent of adults who ate 2+ servings of fruit per day in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Fruit Consumption (Children)</td>
<td>Percent of children (2-11) who ate/drank 2+ servings of fruit/100 percent juice the previous day</td>
<td>Percent of children (2-11) who ate/drank 2+ servings of fruit/100 percent juice the previous day</td>
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<td>2014</td>
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<tr>
<td>Fruit/Vegetable Consumption - Low (Adult)</td>
<td>Percent of adults with inadequate fruit/vegetable consumption</td>
<td>Percentage of adults age 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; accessed via the Health Indicators Warehouse;</td>
<td>2005-09</td>
<td>Community Commons</td>
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<tr>
<td>Fruit/Vegetable Consumption - Low (Youth)</td>
<td>Percent Population age 2-13 with inadequate fruit/vegetable consumption</td>
<td>Percentage of children age 2 and older who are reported to consume fewer than five servings of fruits and vegetables each day</td>
<td>U.S. Department of Health &amp; Human Services, Health Indicators Warehouse</td>
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<tr>
<td>Fruit/Vegetable Expenditures</td>
<td>Fruit/vegetable expenditures, percentage of total food-at-home expenditures</td>
<td>Estimated expenditures for fruits and vegetables purchased for in-home consumption, as a percentage of total household expenditures; relevant because current behaviors are determinants of future health, and because unhealthy eating habits may illustrate a cause of significant health issues, such as obesity and diabetes</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2011-12</td>
<td>Community Commons</td>
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<tr>
<td>Gonorrhea Incidence Rate</td>
<td>Gonorrhea incidence rate</td>
<td>Gonorrhea incidence rate</td>
<td>SCCPHD</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Health Insurance</td>
<td>Percent of adults (18-64) with healthcare coverage</td>
<td>Percent of adults (18-64) with healthcare coverage</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Health Insurance</td>
<td>Percent of children with healthcare coverage (0-11)</td>
<td>Percent of children with healthcare coverage (0-11)</td>
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<tr>
<td>Health Status</td>
<td>Percent of adults who reported their general health status as fair or poor</td>
<td>Percent of adults who reported their general health status as fair or poor</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Heart Disease Mortality (Rate)</td>
<td>Age-adjusted rate of heart disease</td>
<td>Age-adjusted rate of heart disease</td>
<td>SCC Death Statistical File; cited by 2014 CHA</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Heart Disease Prevalence</td>
<td>Percent of adults with heart disease</td>
<td>Percentage of adults age 18 and older who have ever been told by a doctor that they have coronary heart disease or angina; relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2011-12</td>
<td>Community Commons</td>
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<tr>
<td>Hepatitis B Infection Rate</td>
<td>Chronic hepatitis B rate</td>
<td>Chronic hepatitis B rate</td>
<td>SCC PHD</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Hepatitis B Or C - Tested</td>
<td>Percent of adults who have ever been tested for hepatitis B or C</td>
<td>Percent of adults who have ever been tested for hepatitis B or C</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>High Blood Cholesterol</td>
<td>Percent of adults ever diagnosed with high blood cholesterol</td>
<td>Percent of adults ever diagnosed with high blood cholesterol</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>High Blood Pressure</td>
<td>Percent of adults ever diagnosed with high blood pressure</td>
<td>Percent of adults ever diagnosed with high blood pressure</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Latino Population</td>
<td>Percent population Hispanic or Latino</td>
<td>Percentage of population that is of Hispanic, Latino, or Spanish origin; origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States; people who identify their origin as Hispanic, Latino, or Spanish may be of any race</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>HIV Hospitalizations</td>
<td>Age-adjusted discharge rate (per 10,000 pop.)</td>
<td>Patient discharge rate (per 10,000 total population) for HIV-related complications</td>
<td>California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>HIV Infection Rate</td>
<td>Rate of adults and adolescents newly infected with HIV</td>
<td>Rate of adults and adolescents newly infected with HIV</td>
<td>SCCPHD, Enhanced HIV/AIDS Reporting System</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>HIV Infections</td>
<td>Number living with AIDS</td>
<td>Number living with AIDS</td>
<td>SCC PHD eHars; CDPH Office of AIDS, HIV/AIDS Surveillance Section; CDC HIV Surveillance Report</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>HIV Prevalence Rate</td>
<td>Population with HIV/AIDS, rate (per 100,000 pop.)</td>
<td>Prevalence rate of HIV per 100,000 population</td>
<td>U.S. Department of Health &amp; Human Services, Health Indicators Warehouse.</td>
<td>2010</td>
<td>Community Commons</td>
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<tr>
<td>HIV— Tested</td>
<td>Percent of adults (18-64) who have ever been tested for HIV</td>
<td>Percent of adults (18-64) who have ever been tested for HIV</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>HIV/AIDS Mortality</td>
<td>Number of HIV/AIDS deaths</td>
<td>Number of HIV/AIDS deaths</td>
<td>SCCPHD, Enhanced HIV/AIDS Reporting System</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Homelessness - Total</td>
<td>Number of homeless individuals</td>
<td>Number of homeless individuals enumerated during point-in-time count</td>
<td>SCC Homeless PIT Census &amp; Survey</td>
<td>2013</td>
<td>County of Santa Clara</td>
</tr>
<tr>
<td>Homelessness - Unsheltered (Point-In-Time)</td>
<td>Number of homeless individuals living on the street, in abandoned buildings, cars/vans/RVs, or encampment areas</td>
<td>Number of homeless individuals living on the street, in abandoned buildings, cars/vans/RVs, or encampment areas</td>
<td>SCC Homeless PIT Census &amp; Survey</td>
<td>2013</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Homelessness - At Any Point In Year</td>
<td>Number reporting homelessness over the course of a year</td>
<td>Number reporting homelessness over the course of a year</td>
<td>SCC Homeless PIT Census &amp; Survey</td>
<td>2013</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Homicide (Adults)</td>
<td>Homicide rate overall</td>
<td>Homicide rate overall</td>
<td>SCC PHD Death Statistical Master File 2010-2012; CA PHD Vital Stats Query System 2012</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Homicide Mortality</td>
<td>Homicide, age-adjusted mortality rate (per 100,000 population)</td>
<td>Rate of death due to assault (homicide) per 100,000 population, age-adjusted to the year 2000 standard; relevant because homicide rate is a measure of poor community safety and is a leading cause of premature death</td>
<td>University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health, CDPH - Death Public Use Data</td>
<td>2010-12</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Housing - Cost-Burdened Households</td>
<td>Percentage of households where housing costs exceed 30% of income</td>
<td>Percentage of households where housing costs exceed 30% of total household income; provides information on the cost of monthly housing expenses for owners and renters; relevant because it offers a measure of housing affordability and excessive shelter costs that may prohibit an individual's ability to financially meet basic life needs, such as healthcare, child care, healthy food purchasing, and transportation costs</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Housing - Substandard Housing</td>
<td>Percent occupied housing units with one or more substandard conditions</td>
<td>Number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Housing - Vacant Housing</td>
<td>Vacant housing units, percent</td>
<td>Number and percentage of housing units that are vacant; a housing unit is considered vacant by the American Community Survey if no one is living in it at the time of interview; units occupied at the time of interview entirely by persons who are staying two months or less and who have a more permanent residence elsewhere are considered to be temporarily occupied and are classified as “vacant;” relevant because the presence of vacant houses can have adverse effects on community safety, social cohesion and relationships, community economic security, and opportunity</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Housing Costs (Renter-Occupied)</td>
<td>Percent renter occupied units spending 30% or more of household income on housing</td>
<td>Percent renter occupied units spending 30% or more of household income on housing</td>
<td>U.S. Census Bureau, 2010-2012 ACS 3-year estimates</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Housing Costs (With A Mortgage)</td>
<td>Percent housing units with a mortgage spending 30% or more of household income on housing</td>
<td>Percent housing units with a mortgage spending 30% or more of household income on housing</td>
<td>U.S. Census Bureau, 2010-2012 ACS 3-year estimates</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Housing - Overcrowding</td>
<td>Percent of households with more than one persons per room</td>
<td>Percent of households with more than one person per room</td>
<td>U.S. Census Bureau, 2010-2012 ACS 3-year estimates</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<td>Housing - Severe Overcrowding</td>
<td>Percent of households with more than 1.5 person per room</td>
<td>Percent of households with more than 1.5 persons per room</td>
<td>U.S. Census Bureau, 2010-2012 ACS 3-year estimates</td>
<td>2012</td>
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<tr>
<td>Infant Mortality</td>
<td>Infant mortality rate (per 1,000 births)</td>
<td>Rate of deaths to infants younger than 1 year of age per 1,000 births</td>
<td>CDC National Vital Statistics System. Accessed via CDC WONDER; Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10</td>
<td>2006-10</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Inhalant Use (Youth)</td>
<td>Percent of high school students who have ever used inhalants</td>
<td>Percent of high school students who have ever used inhalants</td>
<td>California Healthy Kids Survey</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Insurance - Uninsured Population</td>
<td>Percent uninsured population</td>
<td>Percentage of the total civilian non-institutionalized population without health insurance coverage; relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Ischemic Heart Disease Mortality</td>
<td>Heart disease, age-adjusted mortality rate (per 100,000 population)</td>
<td>Rate of death due to coronary heart disease per 100,000 population, age-adjusted to year 2000 standard; relevant because heart disease is a leading cause of death in the U.S.</td>
<td>University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health, CDPH - Death</td>
<td>2010-12</td>
<td>Community Commons</td>
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<td>Lack of a Consistent Source of Primary Care</td>
<td>Percentage without regular doctor</td>
<td>Percentage of children, teenagers, and adults who self-report that they do not have a usual place to go when sick or needing health advice; relevant because access to regular primary care is important to preventing major health issues and emergency department visits</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2011-12</td>
<td>Community Commons</td>
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<tr>
<td>Lack of Prenatal Care</td>
<td>Percent mothers with late or no prenatal care</td>
<td>Percentage of women who do not obtain prenatal care during their first or second trimesters of pregnancy; relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks; also highlights a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services</td>
<td>CDPH - Birth Profiles by ZIP Code</td>
<td>2011</td>
<td>Community Commons</td>
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<tr>
<td>Linguistically Isolated Households</td>
<td>Percent linguistically isolated population</td>
<td>Percentage of the population age 5 and older that lives in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speaks English &quot;very well&quot;</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2006-2010</td>
<td>Community Commons</td>
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<tr>
<td>Low Birthweight</td>
<td>Percent low birthweight births</td>
<td>Percentage of total births that are low birthweight (Under 2500g); relevant because low birthweight infants are at high risk for health problems.</td>
<td>CDPH - Birth Profiles by ZIP Code</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Marijuana Use (Adult)</td>
<td>Percent of adults who have used marijuana in the past 12 months</td>
<td>Percent of adults who have used marijuana in the past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Marijuana Use (Youth)</td>
<td>Percent middle school and high school students who used marijuana at least once past 30 days</td>
<td>Percent middle school and high school students who used marijuana at least once past 30 days</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Medical Costs</td>
<td>Percent of adults who needed to see a doctor in the past 12 months but could not because of cost</td>
<td>Percent of adults who needed to see a doctor in the past 12 months but could not because of cost</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Mental Distress</td>
<td>Percent of adults who reported frequent mental distress (14 or more mentally unhealthy days) in past 30 days</td>
<td>Percent of adults who reported frequent mental distress (14 or more mentally unhealthy days) in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Mental Health - Needing Mental Health Care</td>
<td>Percentage with poor mental health</td>
<td>Percentage of adults who self-report that there was ever a time during the past 12 months when they felt that they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs; relevant because it is a measure of general poor mental health status and demand for mental and behavioral health services</td>
<td>University of California Center for Health Policy Research, California Health Interview Survey</td>
<td>2013-14</td>
<td>Community Commons</td>
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<td>Indicator</td>
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<tr>
<td>Mental Health - Poor Mental Health Days</td>
<td>Average number of mentally unhealthy days per month</td>
<td>Average number of mentally unhealthy days (during past 30 days) among survey respondents age 18 and older; relevant because it provides a measure of mental health status and health-related quality of life; poor mental health is also associated with climate change</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; accessed via the Health Indicators Warehouse; U.S. Department of Health &amp; Human Services, Health Indicators Warehouse</td>
<td>2006-12</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Mental Health Problems (Adult)</td>
<td>Percent of adults reporting poor mental health on at least one day in last 30 days</td>
<td>Percent of adults reporting poor mental health on at least one day in last 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Mental Health Providers Access</td>
<td>Mental healthcare provider rate (per 100,000 population)</td>
<td>Rate of mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors) that specialize in mental healthcare per 100,000 total population</td>
<td>University of Wisconsin Population Health Institute, County Health Rankings</td>
<td>2014</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Motor Vehicle Accident Mortality</td>
<td>Motor vehicle accident, age-adjusted mortality rate (per 100,000 population)</td>
<td>Rate of death due to motor vehicle crashes per 100,000 population, age-adjusted to year 2000 standard; motor vehicle crashes include collisions with other motor vehicles, non-motorists, fixed objects, non-fixed objects, overturns, and other non-</td>
<td>University of Missouri, Center for Applied Research and Environmental</td>
<td>2010-12</td>
<td>Community Commons</td>
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<tr>
<td>Number Living With HIV</td>
<td>Number of people living with HIV infection</td>
<td>Number of people living with HIV infection</td>
<td>SCC PHD, Enhanced HIV/AIDS Reporting System; CDPH, Office of AIDS, HIV/AIDS Surveillance Section</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Number of TB Infections</td>
<td>Number of TB cases</td>
<td>Number of TB cases</td>
<td>SCC PHD, CA Reportable Disease Information Exchange System; CADPH TB Control Branch</td>
<td>2013</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Obesity (Adolescents)</td>
<td>Percent of adolescents who are overweight or obese</td>
<td>Percent of adolescents who are overweight or obese</td>
<td>CDE</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Obesity (Adult)</td>
<td>Percent of adults with BMI &gt; 30.0 (Obese)</td>
<td>Percentage of adults age 20 and older who self-report that they have a body mass index (BMI) score greater than 30.0 (obese)</td>
<td>Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
<td>2012</td>
<td>Community Commons</td>
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<td>collisions; relevant because motor vehicle crash deaths are preventable and they are a cause of premature death</td>
<td>Systems, California Department of Public Health, CDPH - Death Public Use Data</td>
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<tr>
<td>Obesity (Adult)</td>
<td>Percent of adults considered obese</td>
<td>Percent of adults considered obese</td>
<td>SCC BRFS; CDC 2012 BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Obesity (Young Children)</td>
<td>Percent of children aged 2-5 who are obese</td>
<td>Percent of children aged 2-5 who are obese</td>
<td>CA Department of Health Care Services, Child Health and Disability Prevention Program, Pediatric Nutrition Surveillance 2010 Data tables</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Obesity (Youth)</td>
<td>Percent obese</td>
<td>Percentage of children in grades 5, 7, and 9 ranking within the &quot;High Risk&quot; category (Obese) for body composition on the Fitnessgram physical fitness test</td>
<td>California Department of Education, FITNESSGRAM® Physical Fitness Testing</td>
<td>2013-14</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Overweight (Adolescents)</td>
<td>Percent of adolescents who are overweight</td>
<td>Percent of adolescents who are overweight</td>
<td>CDE</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Overweight (Adult)</td>
<td>Percent of adults overweight</td>
<td>Percentage of adults age 18 and older who self-report that they have a body mass index (BMI) score between 25.0 and 30.0 (overweight).</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.; additional data analysis by CARES</td>
<td>2011-12</td>
<td>Community Commons</td>
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<tr>
<td>Overweight (Adults)</td>
<td>Percent of adults who are overweight</td>
<td>Percent of adults who are overweight</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Overweight (Youth)</td>
<td>Percent overweight</td>
<td>Percentage of children in grades 5, 7, and 9 ranking within the &quot;Needs Improvement&quot; category (Overweight) for body composition on the Fitnessgram physical fitness test</td>
<td>California Department of Education, FITNESSGRAM® Physical Fitness Testing</td>
<td>2013-14</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Overweight Or Obese (Adults)</td>
<td>Percent of adults who are overweight or obese</td>
<td>Percent of adults who are overweight or obese</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Park Access</td>
<td>Percent population within 1/2 mile of a park</td>
<td>Percentage of population living within 1/2 mile of a park; relevant because access to outdoor recreation encourages physical activity and other healthy behaviors</td>
<td>U.S. Census Bureau, Decennial Census, ESRI Map Gallery</td>
<td>2010</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Park, Playground, Open Space Access</td>
<td>Percent of children (1-11) who have a park, playground, or open space within 30 minutes walking distance of home</td>
<td>Percent of children (1-11) who have a park, playground, or open space within 30 minutes walking distance of home</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Park/Playground Safety</td>
<td>Percent of parents (of children 0-11) who agree or strongly agree that the closest park and playground is safe</td>
<td>Percent of parents (of children 0-11) who agree or strongly agree that the closest park and playground is safe</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Pedestrian Accident Mortality</td>
<td>Pedestrian accident, age-adjusted mortality rate (per 100,000 Population)</td>
<td>Rate of pedestrians killed by motor vehicles per 100,000 population, age-adjusted to year 2000 standard; relevant because pedestrian-motor vehicle crash deaths are preventable and they are a cause of premature death</td>
<td>University of Missouri, Center for Applied Research and Environmental Systems,</td>
<td>2010-12</td>
<td>Community Commons</td>
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<tr>
<td>Personal Doctor (Adult)</td>
<td>Percent of adults with a personal doctor</td>
<td>Percent of adults with a personal doctor</td>
<td>California Department of Public Health, CDPH - Death Public Use Data</td>
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<tr>
<td>Personal Doctor (Children)</td>
<td>Percent of children with a personal doctor</td>
<td>Percent of children with a personal doctor</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Percent of adults who participated in physical activities or exercises other than for regular job duties in the past month</td>
<td>Percent of adults who participated in physical activities or exercises other than for regular job duties in the past month</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Physical Activity - Travel Home From School (5 Days)</td>
<td>Percent of children (5-11) who walked, biked, or skateboarded home from school on 5 days in the past week</td>
<td>Percent of children (5-11) who walked, biked, or skateboarded home from school on 5 days in the past week</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Physical Activity - Travel Home From School (Once)</td>
<td>Percent of children (5-11) who walked, biked, or skateboarded home from school at least once in the past week</td>
<td>Percent of children (5-11) who walked, biked, or skateboarded home from school at least once in the past week</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Physical Activity - Walking/Biking /Skating To School</td>
<td>Percentage walking/skating/biking to School</td>
<td>Percentage of children and teens who reported that they walked, biked, or skated to school in the past week (at the time of the interview); relevant because an active commute to school is associated with improvements in physical activity levels and obesity prevention among youth; active transportation is also a climate</td>
<td>University of California Center for Health Policy Research, California Health Interview</td>
<td>2011-12</td>
<td>Community Commons</td>
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<tr>
<td>Indicator</td>
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<tr>
<td><strong>Physical Inactivity (Adult)</strong></td>
<td>Percent population with no leisure time physical activity</td>
<td>Percentage of adults age 20 and older who self-report that they perform no leisure time activity, based on the question: &quot;During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?&quot;</td>
<td>Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion</td>
<td>2012</td>
<td>Community Commons</td>
</tr>
<tr>
<td><strong>Physical Inactivity (Youth)</strong></td>
<td>Percent physically inactive</td>
<td>Percentage of children in grades 5, 7, and 9 ranking within the &quot;High Risk&quot; or &quot;Needs Improvement&quot; zones for aerobic capacity on the Fitnessgram physical fitness test</td>
<td>California Department of Education, FITNESSGRAM® Physical Fitness Testing</td>
<td>2013-14</td>
<td>Community Commons</td>
</tr>
<tr>
<td><strong>Physically Active (Children)</strong></td>
<td>Percent of children (5-11) who were physically active for at least 60 minutes a day in past 7 days</td>
<td>Percent of children (5-11) who were physically active for at least 60 minutes a day in past 7 days</td>
<td>SCC BRF S</td>
<td>2014</td>
<td>SCC PHD CHA or BRF S Data Tables</td>
</tr>
<tr>
<td><strong>Physically Active (Teen)</strong></td>
<td>Percent of teens who were physically active for at least 60 minutes a day in past 7 days</td>
<td>Percent of teens who were physically active for at least 60 minutes a day in past 7 days</td>
<td>CHIS</td>
<td>2012</td>
<td>SCC PHD CHA or BRF S Data Tables</td>
</tr>
<tr>
<td><strong>Physically Hurt By Partner (Adult)</strong></td>
<td>Percent of adults ever hit, slapped, kicked, or hurt in any way by an intimate partner</td>
<td>Percent of adults ever hit, slapped, kicked, or hurt in any way by an intimate partner</td>
<td>SCC BRF S</td>
<td>2014</td>
<td>SCC PHD CHA or BRF S Data Tables</td>
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<tr>
<td>Pneumonia Shots</td>
<td>Percent of adults (ages 65+) who ever had a pneumonia shot</td>
<td>Percent of adults (ages 65+) who ever had a pneumonia shot</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Population (Total)</td>
<td>Population density (per square mile)</td>
<td>Total population and the population density; population density is defined as the number of persons per square mile</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Population Age 55-64</td>
<td>Percent population age 55-64</td>
<td>Percentage of the population age 55-64 in the designated geographic area</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Population Age 65+</td>
<td>Percent population age 65+</td>
<td>Percentage of the population age 65 and older in the designated geographic area</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Population - Female</td>
<td>Percent female population</td>
<td>Total female population</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Population With Limited English Proficiency</td>
<td>Percent population age 5+ with limited English proficiency</td>
<td>Percentage of the population age 5 and older that speaks a language other than English at home and speaks English less than &quot;very well.&quot;</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Population - Median Age</td>
<td>Median age</td>
<td>Population median age based on the 5-year American Community Survey estimate</td>
<td>U.S. Census Bureau, American Community Survey</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Poverty</td>
<td>Percent of people living at 100 percent FLP</td>
<td>Percent of people living at 100 Percent Federal Poverty Level (FPL)</td>
<td>ACS 1-year</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Poverty -</td>
<td>Percentage of children age 0-17 living in households with income below the 100%</td>
<td>Percentage of children age 0-17 living in households with income below the 100%</td>
<td>U.S. Census Bureau, American Community</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Children Below 100% FPL</td>
<td>FPL</td>
<td>FPL</td>
<td>Community Commons</td>
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<tr>
<td>Poverty -</td>
<td>Percentage of the population living in households with income below 100% FPL</td>
<td>Percentage of the population living in households with income below 100% FPL</td>
<td>U.S. Census Bureau, American Community</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Poverty -</td>
<td>Percentage of the population living in households with income below 200% FPL</td>
<td>Percentage of the population living in households with income below 200% FPL</td>
<td>U.S. Census Bureau, American Community</td>
<td>2009-2013</td>
<td>Community Commons</td>
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<tr>
<td>Poverty (Children)</td>
<td>Percent of children living at 100 percent FPL</td>
<td>Percent of children living at 100 percent FPL</td>
<td>ACS 1-year</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Prediabetes</td>
<td>Percent of adults ever diagnosed with prediabetes</td>
<td>Percent of adults ever diagnosed with prediabetes</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Prescription Costs</td>
<td>Percent of adults who could not take prescribed medication in the past 12 months because of cost</td>
<td>Percent of adults who could not take prescribed medication in the past 12 months because of cost</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Prescription Medicine Use (Adults)</td>
<td>Percent of adults who have used any prescription medicines not prescribed to them in the past 12 months</td>
<td>Percent of adults who have used any prescription medicines not prescribed to them in the past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Prescription Pain Killer Use</td>
<td>Percent of high school students who have ever used prescription pain killers without a doctor's order</td>
<td>Percent of high school students who have ever used prescription pain killers without a doctor's order</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<td>(Youth)</td>
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<tr>
<td>Preventable Hospital Events</td>
<td>Age-adjusted discharge rate (per 10,000 pop.)</td>
<td>Patient discharge rate (per 10,000 total population) for conditions that are ambulatory care sensitive (ACS); ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions that could have been prevented if adequate primary care resources were available and accessed by those patients.</td>
<td>California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data</td>
<td>2011</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Primary Care Access</td>
<td>Percent of adults with one or more primary medical providers</td>
<td>Percent of adults with one or more primary medical providers</td>
<td>SCC BRFS</td>
<td>2009</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Primary Care Health Professional Shortage Area -</td>
<td>Percentage of population living in a HPSA</td>
<td>Percentage of the population living in a geographic area designated as a &quot;Health Professional Shortage Area&quot; (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals; relevant because a shortage of health professionals contributes to access and health status issues.</td>
<td>U.S. Department of Health &amp; Human Services, Health Resources and Services Administration</td>
<td>2015</td>
<td>Community Commons</td>
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<tr>
<td>Primary Care Physician Access</td>
<td>Primary care physicians, rate per 100,000 pop.</td>
<td>Rate of primary care physicians per 100,000 population; doctors classified as &quot;primary care physicians&quot; by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs</td>
<td>U.S. Department of Health &amp; Human Services, Health Resources and Services</td>
<td>2012</td>
<td>Community Commons</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Psychological Distress</td>
<td>Percent of adults experiencing serious psychological distress in the past 30 days</td>
<td>Percent of adults experiencing serious psychological distress in the past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Recreation And Fitness Facility Access</td>
<td>Recreation and fitness facilities, rate (per 100,000 population)</td>
<td>Number of recreation and fitness facilities per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 713940; relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors</td>
<td>U.S. Census Bureau, County Business Patterns; additional data analysis by CARES</td>
<td>2012</td>
<td>Community Commons</td>
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<tr>
<td>Smoking (Adults)</td>
<td>Percent of adults who are current smokers</td>
<td>Percent of adults who are current smokers</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Smoking (Youth)</td>
<td>Percent of adolescents who smoked cigarettes on 1+ days in last 30 days</td>
<td>Percent of adolescents who smoked cigarettes on 1+ days in last 30 days</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Smoking In Lifetime (Youth)</td>
<td>Percent of youth who have ever smoked a whole cigarette 1+ times</td>
<td>Percent of youth who have ever smoked a whole cigarette 1+ times</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Soft Drink Expenditures</td>
<td>Soda Expenditures, Percentage of Total Food-At-Home Expenditures</td>
<td>Soft drink consumption by census tract by estimating expenditures for carbonated beverages, as a percentage of total household expenditures</td>
<td>Nielsen, Nielsen SiteReports</td>
<td>2014</td>
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<tr>
<td>Stress (Financial)</td>
<td>Percentage of adults who are somewhat or very stressed about financial concerns</td>
<td>Percentage of adults who are somewhat or very stressed about financial concerns</td>
<td>SCC CAP</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Stress (Food)</td>
<td>Percent of adults who are usually or always worried or stressed about having enough</td>
<td>Percent of adults who are usually or always worried or stressed about having enough money to buy nutritious meals in past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Stress (Health)</td>
<td>Percentage of adults who are somewhat or very stressed about health concerns</td>
<td>Percentage of adults who are somewhat or very stressed about health concerns</td>
<td>SCC CAP</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Stress (Rent Or Mortgage)</td>
<td>Percent of adults who are usually or always worried or stressed about having enough money to pay rent or mortgage in past 12 months</td>
<td>Percent of adults who are usually or always worried or stressed about having enough money to pay rent or mortgage in past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Stress (Work)</td>
<td>Percentage of adults who are somewhat or very stressed about work-related concerns</td>
<td>Percentage of adults who are somewhat or very stressed about work-related concerns</td>
<td>SCC CAP</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Stroke Mortality</td>
<td>Stroke, age-adjusted mortality rate (per 100,000 population)</td>
<td>Rate of death due to cerebrovascular disease (stroke) per 100,000 population, age-adjusted to year 2000 standard; relevant because strokes are a leading cause of death in the U.S.</td>
<td>University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health, CDPH - Death Public Use Data</td>
<td>2010-12</td>
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<tr>
<td>Suicide Ideation (Adults)</td>
<td>Percent of adults who seriously considered attempting suicide in the past 12 months</td>
<td>Percent of adults who seriously considered attempting suicide in the past 12 months</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Suicide Rate</td>
<td>Suicide, age-adjusted mortality rate (per 100,000 Population)</td>
<td>Rate of death due to intentional self-harm (suicide) per 100,000 population, age-adjusted to the year 2000 standard; relevant because suicide is an indicator of poor mental health</td>
<td>University of Missouri, Center for Applied Research and Environmental Systems, California Department of Public Health, CDPH - Death Public Use Data</td>
<td>2010-12</td>
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<tr>
<td>Suspensions Rate Due to Violence</td>
<td>Percent of suspensions related to weapons possession, violent incidents, or drugs</td>
<td>Percent of suspensions related to weapons possession, violent incidents, or drugs</td>
<td>CDE DQ</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<td>Syphilis Incidence Rate</td>
<td>Primary and secondary syphilis incidence rate</td>
<td>Primary and secondary syphilis incidence rate</td>
<td>SCCPHD</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>TB Infection Rate</td>
<td>TB case rate</td>
<td>TB case rate per 100,000</td>
<td>SCC PHD; CDPH Reportable Disease Information Exchange System; CDPH Tuberculosis Control Branch Provisional Data; CDC</td>
<td>2013</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Teen Births (Under Age 20)</td>
<td>Teen birth rate (per 1,000 female pop. Under age 20)</td>
<td>Rate of total births to women under the age of 20 per 1,000 females under age 20; relevant because in many cases, teen parents have unique social, economic, and health support services; additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.</td>
<td>CDPH - Birth Profiles by ZIP Code</td>
<td>2011</td>
<td>Community Commons</td>
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<tr>
<td>Tobacco Usage</td>
<td>Percent population smoking cigarettes(age-adjusted)</td>
<td>Percentage of adults age 18 and older who self-report currently smoking cigarettes some days or every day</td>
<td>Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. U.S. Department of Health &amp; Human Services, Health Indicators Warehouse</td>
<td>2006-12</td>
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<tr>
<td>Unemployed</td>
<td>Percent of unemployed</td>
<td>Percent of unemployed</td>
<td>ACS 1-year</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Vegetable Consumption (Adults)</td>
<td>Percent of adults who ate 3+ servings of vegetables per day in past 30 days</td>
<td>Percent of adults who ate 3+ servings of vegetables per day in past 30 days</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
</tr>
<tr>
<td>Vegetable Consumption (Adults)</td>
<td>Percent of children (2-11) who ate 3+ servings of vegetables the previous day</td>
<td>Percent of children (2-11) who ate 3+ servings of vegetables the previous day</td>
<td>SCC BRFS</td>
<td>2014</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td><strong>Violence - All Violent Crimes</strong></td>
<td>Violent crime rate (per 100,000 pop.)</td>
<td>Rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault; relevant because it assesses community safety</td>
<td>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</td>
<td>2010-12</td>
<td>Community Commons</td>
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<tr>
<td><strong>Violence - Assault (Crime)</strong></td>
<td>Assault rate (per 100,000 pop.)</td>
<td>Rate of assault (reported by law enforcement) per 100,000 residents; relevant because violent crime, including rate of assaults, can be used as a measure of community safety</td>
<td>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</td>
<td>2010-12</td>
<td>Community Commons</td>
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<tr>
<td><strong>Violence - Assault (Injury)</strong></td>
<td>Assault injuries, rate per 100,000 pop.</td>
<td>Number and rate of non-fatal emergency department visits for assault per 100,000 population; data are 3-year averages for 2011-2013 generated using the California EpiCenter data platform for Overall Injury</td>
<td>N/A</td>
<td>2011-13</td>
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<tr>
<td>Indicator</td>
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<td>Description</td>
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<tr>
<td>Violence - Domestic Violence</td>
<td>Domestic violence injuries, rate per 100,000 population (Females Age 10+)</td>
<td>Number and rate of non-fatal emergency department visits among females aged 10+ for domestic violence per 100,000 population; domestic violence incidents are coded using ICD-9 classification E-9673: batter by spouse/partner; data are 3-year averages for 2011-2013 generated using the California EpiCenter data platform for Overall Injury Surveillance</td>
<td>N/A</td>
<td>2011-13</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Violence - Rape (Crime)</td>
<td>Rape rate (per 100,000 pop.)</td>
<td>Rate of rape (reported by law enforcement) per 100,000 residents; relevant because violent crime, including assaults, can be used as a measure of community safety</td>
<td>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</td>
<td>2010-12</td>
<td>Community Commons</td>
</tr>
<tr>
<td>Violence - Robbery (Crime)</td>
<td>Robbery rate (per 100,000 population)</td>
<td>Rate of robbery (reported by law enforcement) per 100,000 residents; relevant because violent crime, including assaults, can be used as a measure of community safety</td>
<td>Federal Bureau of Investigation, FBI Uniform Crime Reports; additional analysis by the National Archive of Criminal Justice</td>
<td>2010-12</td>
<td>Community Commons</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Violence - School Expulsions</td>
<td>Expulsion rate</td>
<td>Rate of expulsions per 100 enrolled students; data are acquired from the California Department of Education from student-level data reported to the California Longitudinal Pupil Achievement Data System (CALPADS); relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcomes, including experiences of stress and trauma.</td>
<td>Data, accessed via the Inter-university Consortium for Political and Social Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence - School Suspensions</td>
<td>Suspension rate</td>
<td>Rate of suspensions per 100 enrolled students; data are acquired for the 2013-14 school year from the California Department of Education from student-level data reported to the California Longitudinal Pupil Achievement Data System (CALPADS); relevant because exclusionary school discipline policies, including suspensions and expulsions, are associated with lower educational attainment, higher dropout rates, engagement with the juvenile justice system, incarceration as an adult, decreased economic security as an adult, and poor mental health outcomes, including experiences of stress and trauma.</td>
<td>California Department of Education</td>
<td></td>
<td>Community Commons</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Violence - Youth Intentional Injury</td>
<td>Intentional injuries, rate per 100,000 population (youth age 13-20)</td>
<td>Number and rate of non-fatal emergency department visits among youth, age 13-20, for intentional injury per 100,000 population; intentional injuries include injuries due to both assault and self-harm; data are 3-year averages for 2011-2013 generated using the California EpiCenter data platform for Overall Injury Surveillance; relevant because youth intentional injury can be used as a measure of community safety, individual mental health, and/or substance abuse prevalence</td>
<td>N/A</td>
<td>2011-13</td>
<td>Community Commons</td>
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<tr>
<td>Violent Crime (Adults)</td>
<td>Adult felony arrest rate for violent offenses</td>
<td>Adult felony arrest rate for violent offenses</td>
<td>CA DOJ, Criminal Justice Statistics Center</td>
<td>2012</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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<tr>
<td>Weapons In School - Guns</td>
<td>Percent of middle school and high school students who carried a gun on school property in past 12 months</td>
<td>Percent of middle school and high school students who carried a gun on school property in past 12 months</td>
<td>CHKS</td>
<td>2010</td>
<td>SCC PHD CHA or BRFS Data Tables</td>
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</tbody>
</table>
Attachment 5: Persons Representing the Broad Interests of the Community

ASR and the Coalition consulted leaders for their expertise in the community. They were identified based on their professional expertise and knowledge of target groups including children, youth, older adults, low-income populations, minorities, and the medically underserved. The Coalition involved leaders from health systems including the Santa Clara County Public Health Department, nonprofit hospital representatives, local government employees, appointed county government leaders, and nonprofit organizations. The list below includes the roles and titles of those consulted.

Public Health Experts and Local Health Departments/Agencies

<table>
<thead>
<tr>
<th>Sector</th>
<th>Organization</th>
<th>Title</th>
<th>Focus/Expertise</th>
<th>Consultation Method</th>
</tr>
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<tbody>
<tr>
<td>County</td>
<td>Santa Clara County Public Health Dept.</td>
<td>Public Health Officer</td>
<td>Public Health</td>
<td>Interview May 2015</td>
</tr>
<tr>
<td>County</td>
<td>Santa Clara County Public Health Dept.</td>
<td>Public Health Nutritionist for the Centers for Chronic Disease and Injury Prevention</td>
<td>Alzheimer's/Older Adult Providers</td>
<td>Focus Group May 2015</td>
</tr>
<tr>
<td>County</td>
<td>Santa Clara County Public Health Dept.</td>
<td>Health Care Program Manager</td>
<td>Public Health</td>
<td>Survey July 2015</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>South County Collaborative</td>
<td>Board Chairperson</td>
<td>Public health South County</td>
<td>Focus Group September 2015</td>
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</table>

Representatives of Target Populations (by Sector, Organization)

<table>
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<tr>
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<th>Organization</th>
<th>Title</th>
<th>Focus/Expertise</th>
<th>Consultation Method</th>
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<tr>
<td>County</td>
<td>Adult Protective Services</td>
<td>Public Guardian</td>
<td>Older Adults</td>
<td>Focus Group May 2015</td>
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<tr>
<td>County</td>
<td>Gilroy Library</td>
<td>Community Librarian</td>
<td>South County</td>
<td>Focus Group September 2015</td>
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<tr>
<td>County</td>
<td>Public Health Department</td>
<td>Injury and Violence Prevention</td>
<td>Alzheimer's/Older Adult Providers</td>
<td>Focus Group May 2015</td>
</tr>
<tr>
<td>County</td>
<td>Santa Clara County Department of Aging and Adult Services</td>
<td>Project Manager</td>
<td>Alzheimer's/Older Adult Providers</td>
<td>Focus Group May 2015</td>
</tr>
<tr>
<td>County</td>
<td>Santa Clara County Office of Education</td>
<td>Board Member</td>
<td>South County</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Sector</td>
<td>Organization</td>
<td>Title</td>
<td>Focus/Expertise</td>
<td>Consultation Method</td>
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<tr>
<td>County</td>
<td>Santa Clara County Office of Housing &amp; Homeless Support Services</td>
<td>Staff</td>
<td>Homeless</td>
<td>September 2015</td>
</tr>
<tr>
<td>County</td>
<td>Santa Clara County Office of Housing &amp; Homeless Support Services</td>
<td>Staff</td>
<td>Homeless</td>
<td>Focus Group April 2015</td>
</tr>
<tr>
<td>County</td>
<td>Valley Health Center Gilroy</td>
<td>M.D. Family Medicine, Department of OBGYN</td>
<td>South County</td>
<td>Focus Group September 2015</td>
</tr>
<tr>
<td>Education</td>
<td>Campbell Union School District</td>
<td>Associate Superintendent</td>
<td>Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Education</td>
<td>Cupertino Union School District</td>
<td>Mental Health Program Manager</td>
<td>Behavioral Health - Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Education</td>
<td>Cupertino Union School District</td>
<td>School Nurse</td>
<td>Health - Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Education</td>
<td>Fremont Union High School District</td>
<td>Director of Educational and Special Services</td>
<td>Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Education</td>
<td>Gavilan College</td>
<td>College Health Nurse</td>
<td>Youth</td>
<td>Focus Group September 2015</td>
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<tr>
<td>Education</td>
<td>Gilroy Unified School District</td>
<td>School Linked Services Coordinator</td>
<td>Youth</td>
<td>Focus Group September 2015</td>
</tr>
<tr>
<td>Education</td>
<td>Mountain View Whisman School District</td>
<td>Assistant Superintendent</td>
<td>Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>County of Santa Clara Health &amp; Hospital System</td>
<td>Employee Wellness Senior Program Manager</td>
<td>Wellness</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>El Camino Hospital; Stanford Adjunct Faculty</td>
<td>Physician/Child &amp; Adolescent Psychiatrist</td>
<td>Behavioral Health</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>Gardner Health Services</td>
<td>CEO</td>
<td>Health</td>
<td>Survey July 2015</td>
</tr>
<tr>
<td>Medical</td>
<td>Good Samaritan Hospital</td>
<td>Registered Nurse</td>
<td>Health</td>
<td>Survey July 2015</td>
</tr>
<tr>
<td>Medical</td>
<td>Lucile Packard Children’s Hospital Stanford</td>
<td>Professor</td>
<td>Health</td>
<td>Survey July 2015</td>
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<tr>
<td>Sector</td>
<td>Organization</td>
<td>Title</td>
<td>Focus/Expertise</td>
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<tr>
<td>Medical</td>
<td>Lucile Packard Children's Hospital Stanford</td>
<td>Clinical Professor</td>
<td>Health</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>Pediatric Healthy Lifestyle Center (Sunnyvale)</td>
<td>Director</td>
<td>Pediatric Diabetes</td>
<td>Interview May 2015</td>
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<tr>
<td>Medical</td>
<td>Santa Clara County Behavioral Health Services</td>
<td>Senior Manager</td>
<td>Behavioral Health</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>School Health Clinics of Santa Clara County</td>
<td>Director of Clinic Services</td>
<td>Health - Children</td>
<td>Interview June 2015</td>
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<tr>
<td>Medical</td>
<td>Stanford University School of Medicine</td>
<td>Chief, Division of Adolescent Medicine</td>
<td>Health - Youth</td>
<td>Survey July 2015</td>
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<tr>
<td>Medical</td>
<td>Stanford University School of Medicine</td>
<td>Clinical Professor, Division of Adolescent Medicine</td>
<td>Health - Youth</td>
<td>Survey July 2015</td>
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<tr>
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<td>Abode Services</td>
<td>Staff</td>
<td>Homeless</td>
<td>Focus Group April 2015</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>Abode Services</td>
<td>Staff</td>
<td>Homeless</td>
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Attachment 6: Primary Data Collection Protocols

Santa Clara CHNA 2015-16 Professionals Focus Group Questions


When this county did its Community Health Needs Assessment in 2013, these are the health needs that came up. (Emphasize that it includes behavioral health, oral health, etc.) (Show flipchart list.)

a. We’d like you to let us know if you think there are any health needs (broadly defined, including social determinants of health) not on there that should be added.

Unmet health needs are those that are not being addressed. For example, maybe we don’t know how to prevent these problems, or we don’t have enough medicines or treatments, or maybe there aren’t enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

b. Please think about the three from the list (including the added needs, if any) you believe are the most important to address in Santa Clara County – the unmet needs.

You’ll find some sticky colored dots on the table; once you’ve decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

c. Any other trends you are seeing in the past 5 years or so? How are the needs changing? [We will discuss your ideas on how these might be able to be addressed later in our conversation.]

2. Access — Health Insurance Changes

Since ACA was implemented...

a. Do you see an increase in the number or proportion of those enrolled in health insurance?
   a. For the first time?
   b. After a lapse in insurance?

b. From what you have observed, is the cost of insurance keeping consumers from enrolling or from getting better coverage?

3. Access — Insurance Benefits/Coverage

Since ACA was implemented...

a. Do you see an increase in the number or proportion with better insurance “coverage” or benefits?

b. From what you have observed, is the cost of getting medical care keeping consumers from getting care?

Prompts: appointment co-pays, co-insurance, and prescriptions

For professionals providing health services only:

c. Do you see an increase in the number or proportion who visit a primary care doctor for preventative care like physicals or regular check-ups?

d. Are patients more likely than before to visit a doctor instead of using urgent care or the ER now compared to before ACA?

e. Are consumers more able than before to make timely appointments with a PCP or specialist? Are there enough providers?

f. Any other things you would like to share about changes due to ACA?

4. Other Access Issues

Are there any other drivers or barriers that are contributing to the unmet health needs that we listed earlier?

Prompts:
- Transportation
- Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
- Policies/laws
- Cultural norms
- Stigma
- Lack of awareness/education
- Socio-economic status (income, education)
- Mental health and/or substance abuse issues
- Being victims of abuse, bullying, or crime

5. Suggestions/Improvements/Solutions

Now that we have discussed unmet health needs and issues related to access to care, we are going to ask you about some possible solutions.

For the unmet needs you prioritized earlier...

a. Are there any policy changes you would recommend that could address these issues?
b. Are there existing resources available to address these needs that people are not using? Why?
c. What other resources are needed?

Resource question prompts:
- Specific new/expanded programs or services?
- Increase knowledge/understanding?
- Address underlying drivers like poverty, crime, education?
- Facilities (incl. hospitals/clinics)
- Infrastructure (transportation, technology, equipment)
- Staffing (incl. medical professionals)
- Information/educational materials
- Funding
- Collaborations and partnerships
- Expertise
Santa Clara CHNA 2015-16 Residents Focus Group Questions

1. **Community Health Needs & Prioritization**

   When this county did its Community Health Needs Assessment in 2013, these are the health needs that came up. (Emphasize that it includes mental health – stress and depression, oral health, etc.) *(Show list on flipchart page.)*

   a. We’d like you to let us know if you think there are any health needs not listed that should be added. [Write them on the list]

   Define unmet health needs: Those that are not being addressed. For example, maybe we don’t know how to prevent these problems, or we don’t have enough medicines or treatments, or maybe there aren’t enough doctors to treat these problems, or maybe health insurance does not cover the treatment. These are unmet because there needs to be more done about this problem.

   b. Please think about the three from the list (including the added needs, if any) you believe are the most important to address in Santa Clara County – the unmet needs.

      ▪ You’ll find some sticky colored dots on the table; once you’ve decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

2. **Health Insurance Changes**

   We are interested in your access to health services in Santa Clara County.

   First, a little about health insurance.

   a. How many of you have heard about the “Affordable Care Act” (ACA), also called “Obamacare” by some, which made health insurance available to U.S. residents about 2 years ago?

   b. How many of you enrolled in health insurance in the last two years (since the ACA went into place)

      ▪ For the first time?
      ▪ After a lapse in insurance?

   c. For how many has the cost of insurance kept you from enrolling or from getting better coverage?

3. **Access Barriers**

   Now, some questions about the “coverage” (benefits, like lower-cost appointments with doctors, lower-cost prescription medicine, being able to see a dentist, mental health counselor, eye doctor, etc.) that you do have.

   a. Do you have more or better insurance “coverage” than you had 2 years ago?

   b. Is the cost of getting medical/healthcare keeping you from getting care (like appointment co-pays, co-insurance, prescriptions)?

   Now a few questions about other ways your access to healthcare may have changed in the past 2 years:

   [Emphasize the comparison of before ACA and now]

   a. Show of hands: how many of you have a **Primary Care Physician (PCP)**? Have you had to make a change in your PCP? If so, why?

   b. Are you more likely now than two years ago to visit a PCP for preventative care like regular check-ups, mammograms, or cholesterol screenings?

   c. Are you more likely now than two years ago to visit a doctor instead of using urgent care or the ER?

   d. Do you have any trouble getting a **timely appointments**? If you had a doctor two years ago: Has this gotten better than it was two years ago?

4. **Suggestions/Improvements/Solutions**

   Now we are going to ask you to do some “magic wand” thinking about what it would take to improve these things...

   **If you had a “magic wand” what would you have local leaders or the “powers that be” do to improve the health conditions we just talked about?**

   *Prompts:*
• New/expanded programs or services (ask for specificity)?
• Increase knowledge/understanding (i.e., more health education)?
• Address more basic issues like poverty, crime, or education, which could also be impacting health?
Santa Clara County Professionals Key Informant Interview Questions

1. **Access — Insurance Changes**
   First, a little about insurance. Please speak to your experience with [health need]. Since ACA was implemented...
   
   a. Do you see an increase in the number or proportion of those enrolled in insurance...?  
      a. For the first time?  
      b. After a lapse in insurance?  
   
   b. From what you have observed, is the **cost** of insurance (i.e., premiums) keeping consumers from enrolling or from getting better coverage?

2. **Access — Coverage/Benefits**
   Now, some questions about the “coverage” (benefits) for the people you serve. Please speak to your experience with [health need]. Since ACA was implemented...
   
   a. Do you see an increase in the number or proportion with better [dental/health] insurance “coverage” or benefits?  
   
   b. From what you have observed, is the **cost** of [health need] care keeping consumers from getting care (like appointment co-pays, co-insurance, and prescriptions)?

   **Supplemental Questions:**
   Since ACA was implemented...
   
   a. Do you see an increase in the number or proportion who visit a primary care doctor for preventative care like physicals or regular check-ups?  
   b. Are patients more likely than before to visit a doctor instead of using urgent care or the ER?  
   c. Are consumers more able than before to make timely appointments with a PCP or specialist? Are there enough providers?

3. **Other Issues**
   Are there any other drivers or barriers that are contributing to health needs?
   We will talk about solutions in just a minute.

   **Prompts:**
   - Transportation
   - Built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things
   - Policies/laws
   - Cultural norms
   - Stigma
   - Lack of awareness/education
   - Socio-economic status (income, education)
   - Mental health and/or substance abuse issues
   - Being victims of abuse, bullying, or crime

4. **Suggestions/Improvements/Solutions**
Now that we have discussed health needs and issues related to access to care, we are going to ask you about some possible solutions. Regarding [health needs/specialty] ...  
   a. Are there any policy changes you would recommend that could address these issues?  
   b. Are there existing resources available to address these needs? If so, why aren’t people using them?  
   c. What other resources are needed?  

Attachment 7: Community Assets & Resources

Santa Clara County is rich in health resources. This section lists facilities, clinics, and general resources available to the public to address health needs.

Existing Healthcare Facilities

- 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
- Santa Clara Valley Medical Center
- Saint Louise Regional Hospital*
- Stanford Health Care*
- VA Palo Alto Health (U.S. Department of Veterans Affairs)
- VA Hospital Menlo Park (U.S. Department of Veterans Affairs)

In addition to providing excellent clinical care to their members, non-profit hospitals (marked with an asterisk [*] above) in Santa Clara County invest in the community with a variety of strategies, including:

- Providing in-kind expertise, training and education for health professionals
- Financial assistance (charity care)
- Subsidies for qualified health services
- Covering unreimbursed Medi-Cal costs
- Community benefit grants for promising and evidence-based strategies that impact health needs identified through the CHNA

Existing Clinics

Many community healthcare clinics in Santa Clara County are funded in part by nonprofit hospitals, private donors, and healthcare districts.

- Asian Americans for Community Involvement
  - San Jose
- Santa Clara Valley Medical Center Express Care Clinics
  - Gilroy
  - Milpitas
  - San Jose: Alexian, Bascom, East Valley, HomeFirst, Lenzen, Tully, Silver Creek, Moorpark
  - Sunnyvale
- MayView Community Health Centers
  - Palo Alto
  - Mountain View
  - Sunnyvale
- Lucile Packard Foundation for Children’s Health Teen Health Van
• Gardner Health Services
• Planned Parenthood
• RotaCare Clinic San Jose
• St. James Health Center

Other Existing Community Resources and Programs

On the following pages are lists of programs and resources available to meet each identified health need, which are organized in the following categories:

• Alliances, initiatives, campaigns and general resources
• Public/government services
• School-based services
• Community-based organization services
• Clinical hospitals and clinic services

Access & Delivery

All nonprofit hospitals provide charity care and cover the cost of unreimbursed Medi-Cal for underinsured patients.

Alliances, Initiatives, & Campaigns and General Resources

• Santa Clara County Public Health Department Nurse-Family Partnership Program helps young, low-income, expectant mothers have healthier pregnancies, become better parents, have emotionally and physically healthier children, and gain greater self-sufficiency (home visit model)
• Santa Clara Family Health Plan

Santa Clara County Services

• Valley Health Plan
• Valley Homeless Healthcare Program

School-Based Services

• School Health Centers

Hospitals and Community Clinics

• O’Connor:
  o Baby Gateway Program providing Medi-Cal enrollees information about physical and social/emotional health to parents and assistance with enrolling their infants in Medi-Cal and choosing a primary care physician
  o Health Benefits Resource Center provides insurance and CalFresh enrollment assistance and referrals social services to low-income, underinsured or uninsured individuals
• Kaiser Permanente Graduate Medical Education and Residency program at School Health Clinics and Indian Health Center
  o Pediatric Center for Life provides comprehensive care and referrals to low-income children
• Kaiser Permanente Subsidized Health Insurance and Medical Care Services including:
  o Child Health Program
  o Healthy Families Program
Steps Health Plan for Adults

- Saint Louise:
  - Baby Gateway Program providing Medi-Cal enrollees information about physical and social/emotional health to parents and assistance with enrolling their infants in Medi-Cal and choosing a primary care physician
  - Health Benefits Resource Center provides Medi-Cal application assistance

- Stanford Health Care:
  - Community Health Partnership:
    - Emergency department registration unit enrolls uninsured pediatrics patients in various assistance and insurance programs
    - Health Advocates subsidized program to help individuals research and enroll in health insurance programs
  - Emergency department registration unit enrolls uninsured pediatrics patients in assistance and insurance programs
  - Health Advocates subsidized program to help individuals research and enroll in health insurance programs
  - Information & Referral website and phone line: fields ~10,000 requests for info annually
  - MayView (increase provider hours; establish formal referral system with free clinic to provide medical home for 50 free clinic clients annually)
  - Medical education: subsidized training for residents/interns
  - Medical Respite Program for the Homeless, a public/private partnership, provides beds and case management for those experiencing homelessness
  - Pacific Free Clinic (EMR & IT support)
  - Pro bono services: labs and radiology Pacific Free Clinic
  - Stanford Health Library: free and open to all; librarians do health-related research for individuals requesting help (e.g., research conditions and put together info packets for anyone requesting; medical info; info on where to get care, etc.; Health Insurance Counseling & Advocacy Program lectures for seniors; bilingual medical librarian at branch in East Palo Alto
  - Stanford Lifeflight: subsidized air ambulance service
  - Stanford University Community Health Advocacy Program: medical students do capacity building projects at community clinics (e.g., developed/built/staff trained on chronic disease registry-MayView)

- Valley Medical Center Baby Gateway Program providing Medi-Cal enrollees information about physical and social/emotional health to parents and assistance with enrolling their infants in Medi-Cal and choosing a primary care physician

- El Camino Hospital
  - Health Library & Resource Center wellness programs, medical searches, health insurance counseling and advocacy for older adults, and Elder Care consultations
  - Medical Respite Program for the Homeless, a public/private partnership, provides beds and case management for those experiencing homelessness
  - MayView Community Health Center – primary care expansion and support for immunization services
  - Valley Health Center Sunnyvale – expansion of Valley Express (evening appointments and nurse case management for patients with chronic diseases)
Community-Based Organizations

- Asian Americans for Community Involvement Patient Navigator Program
- Community Health Partnership and related clinics
- FIRST 5 Santa Clara County: Funds Healthy Families Insurance Program
- Gardner Family Health Network: Public Benefit Screening and Enrollment (establish a Community Services Referral System that links patients to needed services by providing referrals and navigation support)
- Health insurers (Blue Cross, Aetna, etc.)
- Healthy Outcomes project
- InnVision Shelter Network: HealthCare for the Homeless (expanded services to include health support programs and increase patient utilization of scheduled medical visits)
- MayView Community Health Center: Quality Improvement Initiative (support for staffing, processes, tools, and infrastructure to improve both access and quality of care provided to disadvantaged patients).
- RotaCare Bay Area: A Way Home: Clinic Patient Navigator (to help low-income, uninsured residents find a medical home and connect patients to other local health-related services)
- Santa Clara County Public Health Department Nurse-Family Partnership Program home visitation model
- Santa Clara Family Health Foundation: Community Outreach Program (develop/sustain/refine relationships with nonprofit agencies to identify hard-to-reach uninsured children and refer parents to apply for health coverage)
- School Health Clinics of Santa Clara County: Quality Improvement Initiative (at safety net organizations, support for staffing, processes, tools and infrastructure that enable organizations to improve both access and quality of care provided to disadvantaged patients)
Transportation Services
- Avenidas
- Cal Train
- City Team Ministries
- Community Services Agency
- El Camino Hospital Roadrunners
- El Camino Hospital & Stanford Children’s Health Shuttle
- Heart of the Valley Escorted Transportation (nonprofit)
- Love Inc.
- Mountain View Community Shuttle
- Outreach & Escort, Inc.
- Santa Clara Valley Transit Authority (VTA)

ADD/ADHD/Learning Disabilities

Alliances, Initiatives, & Campaigns and General Resources
- First 5 Santa Clara (info, help finding CBOs)
- Santa Clara County Office of Education Inclusion Collaborative

Government Services (City or Santa Clara County or California)
- San Andreas Regional Center—developmental assessments

School-Based Services
- After-school academic tutoring (through school districts)
- Special Education services through public school districts and private schools

Community-Based Organizations
- After-school tutoring services available through private agencies
- Applied Behavior Analysis for autism from various organizations:
  - Morgan Center
  - Pacific Autism Center for Education (PACE)
  - Stepping Stones Triple P Curriculum
- Autism Society of San Francisco Bay Area—information regarding ways for families to get involved, gain knowledge and support, and meet other individuals affected by autism
- Behavioral health agencies with expertise in ADHD (various)
- Children’s Health Council community clinic
- EMQ Families First — serves children on the autism spectrum disorder and other developmental disabilities and their families at home, in school or in clinic.
- EvoLibri
- In-home behavioral therapy and bio-feedback from private practitioners
- Parents Helping Parents
- Social Thinking Center

Hospitals and Clinics
- Lucile Packard Children’s Hospital Stanford Brain and Behavioral Center
Alzheimer’s Disease & Dementia

Alliances, Initiatives, & Campaigns and General Resources
- Sourcewise (formerly the Council on Aging Silicon Valley)
- The Health Trust – Healthy Aging Initiative

Hospitals and Clinics
- El Camino Hospital (ECH) supported monthly learning circle for Chinese caregivers of those with Alzheimer’s disease and other forms of dementia (in partnership with the Alzheimer’s Association and ECH Chinese Health Initiative)
- ECH supported the Latino Family Connections program in partnership with the Alzheimer’s Association, where families receive timely treatment through increased awareness and understanding of Alzheimer’s Disease and dementia
- Stanford/Veteran’s Administration Alzheimer’s Research Center
- Stanford Health Care:
  - Aging Adult Services
  - Alzheimer’s disease clinical trials
  - Neuropsychology Clinic
  - Senior Care Clinic
  - The Stanford Center for Memory Disorders

Community-Based Organizations
- Adult day care programs such as Avenidas Rose Kleiner Center and Alzheimer’s Activity Center
- Alzheimer’s Association of Northern California and Northern Nevada
- Catholic Charities Daybreak Centers

Behavioral Health
See Tobacco Use for tobacco-specific resources.

Alliances, Initiatives, & Campaigns and General Resources
- Community Transformation Grants funding for school-based mental health and wellness in South County, including education for staff at youth-serving organizations on social/emotional assets in youth and young adults
- GoNoodle: online health curriculum and physical activity for all K-12 public schools in Santa Clara County – ECH supported
- HEARD (Health Care Alliance for Response to Adolescent Depression) is a community alliance of healthcare professionals, including primary care and mental health providers working in various settings including clinics, hospitals, private practices, schools, government, and private organizations.
- Network of Care provider directory
- Project Safety Net (Palo Alto)
Santa Clara County Services
- Behavioral Health Department Central Wellness & Benefits Center
- Behavioral Health Department South County Self-Help Center (Gilroy)
- Behavioral Health Department Zephyr Self-Help Center (San Jose)
- Department of Alcohol & Drug Services Gateway program
- Department of Family & Children Services
- Early Head Start Program provides access to mental health services for families of children 0-5
- Santa Clara County Behavioral Health Department (suicide and crisis services)
- Valley Health Center and all ambulatory clinics

School-Based Services
- Counseling at Mountain View Whisman School District (CHAC) – ECH supported
- Counseling services at all Cupertino Union School District Schools – ECH supported
- Counseling services at all high schools in Campbell School District (EMQ Families First) – ECH supported
- Counseling services at all Santa Clara Unified School District schools – ECH supported
- Counseling services at all Sunnyvale School District schools (CHAC) – ECH supported
- Counseling services at Mountain View Los Altos School District (CHAC) – ECH supported
- Counseling Services at Palo Alto School District — counseling and substance abuse treatment
- Mental Health Department Prevention & Early Intervention programs
- Palo Alto Unified School District Sources of Strength

Hospitals and Community Clinics
- Asian Americans for Community Involvement (AACI) — center for victims of torture and trauma
- Gardner Family Health Center
- Gardner Health Centro de Bienestar
- Lucile Packard Children's Hospital Stanford Mobile Adolescent Health Services for homeless and/or uninsured teens; services include risk behavior reduction counseling and substance abuse counseling and referrals
- Lucile Packard Foundation for Children's Health Teen Van at Mountain View Los Altos School District (counseling services) – ECH supported
- Mobile Adolescent Health Services
- San Jose Foothill Family Clinic
- Santa Clara Valley Medical Center Sunnyvale Behavioral Health Center
- Stanford Psychiatry and Behavioral Sciences inpatient and outpatient clinics
El Camino Hospital
- Inpatient mental health programs
- Outpatient mental health program for specific populations
  - Addiction Services
  - After-School Program Interventions and Resiliency Education (ASPIRE)
  - Maternal Outreach Mood Services (MOMS)
  - Older Adult Transitions Services (OATS)
- Community health lectures
- Psychology interns and fellows

Community-Based Organizations:
- 12-step recovery programs
- Alum Rock Counseling Center —Ocala MS Mentoring & Support Services Program (drug, violence, and risk prevention curriculum and emotional health services for at-risk students)
- Asian Americans for Community Involvement (AACI) Project PLUS (14-week life skills development program, providing prevention services for high-risk students at two high schools)
- Bill Wilson Center
- Billy DeFrank LGBT Community Center
- Casa de Clara, a Catholic volunteer group, offers services to women and children in downtown San Jose including shelter, food, clothing, emotional support, and referrals for housing, employment, and counseling
- Catholic Charities OASIS program provides case management, medication support and counseling
- Chamberlain’s Mental Health
- Community Health Awareness Council
- Community Solutions
- Discovery Counseling Center (Morgan Hill)
- Eastern European Services Agency
- Eating Disorder Resource Center of Silicon Valley
- EMQ Families First
- InnVision counseling
- Jewish Family & Children’s Services
- Josefa Chaboya de Narvaez Mental Health
- Law Foundation of Silicon Valley Mental Health Advocacy Project — legal services for people with mental health or developmental disabilities
- Mekong Community Center
- Momentum for Mental Health (includes psychiatric care, medication management, and medications)
- Momentum-Alliance for Community Care
- NAMI (National Alliance on Mental Illness) Peer Pals program—ECH supported
- Peninsula Healthcare Connection —psychiatric care and medication management for primarily homeless individuals
- Peninsula Healthcare New Directions
- Rebekah’s Children’s Services (Gilroy)

Birth Outcomes
Government Services (City or Santa Clara County or California)
- First 5 Santa Clara County New Parent Kits
- Santa Clara County Department of Public Health Black Infant Health (BIH) Program
- Santa Clara County Public Health Department Nurse-Family Partnership Program home visitation model

Community-Based Organizations
- Informed Choices (Gilroy)
- March of Dimes
- Real Options — prenatal care

School-Based Services
- Continuation schools (parenting classes)

Hospitals and Clinics
- O’Connor Hospital Health Benefits Resource Center’s Baby Gateway Program, providing Medi-Cal enrollees information about physical and social/emotional health to parents and assistance with enrolling their infants in Medi-Cal and choosing a primary care physician
- Packard Teen Van
- Planned Parenthood
- Valley Med high-risk OB clinic

Cancer

Community-Based Organizations
- American Cancer Society
- Bonnie J. Addario Lung Cancer Foundation
- Breast Cancer Connections
- Cancer CAREpoint
- Cancer Support Community
- Latinas Contra Cancer
- Leukemia & Lymphoma Society
- Vietnamese Reach for Health Coalition
Hospitals and Community Clinics

In addition to hospitals and clinics that provide cancer care and outpatient chemotherapy, these cancer-specific resources can be found in the community:

- **El Camino Hospital:**
  - Hepatitis B awareness campaign and screenings to prevent liver cancer in at-risk Asian population
  - Community health lectures
  - Art therapy and yoga classes for community members with cancer

- **O’Connor Hospital cancer support groups**

- **Stanford**
  - Blood and Bone Marrow Transplant Program
  - Cancer clinical trials info/referral website and phone line
  - Medicine Asian Liver Center
  - Stanford Cancer Institute
  - Stanford Cancer Supportive Care Program — 55 non-medical services for cancer patients, family and caregivers
  - Valley Medical Center Sobrato Cancer Center

Cardiovascular and Cerebrovascular Diseases

Includes heart disease and stroke.

Alliances, Initiatives, & Campaigns and General Resources

- Community Health Partnership Specialty Care Initiative supports community clinics by increasing access and reducing demand for specialty care among uninsured and underinsured populations. The initiative targets access to care in various specialties such as gastroenterology, orthopedics, neurology, ophthalmology, and cardiology.

- Free blood pressure, cholesterol, and glucose screenings:
  - American Heart Association
  - Health fairs
  - YMCA screenings

- PHASE Initiative — protocols for community clinics

Community-Based Organizations

- Community Service Agency Mountain View — nurse case management and social work case management to help older adults better manage chronic health conditions such as congestive heart failure and hypertension
- Peninsula Stroke Association (symposium)
- Stroke Awareness Foundation
Hospitals and Community Clinics

- **El Camino Hospital**
  - Cardiopulmonary Rehabilitation
  - Chinese Health Initiative lecture series provided in Chinese languages
  - Blood pressure screenings
  - Stroke screenings
  - Heart health lectures
  - Certified stroke center
  - South Asian Heart Center – screening and consultations, physician and community awareness initiative focused on prevalence of heart disease in the South Asian population

- **O’Connor Hospital**:
  - Free blood pressure screenings
  - Stroke support group
  - Certified stroke center
  - Cardiac Rehab Center
  - Community lectures on stroke, hypertension, heart disease

- **Primary care, hypertension, and heart disease case management at community clinics**:
  - Asian Americans for Community Involvement
  - Mayview Community Health Center
  - RotaCare Clinic Mountain View
  - Valley Health Center Sunnyvale

- **Saint Louise Hospital**
  - Certified stroke center

- **Stanford Hospital & Clinics**:
  - Stroke education and support groups
  - Comprehensive Stroke Center
  - Stroke Rehabilitation Program
  - Heart Failure & Cardiomyopathy Clinic
  - Valvular Heart Disease Clinic
  - Women’s Heart Health Clinic
  - Heart Surgery Clinic
  - Heart Transplant Program
  - Cardiac Rehabilitation
  - Heart Transplant Program
  - Stanford South Asian Translational Heart Initiative
  - Adult Congenital Heart Program
Communicable Diseases

See Sexual Health for sexually transmitted infections assets and resources.

Alliances, Initiatives, & Campaigns and General Resources

- Santa Clara County Needle Exchange Program
- SCC Hepatitis B Free Initiative
- Vietnamese Reach for Health Coalition

Government Services (City or Santa Clara County or California)

- Santa Clara County Pediatric TB Clinic
- Santa Clara County Public Health Department ESSENCE program
- Santa Clara County TB/Refugee Health Clinics

School-Based Services

- Lucile Packard Foundation for Children’s Health Teen Van (including STIs and HPV)
- School health clinics of Santa Clara County

Hospitals and Clinics

- El Camino Hospital Chinese Health Initiative—hepatitis B screenings and awareness
- Foothill Community Health
- Peninsula Healthcare Connection (clinic and homeless shelter)
- Stanford Health Care Infectious Disease Clinic
- Valley Homeless Healthcare Mobile Van

Diabetes & Obesity

See Economic Security for free food resources.

Alliances, Initiatives, & Campaigns and General Resources

- Bay Area Nutrition and Physical Activity Collaborative (BANPAC)
- California Food Policy Advocates
- Communities Putting Prevention to Work (CPPW) Obesity Prevention Program
- Community Alliance with Family Farmers (CAFF) Foundation: Expanding Farm to School (at Sunnyvale Elementary School District including Harvest of the Month in ASPs, integrating locally-sourced food in school meals and increasing procurement of locally-sourced produce)
- Community Transformation Grants (CDC)
  - healthy meeting guidelines / healthy vending machine guidelines
  - increasing healthy food and beverages and increased opportunities for physical activity
  - increasing number of cities in South County that offer increased opportunities for healthy eating/active living as well as healthy food and beverage procurement policies
- Green Belt Alliance (collaborative)
- Pacific Institute (public health & environmental justice in land use and transportation planning
- Partners in Health (PIH)
- SCC Diabetes Prevention Initiative
• Stanford Health Library in three community-based locations – librarians research treatment options/other info on diabetes treatment /management
• Sunnyvale Collaborative (obesity focused)

Government Services
• California WALKS Program
• Children’s Health Plan (diabetic services)
• County of Santa Clara Parks and Recreation Department—Healthy Trails Program, bilingual outreach
• Healthy Kids weight management classes
• Nutrition education through Santa Clara County Public Health Department
• San Jose Department of Parks, Recreation, & Neighborhood Services exercise programs at 21 senior centers
• Santa Clara County Public Health Department Breastfeeding Program (education, training public educators, and lactation consultant)

School-Based Services
• 5210 Health awareness Initiative at 9 elementary schools (includes information on nutrition and physical activity for students and parents) – ECH supported
• Alum Rock Union School District: Healthy Eating Active Living (ReThink Your Drink, water station at schools, health messaging on school campus)
• BAWSI Girls in Campbell (physical activity for 3rd-5th grade girls with athlete mentors at six schools) – ECH supported
• District School Wellness policies
• GoNoodle nutrition and fitness health curriculum lessons in numerous school districts – ECH supported
• Healthier Kids Foundation—10 Steps to a Healthier You parent education series
• Kaiser Permanente Educational Theatre Program—obesity prevention programming and messaging to schools and in the community
• Nutrition education in the School Health Clinics of Santa Clara County
• Playworks at eight low-income elementary schools – ECH supported
• Santa Clara County Office of Education’s Coordinated School Health Advisory Council
• Santa Clara County Office of Education’s Coordinated School Health Advisory Council
• School nurses and health clerks in four school districts who manage care for diabetic students – ECH supported

Community-Based Organizations
• Breathe CA: Let’s Get Moving to School (at five schools, increasing number of students who walk and bicycle to school)
• Children’s Discovery Museum: Rainbow Market Project (new exhibit to support children and families in exploring healthy eating)
• Choices for Children: 5 Keys for Child Care (online training module for child care providers to improve feeding knowledge and behaviors)
• Community Service Agency Mountain View—provides nurse case management and social work case management to help older adults better manage diabetes
• FIRST 5 Family Resource Centers (nutrition and physical activity programming)
- Happy Hollow Park and Zoo Eat Like a Lemur Project (provide healthy foods in their cafe and showcase opportunities for increased physical activity around the park)
- Our City Forest fruit tree stewardship programs (benefits community by promoting growing one’s own food and giving away food)
- Silicon Valley HealthCorps developing community and school-based gardens, and farm to school programs
- Somos Mayfair: In Our Hands, Family Wellness Imitative (foster daily exercise, guided by Promotores, in San Jose Mayfair neighborhood)
- Sunnyvale Community Services: Fresh From the Farm (provides low-income families fresh produce, nutrition education, farm and gardening experiences, and community-building activities)
- Various organizations: Early childhood feeding practices parenting classes (“5 Keys to Raising a Happy, Healthy Eater”)
- Various senior centers: Chronic disease self-management workshops
- Veggielution: Healthy Food Access and Engagement for Low-Income Families (hands-on learning, physical activity, fresh fruits and vegetables for individuals and families in low-income East San Jose neighborhoods)
- West Valley Community Services (includes the Raising a Healthy Eater Program)

**Hospitals and Community Clinics**

In addition to health education and chronic disease clinical care provided to members, Hospitals and Community Clinics offer the following services available to the public:

- Asian Americans for Community Involvement Clinic—diabetic case management
- Gardner Clinic—Down with Diabetes program
- Indian Health Center of Santa Clara Valley
  - Health Intervention Program including education, coaching, and fitness training
  - Weight Management Program (health education)
  - Diabetes Prevention Program for pre-diabetic adults including coaching and nutrition counseling
  - Diabetes Prevention & Management Program for type 2 diabetics including medication management and nutrition counseling
- Kaiser Permanente Educational Theatre Program—obesity prevention programming and messaging to schools and in the community
- Kaiser Permanente Farmer’s Markets (open to the community)
- Lucile Packard Foundation for Children’s Health Hospital Mobile Adolescent Health Services for homeless and/or uninsured teens—In addition to acute care and injury prevention, the Teen Van provides primary care services and nutrition counseling
- Lucile Packard Children’s Hospital Pediatric Weight Control Program – tuition scholarships for low-income families
- MayView Clinic in Mountain View—diabetic case management
- O’Connor Hospital Health Benefits Resource Center, insurance and CalFresh coverage for uninsured at hospital and in the community
- O’Connor Hospital—diabetes support group
- Stanford Health Care Diabetes Care Program
- Stanford Hospital and Clinics Strong for Life—free exercise classes at senior centers
- Stanford Transplant Diabetes Program
- Stanford University Pacific Free Clinic: Access to Preventive Health Care for the Uninsured (health education, pharmacy program including protocols and dispensing of medications, adult immunization program for uninsured adults in San Jose area)
- The Health Trust
  - Medical Nutritional Therapy for type 2 diabetics
  - Diabetes Self-Management Program (available in multiple languages)
  - Better Choices, Better Health chronic disease self-management workshops (online or small group, available in multiple languages)
- Timpany Center Diabetes Prevention Study
- Valley Health Center on Bascom and in Sunnyvale—diabetic case management
- YMCA National Diabetes Prevention Program (health education)
- El Camino Hospital
  - Challenge Diabetes Program in partnership with Community Services Agency – Mountain View, Sunnyvale Community Services, West Valley Community Services, and Second Harvest Food Bank - a prediabetes initiative
  - South Asian Heart Center – screening and consultations, physician and community awareness initiative focused on prevalence of diabetes in the South Asian population

**Economic Security**

This need includes education, employment and poverty. Housing is a separate health need.

**Alliances, Initiatives, & Campaigns and General Resources**

- 2-1-1

**Government Services (City or Santa Clara County or California)**

- CalFresh
- City of San José employment resource center
- Connect Center CA (Pro-match and Nova job centers)
- Employment Development Department (in partnership with NOVA
  - CONNECT Center
  - ProMatch career resource center
- Medi-Cal
- Veterans Administration employment center
- WIC
- Women, Infants, and Children (WIC) Nutrition Services
- Work 2 Future—a County of Santa Clara, City of San José, and SJSU collaborative program

**School-Based Services**

- Community colleges
- Salad bars (funded through SVLG—nutrition)

**Community-Based Organizations**

- American Vets Career Center
- Community Service Agency (Mountain View, Sunnyvale, West Valley)
• Day Worker Center (Mountain View)
• Dress for Success, a nonprofit organization that provides interview suits and job development
• Food resources:
  o Loaves and Fishes
  o Meals on Wheels (The Health Trust and Sourcewise)
  o Salvation Army
  o St. Joseph’s Cathedral
  o St. Joseph’s Family Center—food bank and hot meals (Gilroy)
  o Sunnyvale Community Services
  o Second Harvest Food Bank
  o The Health Trust farmer’s market
  o Valley Medical Center farmers’ market
• Goodwill Silicon Valley
• Hope Services—employment for adults with developmental disabilities
• NOVA Workforce development
• Sacred Heart Community Services
• Salvation Army
• Unity Care—foster youth employment assistance

**Hospitals and Clinics**
• Summer youth programs (Medical EMP and College Access)
• Stanford Medicine Summer Youth Program (introduces low income, minority students to careers in healthcare; college application assistance)
• El Camino YMCA summer youth camps – ECH supported

**Housing**

**Alliances, Initiatives, & Campaigns and General Resources**
• “All the Way Home” Campaign to End Veteran Homelessness – City of San Jose, Santa Clara County and the Housing Authority have set a goal of housing all of the estimated 700 homeless veterans by 2017 (new)
• Community plan to end homelessness in Santa Clara County
• Destination Home
• MyHousing.org
• Santa Clara County Housing Task Force
• Santa Clara County Medical Respite for the Homeless
• VA Housing Initiative

**Public/Santa Clara County Services**
• Abode Services—supportive housing- county paying for success initiative for chronic homelessness
• City of San Jose Housing Department and Homelessness Response Team
• County mental health housing through MHSA
• County Office of Supportive Housing
• Housing Authority of SCC
• Housing Trust
• Santa Clara County Valley Health and Hospital System—myhousing.org
• SJC Housing and Homelessness Services Department

Community-Based Organizations – Legal
• Asian Law Center
• Family Advocacy Program (Legal Aid Society)
• Law Foundation of Silicon Valley Mental Health Advocacy Project—legal services for people with mental health or developmental disabilities—ECH supported
• Legal Aid
• Project Sentinel and other dispute resolution providers

Community-Based Organizations – Emergency & Transitional Housing
• 211 (info/referral)
• Bill Wilson Center emergency shelter for youth
• Casa de Clara (Catholic volunteer group)—services to women and children in downtown San Jose 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
• Community Services Agency emergency shelter
• Destination Home
• Downtown Streets Team
• EHC Life Builders Emergency Housing Consortium
• Foster youth group home providers
• Gilroy Compassion Center
• HomeFirst
• Housing Opportunities for Persons with AIDS
• InnVision the Way Home
• Love Inc.
• New Hope House
• Palo Alto Housing Corporation
• Rebuilding Together (repairs to keep people in homes)
• Sacred Heart Community Services emergency assistance
• Senior Housing Solutions
• St. Joseph emergency assistance
• Sunnyvale Community Services—housing and emergency assistance—ECH supported
• The Health Trust Housing for Health
• Unity Care—Foster youth housing
• West Valley Community Services emergency assistance—ECH supported

School-Based Services
• College/university housing offices

Oral/Dental Health
Alliances, Initiatives, & Campaigns and General Resources
- California Dental Association Fund—Santa Clara Fluoridation Initiative
- Onsite Dental Foundation for HIV/AIDS patients

Government Services (City or Santa Clara County or California)
- Superior Court of CA Santa Clara County orthodontic care for foster youth—ECH supported

School-Based Services
- School nurses coordinate dental screenings at schools in four school districts—ECH supported

Community-Based Organizations
- Healthier Kids Foundation (Kids)
- InnVision Shelter Network—Health Care for the Homeless (medical and dental care)
- SCC Dental Society

Hospitals and Community Clinics
- Alviso Health Center
- Children’s Dental Center (Sunnyvale)
- Children’s Dental Center in East San Jose (through The Health Trust)
- CompreCare Clinic
- Dental mobile unit site
- EHC Lifebuilders dental mobile unit site
- FIRST 5 Santa Clara County distributed New Parent Kit and additional oral healthcare kits
- Foothill Clinic (Gilroy)
- Gardner Dental Clinic (South County)
- Gardner Family Health Clinic (Alum Rock)
- Indian Health Center
- St. James Health Center
- Health Mobile (Head Start & Preschools)
- Valley Homeless Healthcare clinics—dental services and dental van
- Valley Health Center, Sunnyvale—adult dental—ECH supported

Respiratory Conditions

Alliances, Initiatives, & Campaigns and General Resources
- Drug assistance programs through pharmaceutical companies
- Stanford Health Library: info and librarian assistant for treatment/management
- Tobacco Free Coalition Santa Clara County

School-Based Services
- Asthma case management by school nurses in four school districts—ECH supported

Community-Based Organizations
- Allergy & Asthma Associates of Santa Clara Valley Research Center
- Breathe California
• California Smokers Helpline
• Respiratory equipment companies
• Second-Hand Smoke Helpline
• Vietnamese Reach for Health Coalition

**Hospitals and Clinics**

• El Camino Hospital
  o Cardiac & Pulmonary Wellness Program
  o Pulmonary Fellows
• O’Connor Hospital
• Saint Louise Pulmonary Rehabilitation Program
• Stanford Health Care
  o Center for Advanced Lung Disease
  o Chest Clinic
  o Pulmonary Rehabilitation Program

**Sexual Health - including STIs/HIV/AIDS**

**Government Services (City or Santa Clara County or California)**

• Santa Clara County HIV Planning council
• Santa Clara County Needle Exchange Program

**School-Based Services**

• College health centers (public and private universities, community colleges)
• Lucile Packard Children’s Hospital Stanford Teen Van
• School health clinics (San Jose High, Overfelt, Washington, Franklin-McKinley Neighborhoods)
Community-Based Organizations

- Asian American Recovery Services
- Billy DeFrank LGBT Community Center
- Community Health Awareness Council (CHAC) Outlet program
- Community Health Partnership—Transgender Health
- Planned Parenthood Mar Monte (including Foster Youth Healthcare Services & Coverage Access, which provides pregnancy prevention/education services to current and former foster youth throughout Santa Clara County)
- The Health Trust AIDS Services
- The Health Trust: Asian Americans for Community Involvement
- Valley Health Center PACE Clinic—HIV services

Hospitals and Clinics

- Lucile Packard Children’s Hospital Mobile Adolescent Health Services for homeless and/or uninsured teens; services include counseling and treatment for HIV and STDs, family planning services, pregnancy testing, and risk behavior reduction counseling
- Stanford Health Care Positive Care Clinic (HIV and AIDS)

Tobacco Use

Alliances, Initiatives, & Campaigns and General Resources

- Tobacco Free Coalition Santa Clara County

Hospitals and Community Clinics:

- Santa Clara County Public Health Department partnerships with Valley Medical Center South County clinic and Gardner to screen for tobacco use)

Unintentional Injuries

Alliances, Initiatives, & Campaigns and General Resources

- Safe Routes to School
- SafeKids Santa Clara County
- Santa Clara County Fall Prevention Task Force
- Santa Clara County Public Health Department Falls Prevention Collaborative
- SJSU Research Foundation Falls Prevention Collaborative
- The Health Trust Healthy Aging Partnership
Government Services (City or Santa Clara County or California)
- City departments of transportation
- County poison control
- PHD Center for Chronic Disease and Injury Prevention

Community-Based Organizations
- 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, balance
- The Health Trust Agents for Change promoting older adult pedestrian safety
- YMCA (free camps and scholarships for swim lessons)

Hospitals and Clinics
- Packard Safely Home car seat fitting station
- Stanford Healthcare:
  - Farewell to Falls free, in-home program including home assessments, exercise program facilitated by occupational therapists, and pharmacist assistance
  - Chronic Disease Self-Management workshops senior centers (pain management, management of conditions causing loss of balance)
  - Provides Lifeline in-home emergency response service to seniors regardless of their ability to pay

Violence and Abuse

Alliances, Initiatives, & Campaigns and General Resources
- South County United for Health Leadership Team focus on active and safe parks
- Violence Prevention Taskforce

Government Services (City or Santa Clara County or California)
- City of Gilroy Gang Taskforce
- City of San Jose BEST-funded programs
- Domestic Violence Intervention Program for foster children through the Superior Court of California Santa Clara County
- San Jose Mayor’s Gang Taskforce
- Santa Clara County Child Abuse Council
- Santa Clara County Domestic Violence Council
- Santa Clara County Juvenile Probation Department programs
- Santa Clara County Office of Human Relations
- Santa Clara County Office of Women’s Policy
- Santa Clara County Public Health Department Anti-bullying Community Transformation Grants in South County school districts
- Santa Clara County Public Health Department Violence Prevention Program
  - Healthy Teen Relationships Campaign (social marketing strategies and programming to prevent teen domestic violence) in South San Jose/South County
  - We All Play a Role in Safe and Peaceful Communities Campaign

School-Based Services
- GoNoodle online lessons on bullying awareness

Community-Based Organizations
- AACI: Victims & violence (torture/trauma center)
- Alum Rock Counseling Center CAPA program
- Asian Women’s Home
- CHAC (Community Health Awareness Counseling) provided at all Sunnyvale School District schools, for Mountain View Whisman School District and Mountain View Los Altos School District – ECH supported
- Community Solutions
- Community Solutions Touch with Teens Program at school sites in South County
- Community Solutions: Healthy Communities Program (violence prevention and intervention services to high-conflict/ underserved children, youth, and families, Morgan Hill & Gilroy)
- Discovery: Community Solutions
- Domestic violence shelters
  - Asian Americans for Community Involvement
  - YWCA Support Network
  - Next Door Solutions
- EMQ Families First counseling for all high schools in the Campbell Union High School District – ECH supported
- EMQ Families First Crisis Intervention Program for northern Santa Clara County
- Girl Scouts of Northern California Got Choices program—prevention/ intervention program to reduce risky behaviors and support informed decision-making in high-risk, disconnected, gang-impacted and court-involved middle- and high-school girls
- ICAN (Vietnamese parenting class focusing on infant/child brain development)
- Next Door Solutions to Domestic Violence Healing Families Pilot Project—for those who have either experienced or been exposed to domestic violence—ECH supported
- Peace Builders Program
- Playworks: Youth development program in elementary school that has positive impact on reducing violence – ECH supported
- Rebekah Children’s Services School-Based Violence and Substance Abuse Prevention Program (elementary school students in Gilroy Unified School District)
- SafeCare Home Visitation Services
- Sunday Friends violence prevention classes
- Various organizations: Triple P parenting program
- YMCA Silicon Valley / Project Cornerstone Creating Caring Schools to Reduce Violence program—partnership with 10 high-need schools and preschools
Hospitals and Clinics

- Kaiser Permanente Educational Theatre Program that delivers violence prevention programming and messaging to schools and in the community
- Lucile Packard Children’s Hospital health education programs with topics including cyber bullying
- Lucile Packard Children’s Hospital residents’ community advocacy projects
- Lucile Packard Children’s Hospital Suspected Child Abuse and Neglect (SCAN) team, a collaboration between Packard Children’s and the Santa Clara Valley Medical Center – Center for Child Protection. The team consults on child abuse cases, reviews all CPS referrals and consultations, provides inpatient and outpatient consultation services, and education for residents, medical students, and staff.
- Lucile Packard Children’s Hospital Safe Kids Coalition

Other Community Provider Resources

End of Life Care

- Coda Alliance
- Home health aides
- Hospice programs
- Palliative Care Programs at the Veterans Administration, Valley Medical Center
- Respite care home health services
- Pathways Home Health, Hospice & Private Duty – ECH supported
Attachment 8: Health Needs Profiles

1. Access to Healthcare
2. Alzheimer’s Disease & Dementia
3. Behavioral Health
4. Birth Outcomes
5. Cancer
6. Communicable Diseases
7. Diabetes & Obesity
8. Economic Security
9. Heart Disease & Stroke
10. Housing & Homelessness
11. Learning Disabilities
12. Oral/Dental Health
13. Respiratory Conditions
14. Sexual Health
15. Tobacco Use
16. Unintentional Injuries
17. Violence & Abuse
How Do We Know There Is a Problem?

The community ranked healthcare access as a top health need in half of CHNA focus groups. While health insurance has been made more accessible since the Covered California Healthcare Exchange was implemented in 2013, community residents and leaders expressed that the costs of insurance, copays, and co-insurance were still too expensive for many. In addition, the community expressed concern over the lack of health system literacy. In a community where 12% of county households are linguistically isolated\(^{40}\), this becomes even more crucial. While more than 8 in 10 have a personal doctor and health insurance in Santa Clara County, access to healthcare is worse for Latinos, as show in the chart on the next page. \textit{See Oral/Dental Health Profile for access issues related to oral/dental health.}

What the Community Said

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

Insurance

- Ranked as a top health need in half (4) of focus groups.
- Health insurance is not affordable.
- Access is lacking for many types of care, including oral/dental health access, long-term care, and acute/urgent care.
- Insurance is unaffordable for many undocumented immigrants, who are not eligible for Covered California subsidies.
- The community lacks health system literacy and is in need of patient navigators and advocates (also cited by African Ancestry report).\(^{41}\) Specifically, the community wants more information about available services and billing.
- Those who participated in the African Ancestry community conversations expressed frustration with the high costs of healthcare services; one participant said, “We aren’t poor but we can’t afford [ambulances].”\(^{41}\)

\(^{41}\) Santa Clara County Public Health Department, \textit{Status of African/African Ancestry Health: Santa Clara County 2014}. 
Healthcare Delivery

- More integrated physical and mental healthcare is needed. (See Behavioral Health Profile.)
- There is a lack of timely appointments; the emergency room is still being used when people can’t get timely appointments. This results in some waiting until issues are grave before they seek care. Wait times in the office are too long, even for those with appointments.
- Many have difficulty understanding some of the information they are receiving during appointments, even when the information is given in their primary language. The problem is worse for those who do not receive care in their primary language.
- Doctors do not spend enough time with patients, nor do they address all of the needs patients have. This is of special concern for seniors and those experiencing homelessness.
- African immigrants are unfamiliar with the health care system, which exacerbates mistrust. 41
- Discrimination was cited as a common experience for Blacks. For example, some female participants said that health professionals had assumed they were poor or single mothers, and these Black patients felt that birth control was being forced upon them. 41
- LGBTQ community members said health professionals are not adequately trained to work with LGBTQ people. Also, 42% said they were treated differently because they are LGBTQ. 42
- One in 10 LGBTQ community members said that health professionals had refused to touch them or used excessive precautions, or used harsh/abusive language. Transgender respondents reported the highest levels of discrimination; 18% said they had been refused care compared to 6% other LGBTQ. 42
- The community perceives that homeless people are being discharged from the hospital without a place to go, reflecting the small number of available shelter beds; this impacts the ability of those individuals to recuperate and maintain good health.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified healthcare access and delivery as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

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42 Santa Clara County Public Health Department, Status of LGBTQ Health: Santa Clara County 2013.

Data found in this health profile was collected during the 2016 Community Health Needs Assessment. The annual Community Benefit report describes in detail the investments made in the community, including programming and partnerships.
How Do We Know There Is a Problem?

Alzheimer’s disease and dementia are health needs in Santa Clara County as marked by Alzheimer’s disease being the third leading cause of death. The mortality rate from Alzheimer’s in the county is higher than the state, and the median age of the population in the county is older than the state. It is the fastest-growing cause of death in California and the number of people living with Alzheimer’s disease is also growing rapidly. While specific data about the number diagnosed with dementia are lacking, this health need will impact the community’s health and economic security as the cost of care for older adults with dementia increases.

- The greatest risk for Alzheimer’s disease is age. In Santa Clara County, the median age of the county’s population (36.4) is slightly older than the population of the state overall (35.4). By 2025, nearly one in five Silicon Valley residents will be 65 years or older. This is an increase from the current 2015 proportion of 13%.

- In 2012, Alzheimer’s disease was the third leading cause of death in Santa Clara County, accounting for 8% of all deaths. In California, it was the fifth leading cause.

- The age-adjusted death rate of Alzheimer’s disease in Santa Clara County in 2011 was 35.9 per 100,000, which was higher than the state overall in 2010 (30.1 per 100,000).

- The highest concentration of older adults is in the Saratoga foothills, the southern end of Mountain View, southwest Sunnyvale, Los Gatos, Los Altos, and Palo Alto. (See map on next page.) Information about where older adult populations live can be helpful for planning services to address dementia.

SANTA CLARA COUNTY POPULATION 65 YEARS AND OLDER

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44 US Census Bureau, State and County QuickFacts, 2009-2013.
45 Silicon Valley Institute for Regional Studies, Population Growth in Silicon Valley, 2015.
46 California Department of Public Health, Leading Causes of Death; California Counties and Selected City Health Departments, 2012, Table 5-20.
47 Centers for Disease Control and Prevention (CDC), Community Health Status Indicators (CHSI)/National Center for Health Statistics, County Profile, 2011; CDC, National Center for Health Statistics (NCHS) Data Brief, 2010; CDC, Health Data Interactive for National Data, 2011.
Data found in this health profile was collected during the 2016 Community Health Needs Assessment. The annual Community Benefit report describes in detail the investments made in the community, including programming and partnerships.

What Did the Community Say?

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Participants in a focus group of professionals who serve seniors expressed concern over what they perceive is a relatively small number of dementia and Alzheimer’s diagnoses, and about how these diagnoses are disclosed to patients.
- Participants in a focus group composed of providers who serve the homeless stated that there are no services for homeless individuals with dementia or Alzheimer’s.
- A focus group of family caregivers said that for patients with dementia, more coordination is needed between mental health providers and primary care physicians.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified Alzheimer’s disease and dementia as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

Mental health (including sub-clinical stress, anxiety, and depression in addition to diagnosed mental health disorders) and substance abuse are co-occurring problems that are a substantial concern to the community. Substance abuse is related to mental health because many cope with mental health issues by using drugs or abusing alcohol. In the community input phase of the CHNA, it was clear that the community sees the need for addressing these co-occurring conditions in a coordinated approach.

Mental Health Data

- 38% of county adults report poor mental health on at least one day in last 30 days. 48
- Suicide was the tenth leading cause of death in Santa Clara County in 2013 (156 or 2% of deaths).49 The suicide rate is 7.9, lower than CA (9.8) and the HP2020 benchmark (10.2).50

Substance Abuse Data

- Liver disease/cirrhosis was the ninth leading cause of death in Santa Clara County in 2013 (168 or 2% of deaths).49
- 14% of adults and 11% of youth binge drink. 48 51
- 29% of high school youth say they have used marijuana.4
- 7% of high school youth say they have used cocaine. 4
- 10-11% of high school youth say they have used ecstasy, inhalants and prescription pain medication.51

MENTAL HEALTH A TOP COMMUNITY CONCERN

While those with diagnosed mental health disorders have access to treatment, those with sub-clinical anxiety and depression may not be receiving care.

PERCENTAGE OF SCC ADULTS WHO ARE SOMEWHAT OR VERY STRESSED, BY TOPIC, 2014

Financial  60%
Work  53%
Health  44%


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49 California Department of Public Health, Leading Causes of Death; California Counties and Selected City Health Department, 2013.
50 California Department of Public Health, Death Public Use Data. 2010-12.
Who Is Most Affected?

- The death rate from suicide is highest among residents aged 45 and older; 58% of deaths by suicide are among that age group.\(^5^2\)
- Nearly one quarter (23%) of LGBTQ respondents have seriously considered attempting suicide or physically harming themselves within the past 12 months.\(^5^3\)

Suicidal ideation among LGBTQ respondents is highest among transgender respondents (47%), Latinos (28%), and young adults aged 18 to 24 (37%).

LGBTQ individuals with annual household incomes of less than $40,000 (27%) and $40,000 to $74,999 (28%) more often reported self-harm ideation than those in households with incomes of $75,000 or more (15%).

What the Community Said About Behavioral Health

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Six out of eight focus groups ranked behavioral health as a top three need in the county in, and three out of five key informants mentioned it in their interviews. Substance abuse was mentioned in four out of eight focus groups.
- Depression, stress, and anxiety were the mental health issues mentioned most in focus groups (3) and in the LGBTQ report. Also, hoarding was mentioned in more than one focus group or key informant interview.

Populations

- LGBTQ community members and Black community members noted that discrimination contributes to mental health issues in their respective communities.\(^5^3,5^4\)
- Providers of older adult services recommended increasing awareness about the high suicide rate among older adults and said that this population is depressed because of isolation and financial struggles, including housing costs.
- Substance abuse treatment providers expressed concerned about increasing numbers of youth with methamphetamine and marijuana dependency; this is exacerbated by the legalization of marijuana for those with medical cards (i.e., some youth have increased access through their parents).
- Parents may be contributing to stress among adolescents by putting pressure on them to succeed.

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\(^{5^2}\) Santa Clara County Public Health Department, *Santa Clara County: Suicide*, 2015.

\(^{5^3}\) Santa Clara County Public Health Department, *Status of LGBTQ Health: Santa Clara County 2013*.

\(^{5^4}\) Santa Clara County Public Health Department, *Status of African/African Ancestry Health: Santa Clara County 2014*. 
• **Immigrant children** experience physical and mental trauma from experiences such as witnessing drug cartel crime and violence during the journey to U.S.

• Stigma about mental health results in issues being swept under the rug, and more so among older adults and in some ethnic **cultures** (such as Vietnamese).

• There is a lack of knowledge about mental health issues in **homeless** populations.

**Insurance and Services**

• Mental health services that are available are often unaffordable or not adequate, especially for those who have not been formally diagnosed with a mental health disorder.

• There are a lack of substance use services countywide, but especially for women and teens; specifically there is a lack of residential treatment facilities.

• There are insufficient mental health staff in schools.

**Commitment to Improving Community Health**

In 2016, the Santa Clara County Community Benefit Coalition identified behavioral health as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There Is a Problem?

Overall, birth outcomes in Santa Clara County meet Healthy People 2020 (HP2020) targets and are similar to California. However, Blacks and Asian/Pacific Islanders are disproportionately affected, with higher percentages of low birthweight babies than the county average. Blacks and those of “other” races\(^5\) also have higher proportions of pre-term births and of infant mortality compared to the county overall. These problems are more likely to occur when mothers do not receive early prenatal care. Ethnic disparities are evident in the percentage of Santa Clara County mothers who receive adequate prenatal care.

As shown in the chart, Santa Clara County birth outcomes look favorable compared to the state and meet HP2020 targets.

- The percentage of infants with low birthweight (6.9%) is almost the same as California.
- The percentage of infants born pre-term (8.6%) is better than California (9.8%).
- Overall infant mortality rate (2.9 per 1,000) is below the HP2020 target of 6.0.
- 24% of births are by mothers who received inadequate prenatal care, which misses the HP2020 target of 22% or less.

\(^5\) Those who identified as a race other than White, Black, Asian, Asian/Pacific Islander.
Who Is Most Affected?

Geographic Disparities

Babies in certain geographic areas are more likely to be born at low birthweight. The highest rates are in Alviso (25% of births are low birthweight), Milpitas (7%), Gilroy (7%), and zip codes 95134 in North San Jose (9%), 95139 in South San Jose (9%), and 94301 in Palo Alto (8%).

Ethnic Disparities

In Santa Clara County, Latino and Black mothers are more likely to receive inadequate prenatal care and to have poor birth outcomes of low birthweight, pre-term birth, and infant mortality. See chart below.

- Black mothers and mothers of “other” races (not White, Hispanic, or Asian/Pacific Islander) are slightly more likely to have low birthweight babies to deliver pre-term, but these rates are within 2% of the county overall.
- The mortality rate for Black infants in the county is higher than the HP2020 target, at 7.8 per 1,000. This trend is also seen in California.
- Proportions of inadequate prenatal care are worst for Blacks (29%) and Hispanics (26%).

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified birth outcomes as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

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56 California Department of Public Health, Birth Profiles by Zip Code, 2011.
How Do We Know There is a Problem?

Cancer was the leading cause of death in Santa Clara County in 2013, accounting for 2,372 deaths.\(^{57}\) Indicator data show that colorectal and prostate cancer prevalence rates are higher than both the Healthy People 2020 target and the state average. Also, data show that members of some ethnic groups in Santa Clara County are more likely to be diagnosed or die from cancer than residents from other ethnic groups.

### COUNTYWIDE CANCER DATA FAILING BENCHMARKS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Santa Clara County</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause of death due to cancer</td>
<td>#1 cause (25%)</td>
<td>#2 cause (23%)  (CA)</td>
</tr>
<tr>
<td>Colon/rectum cancer incidence</td>
<td>40.0</td>
<td>38.7 (HP2020)</td>
</tr>
<tr>
<td>Prostate cancer incidence</td>
<td>148.3</td>
<td>136.4 (CA)</td>
</tr>
</tbody>
</table>

Source: National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11; California Department of Health Death Statistical Tables. 2013, Table 5-20.

What Else Contributes to Cancer?

- **Hepatitis B** is a risk factor for liver cancer, and Santa Clara County rates are nearly double California rates: 50.1 compared with 27.4 per 100,000.\(^{58}\)
- **Alcohol consumption** is a driver of cancer. In Santa Clara County 13% of adults report that they are heavy drinkers (consuming one or more drinks per day for women and two drinks or more for men).\(^{59}\)
- Poor **fruit and vegetable consumption** is related to some types of cancer. More than two thirds of adults (69%)\(^{60}\) and 60%\(^{61}\) of youth report inadequate fruit and vegetable consumption.

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\(^{57}\) California Department of Public Health, *Leading Causes of Death; California Counties and Selected City Health Department*, 2013.

\(^{58}\) Santa Clara County Public Health Department, *2014 Community Health Assessment*.


• **Cancer screening** can help prevent cancer and allow for intervention early enough to prevent death in some cases. Screening rates for breast cancer and colon cancer are better in Santa Clara County than in California.

• **Air quality** contributes to lung cancer. Air quality is good in Santa Clara County, with an average of 3.71% of days where particulate matter is 2.5 levels above the standard,\(^\text{62}\) which is better than California overall.

• **Tobacco use** also contributes to lung cancer. In Santa Clara County, rates of tobacco use are similar to that in California. Ten percent (10%) of Santa Clara County adults and 8% of youth smoke cigarettes.\(^\text{63}\)

### Who Is Most Affected?

• Whites, Blacks, Latinos, and Vietnamese are disproportionately affected by cancer as demonstrated by incidence and/or mortality rates. (See following charts.)

![Cancer Rates (Per 100,000) by Type](image)

![Adult Liver Cancer Incidence Rate by Ethnicity and Gender, 2007-2009](image)


Source: Santa Clara County Public Health Department Vietnamese Report. (2011). Rates are per 100,000 of the population. "Vtnm"=Vietnamese, "Pl"=Pacific Islander.

### Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified cancer as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit

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\(^\text{63}\) Santa Clara County Public Health Department, *Tobacco Use in Santa Clara County* 2014.
Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There Is a Problem?

Santa Clara County has high rates of tuberculosis (TB) and Hepatitis B compared to the state. Ethnic disparities are also seen in TB rates, with the rate for Asian and Pacific Islanders more than double that of the county overall. Influenza is the eighth leading cause of death in Santa Clara County.

Hepatitis B

- Santa Clara County Hepatitis B rates are nearly double those in California overall: 50.1 vs. 27.4 per 100,000.64
- Community participants expressed concern about the increased risk for liver cancer for Hepatitis B patients.
- Respondents also expressed concern about the lack of Hepatitis B screenings and the lack of systems for referrals, follow-ups, and screening of each patient’s contacts. This is especially concerning given the large county population of Asian immigrants from countries where Hepatitis B is common.

Tuberculosis (TB)

- 2013 tuberculosis rates (per 100,000) fail the Healthy People 2020 target, and ethnic disparities are prevalent. (See chart.)64
- In 2010, Vietnamese-born residents represented 26% of all county TB cases—the highest of any other country of birth.65
- An expert noted that TB screening is covered by insurance, but treatment is not. Participants also expressed concern about active TB patients who can’t be discharged because they lack a home environment where they can safely be isolated.

Other Communicable Disease Data

- Influenza was the eighth leading cause of death in 2013 (244 or 3% of deaths).66
- Ebola concerns: one professional indicated that some undocumented immigrants are concerned and fearful of accessing care because of the stigma of being diagnosed with Ebola, so they do not access care or delay access.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified communicable diseases as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community

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64 Santa Clara County Public Health Department, 2014 Community Health Assessment.
65 Santa Clara County Public Health Department, Status of Vietnamese Health 2011.
66 California Department of Public Health, Leading Causes of Death; California Counties and Selected City Health Department, 2013.
Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

Diabetes and obesity are related health conditions that are health needs in Santa Clara County in part because of the proportion of obese children younger than six, which is higher than California overall and the Healthy People 2020 target. As illustrated in the graph below, obesity rates for both Latino and Black adolescents and adults are worse than the state. While adult diabetes rates in Santa Clara County are no worse than in California, there is a perception in the community that childhood diabetes diagnoses are increasing. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption and soda consumption, as well as environmental factors; indicators of proximity of fast food establishments, a lack of grocery stores, and a lack of WIC-authorized food sources are all unfavorable compared to the state overall.

Obesity Data

- While the overall percentage of adolescents who are overweight or obese does not exceed the HP2020 benchmark (16%), Latino and Black adolescents are worse off (see chart).\(^67\)
- Overall, one in five adults are obese. By race/ethnicity, one in three Latinos and more than one in four Black adults are obese.\(^68\)
- One in four LGBTQ survey respondents is obese. Among the LGBTQ community, obesity is most common among lesbian, older, and Latino and White respondents.\(^69\)

Healthy Eating\(^67\)

- 60% of youth have inadequate fruit/vegetable consumption (worse than CA at 47%).

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\(^67\) University of Missouri, Center for Applied Research and Environmental Systems. Community Commons Data Platform.

\(^68\) Santa Clara County Public Health Department, 2014 Santa Clara County Community Health Assessment.

\(^69\) Santa Clara County Public Health Department, Status of LGBTQ Health: Santa Clara County 2013.
• Adults have higher rates of *inadequate* fruit/vegetable consumption (69%) than youth, but do better than CA (72%).

• While Santa Clara County residents are less likely to live in a food desert\(^{70}\) (10% compared with 14% in CA), they have slightly worse access to grocery stores than Californians (19 stores per 100,000 residents compared with 22 in California). Santa Clara County also has worse access to WIC-authorized food stores (9 stores per 100,000 compared to 16 in California).

• County residents have more access to fast food restaurants (79 per 100,000 people) than Californians overall (75). Thirty-eight percent (38%) report eating fast food weekly, with Latinos doing so most (47%) compared with other ethnic populations.\(^ {71}\)

• 97% of Santa Clara County infants born in the hospital were breastfed in the hospital. Breastfed infants are more likely to gain the right amount of weight as they grow rather than become overweight children.\(^ {72}\)

**Physical Activity**\(^ {57}\)

Santa Clara County indicators of physical activity are better than in California overall by these measures:

Percent physically *inactive* adults: 15%

\(^{70}\) Defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery store.

\(^{71}\) Santa Clara County Public Health Department, Behavioral Risk Factor Survey, 2013-2014.


**Profile of Santa Clara County Health Needs**

**DIABETES & OBESITY**

- Percent of adults who bike/walk to work: 3.7%
- Percent physically inactive youth: 25%
- Percent who live within a half mile of a park: 71%
- Number of fitness/recreation facilities per 100,000 residents: 12

- Percent of youth who bike/walk to school: 48%

**What Did the Community Say?**

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics. Diet and nutrition came up in four focus groups and in one key informant interview (with a diabetes expert). Their comments relate to:

- Lack of access to healthy food including high costs
- The need for improved nutrition and nutrition education in schools
- The need for education about the nutritional needs of infants

**Commitment to Improving Community Health**

In 2016, the Santa Clara County Community Benefit Coalition identified obesity and diabetes as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

Economic security is impacted by unemployment, poverty or low income, lack of education. By all extant measures, Santa Clara County residents fare better than Californians overall. However, in many of these categories, ethnic subpopulations are faring worse than the county overall and/or California.

- As seen in the graph below, in 2014, 32% of Latinos did not graduate from high school, compared to 18% of residents countywide.
- In terms of poverty, the graph shows that 10% of Santa Clara County residents live below the federal poverty level. However, the percentage living below the self-sufficiency standard\(^{73}\), which is a more comprehensive measure of poverty, is higher (23%). Please see profiles for Healthcare Access & Delivery and Housing & Homelessness for more specific information about affordability of those basic needs.

\(^{73}\) The Self-Sufficiency Standard for a family of four (two adults, one pre-schooler, one school-age child) in 2014 in California was $63,979. In Santa Clara County it was $81,774 for the same family size. (Not available for 2013.) [http://obamacarefacts.com/federal-poverty-level](http://obamacarefacts.com/federal-poverty-level).
What Did the Community Say?

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Residents feel stress about the cost of housing, food, and healthcare. They understand that this leads to poor health.
- Income inequality and the wage gap have an impact on access to basic needs. Having insufficient means for basic needs such as housing and food contributes to poor health outcomes.
- The cost of living in Santa Clara County, including the costs of housing and food, is high, leaving some with the question “Do I eat, or do I go to the doctor?”

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified economic security as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

**Heart Disease and Stroke** are responsible for 26% of deaths in Santa Clara County (making them the leading cause of death when combined). Rates of heart attack and stroke death show ethnic disparities. For example, the table below illustrates that the rate of heart disease deaths is considerably higher among Blacks and Whites than the county.

### HEART DISEASE AND STROKE DATA AND RELATED INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SCC</th>
<th>Benchmark</th>
<th>Notable Disparities</th>
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</thead>
<tbody>
<tr>
<td>Cause of death – heart</td>
<td>#2</td>
<td>#1 (CA)</td>
<td>Blacks: 149.2 Whites: 136.0</td>
</tr>
<tr>
<td>(21% of deaths)</td>
<td>(24% of deaths)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause of death – stroke</td>
<td>#3</td>
<td>#3 (CA)</td>
<td>Native Hawaiian/Pacific Islander: 73.88</td>
</tr>
<tr>
<td>(5% of deaths)</td>
<td>(5% of deaths)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease death rate</td>
<td>118.6</td>
<td>100.8 (HP2020)</td>
<td>Blacks: 149.2 Whites: 136.0</td>
</tr>
<tr>
<td>Stroke death rate</td>
<td>27.15</td>
<td>37.38 (CA)</td>
<td>Native Hawaiian/Pacific Islander: 73.88</td>
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<tr>
<td>Fast food</td>
<td>78.7</td>
<td>75.4 (CA)</td>
<td></td>
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<tr>
<td>Grocery Stores</td>
<td>19.0</td>
<td>21.59 (CA)</td>
<td></td>
</tr>
<tr>
<td>WIC</td>
<td>9.45</td>
<td>15.8 (CA)</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Percent of deaths: CDPH Death Records, Table 5-20. 2013. Death rates: Community Commons. Note: Red font indicates that the rate is higher than the benchmark. HP2020=Healthy People 2020.

- **Poor nutrition** is a driver of cerebrovascular diseases. Youth consumption of fruits and vegetables is worse in Santa Clara County compared with California. Compared with California overall, there are more fast food restaurants, fewer grocery stores, and fewer WIC-authorized stores per child in Santa Clara County.

- More than a quarter of Santa Clara County residents have been diagnosed with [high blood cholesterol](#) and/or [high blood pressure](#). (See chart on the following page.)

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*California Department of Public Health, Leading Causes of Death; California Counties and Selected City Health Department, 2013.*
Who is Most Affected?

- As shown in the chart, older residents and White residents are more likely to be diagnosed with high cholesterol than county residents overall. Blacks and older adults are more likely to be diagnosed with high blood pressure than county residents overall.

![Graph showing percent diagnosed with high blood cholesterol and high blood pressure, 2013-14](Source: Santa Clara County Public Health Department, Behavioral Risk Factor Survey, 2013-14.)

- At over 200 per 100,000, the rate of heart disease deaths is worst in the city of Gilroy, which also has the highest levels of poverty (over 50% living below 200% of the federal poverty level).^{75}

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified cerebrovascular disease as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

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^{75} U.S. Census Bureau, American Community Survey, 2009-13.
How Do We Know There is a Problem?

Housing is a health need because the lack of safe, stable housing is related to poor physical and mental health outcomes. Santa Clara County is one of the most expensive places to live in California, and the stress of affording housing can lead to poor mental health. When the lack of sufficient housing leads to homelessness, residents are at even greater risk for health problems. Housing and homelessness were top concerns among community focus group participants. Homelessness has increased in Gilroy, Mountain View, and Palo Alto. See the Economic Security profile for more details about income and unemployment.

Housing Data

- As shown in the graph below, rents increased significantly in the past five years in the San Jose-Sunnyvale-Santa Clara metropolitan area. Rents for a two-bedroom residence averaged $1,994 in the area in 2015, a 21% increase from 2013. In comparison, rents across all the metro areas in the state ranged from an average low of $758 to an average high of $2,289 for a two-bedroom residence in 2015.


- Of mortgage-holders, a higher proportion of Blacks and Latinos spend 30% or more of household income on housing (52% and 59% respectively) compared to Santa Clara County overall (45%) and California (46%).

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76 Santa Clara County Public Health Department, 2014 Community Health Assessment.
• Twenty-two percent (22%) of Latinos live in overcrowded households (defined as more than one person per room), compared with 8% of all Santa Clara County residents and 8% of Californians overall.76

How Homelessness Affects Health
According to the National Health Care for the Homeless Council, those experiencing homelessness are three to four times more likely to die prematurely than their housed counterparts and experience an average life expectancy as low as 41 years, which is significantly lower than the normal national life expectancy of 78.8 years. Those experiencing homelessness are at higher risk for contracting communicable diseases and being the victims of violence. Those who have common conditions such as high blood pressure, diabetes, and asthma do worse because they lack safe places to properly store medications or health supplies such as syringes. Of course, getting enough food is an issue, and getting healthy food is even more difficult. Those experiencing homelessness often develop depression or alcoholism during this time, and finding solutions to these problems is difficult. Recovering from injuries (such as accidents or those incurred during violent encounters) is more difficult due to the lack of regular bathing and difficulty keeping bandages clean and getting proper rest. Minor health issues such as cuts or common colds can easily develop into infections or pneumonia. Those experiencing homelessness often have co-occurring conditions of physical health problems, mental health disorders, substance use issues, and social problems.77

Homelessness Data 78
• The 2015 Point-in-Time count identified 6,556 homeless individuals in Santa Clara County. While this is the lowest number in over 10 years, more than 4,625 of those homeless individuals are unsheltered and living on the streets. San José has the largest number of unsheltered homeless individuals (2,810).

![NUMBER OF UNSHELTERED HOMELESS INDIVIDUALS, SELECTED JURISDICTIONS](image)


• As shown in the graph, there has been an increase in homelessness since 2013 in North County and South County, while decreases were observed in San Jose and the county overall.

• The most frequently cited obstacle to obtaining housing is the inability to afford rent (68%); more than half of homeless persons surveyed report that they have had no work or income.

What Did the Community Say?

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Five of eight focus groups discussed housing and/or homelessness.
- The lack of a stable home prevents homeless people from enrolling in health insurance and can be a barrier to getting care. For example, those who need chemotherapy or outpatient mental health/substance abuse treatment cannot access those services without a stable place to live.
- Lack of affordable senior housing and assisted living puts older adults at greater risk for homelessness, and is suspected to be a driver of the high suicide rate among older adults.
- People moving from residential mental health/substance abuse treatment or incarceration (for both youth and adults) need transitional housing.
- Some service providers perceive that clinicians have nowhere to discharge homeless patients, so they are kept in acute care or isolated beds if such are available. As an example, they cited instances when stable, active TB patients have not been discharged because they don’t have a home environment in which they can be isolated safely and recover.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified housing and homelessness as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

One in 10 children receive special education in Santa Clara County schools, which indicates that many children have been diagnosed with learning disabilities such as attention deficit disorder (ADD) and attention deficit-hyperactivity disorder (ADHD), or have been identified on the autism spectrum. While data are lacking about the prevalence of specific learning disabilities in the community, trend data show an increase in the proportion of students enrolled in special education, which indicates a growing need for support. The community expressed concern about the lack of diagnoses of learning disabilities and special needs among certain subpopulations.

- As shown in the chart below, the percentage of Santa Clara County children enrolled in special education classes has increased slightly between 2011 and 2015, but slightly slower than the increase in the state overall during that time. Between 2002 and 2011, the proportion in Santa Clara County was stable at about 9.5%. While this population includes those with emotional and physical disabilities (such as blindness), about 38% of those enrolled in special education have learning disabilities, similar to California (40%).

- ADHD affects 3-7% of American children and often continues into adulthood, making it the most common developmental disorder. Children with ADHD have an increased risk for antisocial disorders.

![Percent of Public School Children in Grades K-12 Receiving Special Education Services](chart.png)


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drug abuse, automobile accidents, and teenage pregnancy.\textsuperscript{80} The proportion of U.S. children ever diagnosed with ADHD increased from 7\% to 9\% from 1998–2000 through 2007–2009.\textsuperscript{81}

### What the Community Said

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Screening and diagnoses may be more lacking among those experiencing homelessness and immigrant children (especially those who enter the country unaccompanied).
- Services are lacking for parents with children who have learning disabilities. While support for some learning disabilities exists in the school system, many families rely on services from private practitioners to help them with managing behaviors at home, which is expensive.
- There is disagreement among professionals about the best ways to support and manage students with learning disabilities and their families.
- Most children with ADD/ADHD are treated with medication because this is offered through insurance, but there are very few insurance carriers that offer other forms of treatment to help the child such as in-home behavioral therapy and bio-feedback.

### Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified learning disabilities as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

\textsuperscript{80} Stanford Medicine, Center for Interdisciplinary Brain Sciences Research, \textit{Attention Deficit Hyperactivity Disorder (ADHD)}, 2016.

\textsuperscript{81} Centers for Disease Control and Prevention, \textit{Attention Deficit Hyperactivity Disorder Among Children Aged 5–17 Years in the United States, 1998–2009}, 2011.
How Do We Know There is a Problem?

In Santa Clara County, a majority of adults lack dental insurance. For those who have insurance, benefits and services can be expensive and insufficient. Moreover, one in three adults have had tooth loss in the county, a problem that is notably worse among the Black population. Lastly, although data indicate that there is no shortage of dental providers in the county, community participants reported the lack of access to dental care as a concern.

- Nearly two thirds (64%) of adults lack dental insurance. This includes older adults since Medicare does not include oral/dental health benefits.
- One in three adults have had tooth loss. Tooth loss statistics are worse for Black adults (49%).
- Almost half (44%) of adults aged 45-64 have had teeth removed due to tooth decay or gum loss.
- Youth dental care utilization rates (15%) are worse than the state (19%).
- More than seven in 10 adults (72%) visited the dentist annually, but Latino adults were less likely to have done so (59%).
- More than three fourths of children aged 1-11 (76%) visited the dentist in the last year. The lack of parental knowledge about dental cavities in children was a concern to some community members.
- Dental utilization rates for both adults and youth are better in the county than in California overall. However, almost one in five adults reported not having a recent dental exam.
What the Community Said

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- Both dental insurance and dental services are expensive.
- For those with insurance, benefits and services are still expensive, and they are insufficient (e.g., approved for tooth extraction only, or only one appointment when more care may be needed).
- Dental care is not provided at all community clinics.
- Dentures are difficult to obtain for people with Medi-Cal/Denti-Cal.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified oral and dental health as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

In Santa Clara County, Black and multiracial adults have a higher prevalence of asthma. Those earning between $50,000 and $75,000 also have higher rates of asthma than counterparts earning higher incomes. Although there are lower asthma hospitalization rates in Santa Clara County compared with California (CA), there are ethnic and geographical disparities. For example, Blacks are twice as likely as Whites to be hospitalized for asthma, as are those living in parts of East San Jose and North San Jose. The health need is likely being impacted by health behaviors, such as smoking at an early age, and by environmental factors, such as air quality levels. Asthma is also associated with obesity, which is a problem for Santa Clara County residents.

- Asthma hospitalization rates in Santa Clara County are better than CA (6.57 vs. 8.9).
- The proportion of adults ever diagnosed with asthma is the same as CA (14%) but disparities are seen in the county.
  - 22% among adults of two or more races
  - 19% among Black adults
  - 19% among youth 18 to 24
  - 25% among those with household incomes $50,000-$74,999 (worse than those with higher incomes)
  - 19% among foreign-born (worse than U.S.-born at 9%)
  - 24% among LGBTQ (worse than heterosexuals at 14%)
- Children aged 0 to 11 ever diagnosed: 7%
  - Boys are more likely to have been diagnosed with asthma than girls (10% as compared to 4%)

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified respiratory conditions as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

86 Santa Clara County Public Health Department, 2014 Community Health Assessment.
88 Due to the relatively small number of Black adults in the survey, the margin of error is high: 9.6% – 28.0%.

Data found in this health profile was collected during the 2016 Community Health Needs Assessment. The annual Community Benefit report describes in detail the investments made in the community, including programming and partnerships.
How Do We Know There is a Problem?

Data indicate that rates of sexually transmitted infections (STIs) and teen births in Santa Clara County are similar to California. However, disparities are pervasive and screening rates for HIV and other STIs are lower than the state. With regards to disparities, women are twice as likely to contract chlamydia, the most common STIs in Santa Clara County. The rate of teen births has been declining countywide, but remains six times higher for Latinas than their White counterparts. Finally, community feedback suggests that STIs are perceived as primarily affecting youth, the LGBTQ community, and single people, which could be driving lower screening rates.

Sexually Transmitted Infections

- The primary and secondary syphilis incidence rate is only slightly higher than the CA rate at 8.0 per 100,000, but the rate is 14.7 for Blacks and 8.2 for Latinos.  

- Women are twice as likely to contract chlamydia as men, at a rate of 422.3 per 100,000 compared to 203.7. Those aged 18-44 are much more likely to contract chlamydia than their older counterparts (715 per 100,000 compared to 51 for those aged 45-64).  

- While the HIV prevalence rate of 210 per 100,000 in Santa Clara County is better than CA overall (363), the rate for Blacks is five times that at 1,009 per 100,000. Rates for Latinos (300.9) and Whites (240.1) are better than the state rate but worse than the county overall.  

- Between 2006 and 2012, there was a steady reduction in the number of newly diagnosed HIV cases. See chart for data on new HIV diagnoses by ethnicity.

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89 Santa Clara County Public Health Department, 2014 Community Health Assessment.
90 US Department of Health & Human Services, Health Indicators Warehouse; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2010.
91 Santa Clara County Public Health Department, HIV/AIDS Epidemic in Santa Clara County 2012.
The number of people living with HIV/AIDS increased from 2,216 in 2003 to 3,342 in 2012. Nearly three quarters of the reported HIV cases in Santa Clara County were contracted through male-to-male sexual contact (MSM), including those who are both MSM and injection drug users. About one in five MSM respondents has never been tested for HIV.

More than four in 10 MSM respondents report never having being tested for syphilis. Approximately two thirds of transgender respondents have never been tested for syphilis.

Approximately two thirds of lesbian, half of bisexual, and half of transgender respondents have never been tested for chlamydia or gonorrhea.

Teen Births

The Santa Clara County teen birth rate (per 1,000 females aged 15-19) decreased from 24.6 in 2003 to 16.8 in 2012. However, the Latina teen birth rate (36.9 per 1,000 females aged 15-19) was more than twice as high as the Black teen birth rate (14.4) and six times higher than the White teen birth rate (6.3). With regards to geographic disparities, the teen birth rate is higher (over 12%) in the 95122 zip code of Southeast San Jose and 94303 in the east area of Palo Alto.

What Did the Community Say?

The section below presents community feedback related to sexual health that was gathered by the Santa Clara County Public Health Department for the 2013 LGBTQ Assessment (unless otherwise noted). ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

There is a perception that HIV transmissions are increasing. In fact, between 2006 and 2012, there was a steady reduction in the number of cases newly diagnosed.

Stereotypes persist about who is at risk for HIV and other STIs. Such stereotypes are a barrier to extending HIV and other STI testing to the broader community. Providers often do not associate certain groups with HIV risk, such as seniors, married men, and transgender men. Participants noted that these populations tend to “get forgotten” when it comes to HIV prevention and testing. For example, one participant observed, “There are misconceptions that Asians are not at risk for HIV because many are married.”

Community members expressed concern that stigma around having AIDS leads to fear of being tested.

There is a shortage of free and comprehensive HIV and other STI testing, as well as a lack of awareness about those services that do exist. Participants explained that testing for HIV and other STIs is generally separate. One community member shared, “Normally, gay men go out of the county to San Francisco to get a one-stop shop service.” Community members also raised concerns about confidentiality and anonymity of testing, noting fears that providers may share test results with clients’ family members and partners.

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92 Santa Clara County Public Health Department, Status of LGBTQ Health: Santa Clara County 2013.
93 Santa Clara County Public Health Department, Maternal, Infant, and Child Health Brief Santa Clara County, 2014.
Regarding teen pregnancy, CHNA youth focus group participants cited lack of access to free condoms as a driver.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified sexual health as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.
How Do We Know There is a Problem?

Although Santa Clara County residents are less likely to be smokers, there are ethnic disparities in the prevalence of smoking.

Smoking Data

- As shown in the graph below, only 10% of county residents are current smokers, which is lower than the Healthy People 2020 target of 12%. Men are more likely to smoke than women (13% compared to 7%), and Filipinos have the highest smoking prevalence (21%) of all racial and ethnic groups.

- Adult smoking by ethnicity ranges from 6% (multiracial) to 12% (Whites). Specifically among Asian adults, 15% of Vietnamese adults use tobacco.\(^{95,96}\)

\(^{95}\) Santa Clara County Public Health Department, Behavioral Risk Factor Survey, 2013-2014.
\(^{96}\) Results for Blacks not reported due to small sample size.
• Among men, Vietnamese (24%) and Filipinos (32%) are more likely to smoke than men of other ethnicities.\textsuperscript{97}
• Specifically among Latinos, those who were foreign-born are much more likely to smoke (16%) than those born in the U.S. (6%).\textsuperscript{3}
• Latino (12%) and Black (11%) adolescents are disproportionately more likely to smoke than teens overall (8%); smoking among both these groups as well as Asian/PI youth rose between 2005 and 2010.\textsuperscript{3}

What the Community Said

ASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

• The Santa Clara County Public Health Officer noted that tobacco use is one of the unmet health needs in the county.
• There is a lack of education about tobacco prevention in schools.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified tobacco use as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

\textsuperscript{97} Santa Clara County Public Health Department, \textit{Tobacco Use in Santa Clara County 2014}. 
How Do We Know There is a Problem?

In Santa Clara County, 5% of deaths are due to accidental (unintentional) injuries, higher than the state (4%). The percentage is higher for Latino residents (7%) than the county overall.\(^98\)

Falls

- The rate of 7.7 unintentional falls deaths in Santa Clara County per 100,000 people slightly exceeds the HP2020 maximum of 7.0 per 100,000 people.\(^99\)

- The annual economic cost of falls among adults aged 65 and older includes medical costs and work loss due to emergency department visits, hospitalizations, and deaths. In 2013 these costs amounted to more than $265 million in Santa Clara County.\(^100\)

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Hospitalizations</th>
<th>ED visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Annual Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Santa Clara County</td>
<td>3,028</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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<td>Female</td>
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<td>Age Group</td>
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<tr>
<td>65-74</td>
<td>605</td>
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<td>75-84</td>
<td>1,108</td>
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<td>Race/Ethnicity</td>
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<tr>
<td>African American</td>
<td>38</td>
<td>1</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>501</td>
<td>17</td>
</tr>
<tr>
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<td>332</td>
<td>11</td>
</tr>
<tr>
<td>White</td>
<td>2,063</td>
<td>68</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Public Health Department, Santa Clara County: Unintentional Falls Among Older Adults, 2015. Note: Red font indicates that the rate is higher than the county overall.

\(^{98}\) Santa Clara County Public Health Department, 2014 Community Health Assessment.
\(^{100}\) Santa Clara County Public Health Department, Santa Clara County: Unintentional Falls Among Older Adults, 2015.
Drownings\textsuperscript{37}

- The rate of 0.9 deaths from unintentional drowning in Santa Clara County per 100,000 people meets the Healthy People 2020 objective of 1.1 per 100,000.
- The adult drowning rate for those aged 24 and older is 1.2—slightly higher than the state average (1.1) for the same age group. The rate of drownings for those under age 24 (0.2) does not exceed the state average (0.9) for the same age group.

Pedestrian Accidents

- Santa Clara County’s rate of 1.5 deaths per 100,000 from pedestrian accidents slightly exceeds the Healthy People 2020 objective of 1.3, and the rates are higher among Latinos (2.2) and Asians (1.6).\textsuperscript{101}

What the Community Said

CASR gathered community input for the 2016 Community Health Needs Assessment. This section presents community perceptions. ASR asked community members to share about their experiences and observations, and their comments are not necessarily based on data or statistics.

- The community indicated that the older adult population has issues related to frailty and higher susceptibility for accidents and falls.

Commitment to Improving Community Health

In 2016, the Santa Clara County Community Benefit Coalition identified unintentional injuries as one of the top health needs in the county based on statistical data and community input. The Santa Clara County Community Benefit Coalition works to improve community health through its partnerships among hospitals, county agencies, and community organizations.

\textsuperscript{101} University of Missouri, Center for Applied Research and Environmental Systems; California Department of Public Health, \textit{Death Public Use Data}, 2010-12.
How Do We Know There is a Problem?

Statistical data from 2012 show that violent crime rates (per 100,000) in Santa Clara County (SCC) are mostly better than California (CA). However, Latinos and Blacks are more likely to die due to homicide (including domestic violence) than their counterparts. The community also expressed concern about violence as a health need.

### VIOLENCE DATA IN SANTA CLARA COUNTY COMPARED TO THE STATE

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SCC</th>
<th>SCC Disparities</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall violent crime rate(^{102}) (per 100,000 population)</td>
<td>262.1</td>
<td>N/A</td>
<td>425.0</td>
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<tr>
<td>Rape rate(^{1}) (per 100,000 population)</td>
<td>21.1</td>
<td>N/A</td>
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</tr>
<tr>
<td>School suspensions rate(^{1}) (per 100 students)</td>
<td>2.53</td>
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<td>School expulsion rate(^{1}) (per 100 students)</td>
<td>0.05</td>
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</tr>
<tr>
<td>Adult homicide mortality rate(^{1}) (per 100,000 population)</td>
<td>2.8</td>
<td>Latino: 5.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Domestic violence mortality rate(^{103}) (per 100,000 population)</td>
<td>6.5</td>
<td>Latino: 10.7(^{104})</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Ethnic disparities in mortality rates due to homicide or domestic violence are of concern.
- Santa Clara County fares no better than the state with regard to the rate of school expulsions (both 0.05). Exclusionary school discipline policies, including suspensions and expulsions, are associated with poorer outcomes, such as lower educational attainment, higher dropout rates, engagement with the

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\(^{102}\) University of Missouri, Center for Applied Research and Environmental Systems. Community Commons Data Platform.

\(^{103}\) Santa Clara County Public Health Department. 2014. *Santa Clara County Community Health Assessment.*

\(^{104}\) Statistical data rates for black victims not available due to the small number of cases.
Data found in this health profile was collected during the 2016 Community Health Needs Assessment. The annual Community Benefit report describes in detail the investments made in the community, including programming and partnerships.