El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2019 Community Health Needs Assessment

June 2019

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1. Executive Summary

BACKGROUND

The Santa Clara County Community Benefit Hospital Coalition ("the Coalition") is a group of organizations that includes seven nonprofit hospitals, the Hospital Council of Northern and Central California (a nonprofit hospital and health system trade association), the Santa Clara County Public Health Department and the Palo Alto Medical Foundation (a nonprofit multi-specialty group). The Coalition formed in 1995 for the purpose of identifying and addressing critical health needs of the community. Since then, the Coalition's members have worked together to conduct an extensive triennial Community Health Needs Assessment (CHNA) in compliance with current federal requirements. The 2019 CHNA builds upon those earlier assessments.

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

With this assessment, the Coalition uses data to identify health trends and continues to address critical health needs. Individually and collectively, Coalition members will develop strategies to tackle these needs and to improve the health and well-being of community members. As with prior CHNAs, this assessment also highlights Santa Clara County's assets and resources. (*See Attachment 4: Community Assets and Resources.*)

Available to the public, the 2019 CHNA report serves as a tool for guiding policy and program planning efforts. For Coalition member hospitals, it also supports developing Community Benefit Plans pursuant to California State Senate Bill 697 and meeting IRS requirements for Community Health Needs Assessment and Implementation Strategies pursuant to the Affordable Care Act of 2010.

PROCESS AND METHODS

The Coalition began the 2019 CHNA process in the fall of 2017. The collective goal for the assessment was to gather community feedback and existing data about local health needs to inform how each member hospital selects specific issues to address with Community Benefit in its service area. The Coalition engaged Actionable Insights, a local consulting firm with expertise in community health needs assessments.

Between January and May 2018, community feedback was gathered through interviews with eight local experts and discussions with eight focus groups. The experts were individually asked to: identify and discuss the top needs of their constituencies, including barriers to health; give their perceptions of access to healthcare and mental health needs; and share which solutions may improve health (such as services and policies).

The focus group discussions centered around five questions, which were modified appropriately for each audience:

- What are the most important health needs that you see in Santa Clara County? Which are the most pressing among the community? How are the needs changing?
- What drivers or barriers are impacting the top health needs?
- To what extent is healthcare access a need in the community? If certain groups are identified as having less access than others, what are the barriers for them?
- To what extent is mental health a need in the community? How do mental health challenges affect physical health?
- What policies or resources are needed to impact health needs?

The focus groups comprised local residents and people who serve them. Participants included professionals in the fields representing low-income, minority, and/or medically underserved populations in the community.

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

DEFINITIONS

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

Health driver: A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes.

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

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

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

Health needs described in this report fall into three categories, as described in the Definitions chart on the previous page:

- Health condition
- Health driver
- Health outcome

El Camino Hospital generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which were filtered using the following criteria:

1. Must fit the definition of a "health need" (*See Definitions box, page 7*)
2. Is suggested or confirmed by more than one source of secondary and/or primary data
3. Meets qualitative threshold:
   (a) Two of eight key informants identified the need, or
   (b) The community prioritized it over other health issues in at least two of eight focus groups

In addition, available statistical data for some health needs failed benchmarks by 5 percent or more. The benchmarks used for comparison came from Healthy People 2020 or, when unavailable, the California state average. These data are described in the summary descriptions of the health needs below.

HEALTH NEEDS

The 2019 community health needs were mapped to three priority areas: Healthy Body, Healthy Mind and Healthy Community. Each need is also presented in alphabetical order in this section. Rates are per 100,000 unless otherwise specified.

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

- Behavioral Health
- Cognitive Decline

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

Health Need	Justification
Access and Delivery	• Healthcare access and delivery was identified as a top health need by half of focus groups and key informants. • The community expressed concern that healthcare is unaffordable, especially for people who do not receive health insurance subsidies, such as undocumented immigrants. • Approximately one in every 13 people (8 percent) is uninsured countywide.[1] • The community expressed concern about the ability of older adults to pay for healthcare (including long-term care) if they are not eligible for Medi-Cal. • Meets quantitative threshold. (*See #3 on page 8*) • Two in 10 Santa Clara County residents speaks limited English, which can restrict healthcare access. • The county's rate of Federally Qualified Health Centers and access to mental-health care fall below state averages. • Health clinic professionals expressed concern about attracting and retaining talent (especially bilingual staff) in the healthcare sector due to the high cost of living in the Bay Area.

[1] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016.

Health Need	Justification
Behavioral Health (including mental health and substance use)	• Behavioral Health ranked high as a health need, with the community prioritizing it in more than two-thirds of discussions. • The co-occurrence of mental health and substance use emerged as a common theme. • The community expressed concern about a lack of services for behavioral health, including preventive mental-health care and detox centers. • Professionals who work in behavioral health described experiencing challenges with health systems that were established to serve people with these conditions. • LGBTQ residents expressed a need for mental health and suicide prevention assistance. • Meets quantitative threshold. (*See #3 on page 8.*) • Disparities in Santa Clara County include: - Hospitalization rates for attempted suicide are 73 percent higher among females than males, whereas men nationwide are 3.5 times more likely than women to commit suicide. - Adult men are more likely to binge drink than women, but adolescent females are more likely to binge drink (15 percent) than adolescent males (13 percent). - 21 percent of Latinx adults binge drink, compared to 15 percent of Whites and 8 percent of other ethnic groups. - Adults of White or Latinx ancestry are most likely to use marijuana (12 percent and 13 percent, respectively).
Cognitive Decline (including dementia)	• Cognitive decline was mentioned in half of focus groups and two interviews with experts. • One in nine Californians is experiencing subjective cognitive decline. • The median age in Santa Clara County (36.8 years) is higher than the median age of California (35.8). • The county death rate due to Alzheimer's disease (35.9 per 100,000) is nineteen percent higher than the state's rate (30.1). • Community said that serving individuals who are cognitively impaired is difficult for providers. • Professionals who serve people experiencing chronic

Health Need	Justification
	homelessness and abusing substances report cases of early dementia and increased difficulty with treating and housing people with these impairments. • Community expressed concern about the ability of older adults to pay for healthcare, including long-term care, if not Medi-Cal eligible. • Professionals rely on family members to coordinate care for their loved ones, which can affect the health, well-being, and economic stability of those family members.
Diabetes/ Obesity	• Diabetes/Obesity was identified as a top health need in half of key informant interviews and one-third of focus groups. • The community discussed factors that contribute to diabetes and obesity, such as the built environment, stress and poverty. • The county has a significantly higher proportion of fast-food restaurants (86.7 per 100,000) than California overall (78.7). • Santa Clara County has lower proportions of grocery and WIC-authorized[2] stores to residents than state benchmarks. For example, there are 9.5 WIC-authorized stores per 100,000 residents in the county compared to 15.8 in the state overall. • Diabetes prevalence is higher in Santa Clara County (9.8 percent) than in California overall (9.1 percent) — and trending up both locally and statewide. • A significant number of LGBTQ survey respondents report being overweight or obese. • 28 percent of youth are physically inactive. • Disparities in Santa Clara County include: - Males are almost twice as likely as females to be obese (18 percent compared to 10 percent). - Although obesity rates overall do not fail benchmarks, the overweight and obesity rates among Latinx youth (about 20 percent each) are significantly higher than state averages

[2] The Women, Infants and Children (WIC) Program is a federally funded health and nutrition program that provides assistance to pregnant women, new mothers, and children aged 0–5. The California Department of Public Health approves the grocers and other vendors statewide who accept program vouchers. https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx

Health Need	Justification
	(about 17 percent), possibly driven by physical inactivity (42 percent). - Being overweight or obese is also a problem among youth who identify as Pacific Islanders (about 25 percent each). - African ancestry[3] youth have higher rates of physical inactivity (33 percent) and inadequate fruit and vegetable consumption (73 percent) than the state benchmarks (38 percent and 47 percent, respectively).
Economic Security (including food security and education)	• Economic security was identified as a top health need by one-third of focus groups and key informants. • Meets quantitative threshold (see #3 on page 8). • The very high cost of living in Santa Clara County and concern about the low-income population emerged as common themes of community input. • The 2018 Self-Sufficiency Standard for a family of two adults, one infant, and one preschool-aged child is over $120,600, which is more than four times higher than the 2018 Federal Poverty Level ($25,100). • Almost four in 10 people in Santa Clara County experiencing food insecurity do not qualify for federal food assistance because of their household incomes. (This includes 46 percent of all food-insecure children.) • The cost of long-term care for older adults with fixed incomes who are ineligible for Medi-Cal is a concern of the community. • Cost of mental health care is also difficult for middle-income parents according to focus group participants. • Economic security is crucial to stable housing. (*See Housing and Homelessness health need description on page 13.*) • Disparities in Santa Clara County include: - The rates of poverty among residents of African ancestry and Other[4] races fail benchmarks.

[3] African ancestry refers to all people of African descent, whether they are recent immigrants or have been in the U.S. for generations. This term is in keeping with a 2015 report by the Black Leadership Kitchen Cabinet of Silicon Valley, in conjunction with the Santa Clara Public Health Department. See http://blkc.org for the full report. Many original data sources alternately use the category Black/African-American or African-American.
[4] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

Health Need	Justification
	- One in four Latinx households and more than one in 10 African ancestry households received food from a food bank in recent years. - More than nine in 10 (93 percent) White high school students graduate, while only seven in 10 Latinx and Native American students graduate. Almost eight in 10 African ancestry students graduate. - Fourth-grade reading proficiency is a predictor of high school graduation.[5] About 27 percent of White fourth-grade students are reading below proficiency. This proportion is significantly worse for other children: African ancestry (60 percent), Latinx (67 percent), Pacific Islander (61 percent) and Native American ancestry (58 percent).
Housing and Homelessness	• Housing and Homelessness was identified as a top health need by more than half of focus groups and key informants. • The community described stress about the high costs of housing and the lack of affordable rent as a major priority. • Professionals who serve families report an increase in families seeking help from food banks and making difficult choices about how to spend remaining funds (healthy food, medicine, doctor visits, therapeutic services). • The community reports that families often move to a different home or leave the area due to the increased cost of living. • The 2018 Santa Clara County Self-Sufficiency Standard indicates that a family of two adults, one infant, and one preschool-aged child requires $120,600 in annual income to be self-sufficient. • There are approximately 7,400 people experiencing homelessness in the county (15 percent of whom are aged 0–17), which is the highest number since 2013. • In Mountain View, the number of people experiencing homelessness (416) increased 51 percent since 2015.

[5] The Campaign for Grade-Level Reading (https://gradelevelreading.net) and Reading Partners (https://readingpartners.org/blog/why-reading-by-fourth-grade-matters-for-student-success/)

Health Need	Justification
Oral/Dental Health	• Oral/Dental Health was identified as a top health need in two interviews and one focus group. • There is a perceived lack of access to dental insurance in the community. • More than one-third of adults in Santa Clara County do not have dental insurance. • Nearly one-third (30 percent) of county children aged 2–11 have not had a recent dental exam, which is 61 percent worse than the state. The rates were the worst among White (31 percent) and Latinx (52 percent) children. • More than half of residents of African, Asian and Latinx ancestry have had dental decay or gum disease, which is worse than the county overall (45 percent).

The data also support continuing El Camino Hospital's work to address two health needs in which it has specific expertise: chronic conditions and violence/injury prevention.

Health Need	Justification
Chronic Conditions (other than Diabetes/ Obesity)	• Health conditions such as cardiovascular disease, cancer and respiratory problems are among the top 10 causes of death in the service area. • The proportion of hospitalization discharges due to asthma for children, youth and older adults are all higher than the state. • The county's prostate cancer incidence rate (127.3) is significantly higher than that of the state (109.2). • Disparities in chronic conditions in Santa Clara County include: - Cancer incidence and mortality rates for various cancer sites are higher for African ancestry and White residents than for those of other ethnicities. For example, overall incidence of cancer is 22 percent higher for African ancestry residents than the county overall, and 51 percent higher than Asian residents. Also, overall cancer mortality for African ancestry residents is 71 percent higher than in than the county overall, and 67 percent higher than Asian residents.

Health Need	Justification
	- African ancestry residents are hospitalized for asthma at a rate (1.7 percent) that is disproportionately higher than the rates for residents of other ethnicities (all of which are below 1 percent, such as 0.7 percent for White residents).
Violence and Injury Prevention	• Violence is a major driver of poor behavioral health. Preventing violence in the service area will affect behavioral health. • The rate of rape (22.8 per 100,000 people) in Santa Clara County is 8.5 percent higher than the state rate (21.0). • Preventable unintentional injuries are a leading cause of death in the county (5 percent of all deaths) and the state (4 percent). • 67 percent of all unintentional injury deaths are due to senior falls. This is higher compared to deaths due to accidental falls among the total population (31 percent). • Disparities in violence and injury in the county include: - The mortality rate (43.0 deaths per 100,000 people) from all unintentional injuries is highest for African ancestry residents. - Community safety data — including homicides, violent assault, youth assault and self-harm, and school suspensions and expulsions — are all higher for Latinxs and African ancestry residents than for those of other ethnicities.

KEY TAKEAWAYS

The community health needs identified in Santa Clara County during the 2019 assessment were the same as those identified in 2016. However, the 2019 CHNA also revealed new or increased concerns related to housing insecurity, mental health, access to healthcare, and diabetes prevalence.

The Coalition conducted a robust assessment to meet state and federal requirements and to identify community health needs. The 2019 CHNA findings in this report reflect hundreds of statistical data points, interviews with local health experts, and conversations with community members and service providers representing some of the Santa Clara County's most vulnerable populations. It provides a clear picture of how the community prioritizes its current health needs.

Housing Insecurity and **Mental Health:** A common theme of the community's input was that housing insecurity is a driver of poor mental health. Focus group

participants and key informants said community members are enduring unsafe or unhealthy housing conditions because some tenants fear that asking their landlords to remedy such conditions will result in eviction and homelessness. They also noted that families are moving out of the area because of the high cost of living and, in many cases, commuting longer distances to work. The stress and disruption of family connections due to relocation can negatively affect mental health, they added. Service providers who help community members find housing emphasized that people with mental health issues need supportive arrangements, yet there may be less tolerance for these individuals in the current rental market, which favors property owners.

Access to Healthcare: The Coalition has focused on access to healthcare in every CHNA because access is crucial to improving the health of community members, in terms of both prevention and intervention. The Affordable Care Act and subsequent Medi-Cal expansion provided more opportunities for people to obtain health insurance. In the 2019 CHNA, the Coalition explored whether improved access to care was making a difference. It found that healthcare access remains a concern, particularly the difficulty of navigating health systems and the shortage of healthcare providers, which can make it challenging for patients to get appointments, especially for specialty care.

As in 2016, community members in 2019 described the struggle to afford healthcare, even with Covered California options. The costs of copays and medicines still concern many people, including those who have health insurance. In the 2019 CHNA, focus group participants and key informants worried about the health needs of immigrants in Santa Clara County, including: a lack of health insurance among immigrants without legal resident status, a reluctance among immigrants to use services for which they qualify, for fear of deportation (because of reports that Immigration and Customs Enforcement targets people in public places) and concerns about being deemed a "public charge" for accessing services (which may negatively affect their immigration status). Medical professionals reported an increase in no-shows for appointments among the immigrant population.

Diabetes Prevalence: The Coalition has long focused on the rising trends in obesity. Data show that 17 percent of Santa Clara County residents are obese, a proportion that has increased incrementally every year since 2010 (when it was 15 percent).[6] In the 2019 CHNA, the Coalition found that diabetes is also increasing across California. In Santa Clara County, almost 10 percent of adults have been diagnosed with diabetes[7] and 36

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[6] UCLA Center for Health Policy Research, AskCHIS 2007–2016. Santa Clara County Public Health Department.
[7] UCLA Center for Health Policy Research, AskCHIS 2015. Santa Clara County Public Health Department.

percent have been diagnosed with pre-diabetes.[8] Although updated statistics on childhood diabetes rates were unavailable, community health experts indicated that the number of overweight children being diagnosed with pre-diabetes is on the rise.

NEXT STEPS

After making this CHNA report publicly available by June 30, 2019, El Camino Hospital will solicit feedback and comments through its website's contact form. Community input will be collected until two subsequent CHNA reports have been posted to the Community Benefit page of its website.[9] The hospital will also develop a Plan and Implementation Strategy (based on the 2019 CHNA results).

[8] Santa Clara County Public Health Department. Retrieved from https://arcg.is/1mTHbu, April 2019.
[9] https://www.elcaminohospital.org/about-us/community-benefit

2. Background

The Santa Clara County Community Benefit Hospital Coalition ("the Coalition") is a group of organizations that includes seven nonprofit hospitals, the Hospital Council of Northern and Central California (a nonprofit hospital and health system trade association), the Santa Clara County Public Health Department, and the Palo Alto Medical Foundation (a nonprofit multispecialty group). The Coalition formed in 1995 for the purpose of identifying and addressing critical health needs of the community. Every three years since then, the Coalition's members have worked together to conduct an extensive Community Health Needs Assessment (CHNA). The 2019 CHNA builds upon those earlier assessments.

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

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

CHNA PURPOSE AND ACA REQUIREMENTS

In 2018–2019, the hospital conducted an extensive community health needs assessment (CHNA) for the purpose of identifying critical health needs of the community. The 2019 CHNA will also serve to assist the hospital in meeting IRS CHNA requirements pursuant to the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA, which was enacted on March 23, 2010, includes requirements for nonprofit hospitals that wish to maintain their tax-exempt status. Regulations finalized December 31, 2014, also provided guidance related to section 501(r) of the Internal Revenue Code. These regulations mandate all nonprofit hospitals to conduct a CHNA and develop and adopt

an implementation strategy every three years.[10] The CHNA must be conducted by the last day of a hospital's taxable year.

The CHNA process, completed in 2019 and described in this report, was conducted in compliance with current federal requirements. This CHNA report documents how the assessment was conducted, including the community served, who was involved in the assessment, the process and methods used, and the community's significant health needs that were identified and prioritized as a result of the assessment. The 2019 assessment includes input from local residents and experts in public health, clinical care and others.

Available to the public, the 2019 CHNA serves as a tool for guiding policy and program planning efforts. For Coalition member hospitals, it also serves to assist in developing Community Benefit Plans pursuant to California State Senate Bill (SB) 697.

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

The 2019 CHNA meets both State of California (SB 697) and federal (IRS) requirements mandated by the ACA.

BRIEF SUMMARY OF 2016 CHNA

In 2016, the hospital participated in a collaborative process to identify significant community health needs and meet state and federal requirements. The 2016 CHNA is posted on El Camino Health's public website.[11]

The health needs that were identified and prioritized through the 2016 CHNA process are listed below in order of priority:

1. Economic Security
2. Obesity and Diabetes
3. Housing
4. Behavioral Health

[10] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf
[11] https://www.elcaminohospital.org/sites/ech/files/2016-Community-Health-Needs-Assessment-20160615.pdf

5. Access and Delivery
6. Oral and Dental Health
7. Cardiovascular (Heart) and Cerebrovascular (Stroke) Diseases
8. Hypertension
9. Tobacco Use
10. Violence and Abuse
11. Cancer
12. Birth Outcomes
13. Alzheimer's Disease and Dementia
14. Communicable Diseases
15. Unintentional Injuries
16. Learning Disabilities
17. Respiratory Conditions
18. Sexual Health

For the 2019 CHNA, the hospital coalition built upon existing work by starting with a list of previously identified health needs. Updated secondary data were collected for these health needs, and community input was used to add health needs to the list and to delve deeper into questions about healthcare access, delivery, barriers to care and solutions. The CHNA team also specifically sought to understand mental health needs in the community.

WRITTEN PUBLIC COMMENTS ON 2016 CHNA

To offer the public a means to provide written input on the 2016 CHNA, the hospital maintains a Community Benefit page on its website,[12] where it posts reports and provides an online contact form. This venue will allow for continued public comments on the 2019 CHNA report.

At the time this CHNA report was completed, El Camino Health had not received written comments about the 2016 CHNA report. The hospital will continue to track any submissions made and will ensure that all relevant comments are reviewed and addressed by appropriate staff.

[12] https://www.elcaminohospital.org/about-us/community-benefit

3. About El Camino Hospital

El Camino Health includes two nonprofit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care and primary care locations across Santa Clara County. Hospital key medical specialties include cancer, heart and vascular, lifestyle medicine, men's health, mental health and addictions, lung, mother-baby, orthopedic and spine, stroke and urology. Affiliated partners include Silicon Valley Medical Development, El Camino Health Foundation and Concern. Mission

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.

HISTORY IN BRIEF

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

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

In 2006, after the second groundbreaking event in El Camino Hospital's history, construction began on the new seismically compliant main hospital building at the Mountain View campus. Three years later, the state-of-the-art hospital in Mountain View opened on November 15, 2009.

In 2008, the hospital acquired the assets of the former Community Hospital of Los Gatos. The former owners closed the hospital in April 2009, but a fully renovated and staffed Los Gatos Hospital reopened that July. The 143-bed hospital continues to offer

full-service, acute care to residents of Los Gatos and surrounding communities, just as it had been doing since it opened in 1962.

Silicon Valley Medical Development LLC, an affiliate of El Camino Hospital, aspires to elevate the healthcare experience – beyond healing – for the communities we serve. Through physician partnerships, we provide our patients with healthcare options that fit their lifestyle. Urgent care, primary care and specialty care services are provided at 11 locations across Santa Clara County.

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

SPECIALTY CARE AND INNOVATIONS

El Camino 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. The hospital 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.

Medical Conditions Treated and Services Provided at El Camino Hospital

Fiscal Year 2018 Cases by Service	Total Number of Cases	% of Total
Behavioral Health	4,250	2.4
Emergency	49,417	28.5
General Medicine	12,070	7.0
General Surgery	3,311	1.9
GYN	1,338	0.8
Heart and Vascular	6,738	3.9
Imaging Services	18,509	10.7
Laboratory Services	28,568	16.5
MCH	15,125	8.7
Neurosciences	984	0.6
Oncology	19,908	11.5
Orthopedics	2,348	1.4
Other	513	0.3
Outpatient Clinics	1,890	1.1
Rehab Services	5,369	3.1
Sleep Center	211	0.1
Spine Surgery	685	0.4
Urology	2,307	1.3
GRAND TOTAL	173,541	100.0

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 expertise in

understanding health disparities in local cities, as well as organizations with similar missions. 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 to organizations that demonstrate an ability to impact the health needs of vulnerable, 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 comprises an El Camino Hospital Board Liaison, 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 the Community Benefit Annual Report to inform the community about Community Benefit Program financials, the grant programs and how these funded services improve the health of vulnerable populations both through direct services and prevention initiatives.[13]

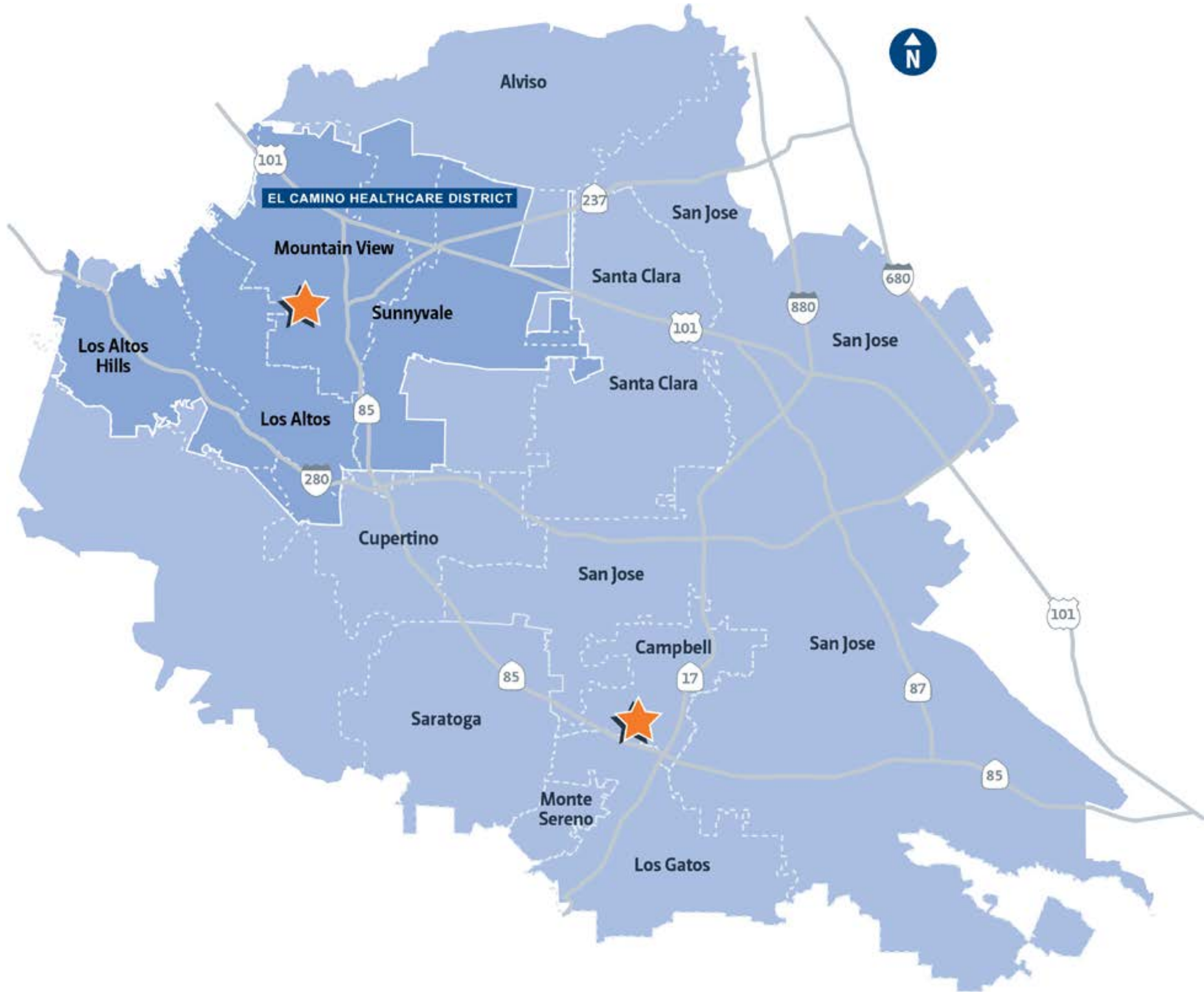
DEMOGRAPHIC PROFILE OF COMMUNITY SERVED

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

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

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

MAP OF SERVICE AREA



Orange stars represent El Camino Hospital campuses.

SANTA CLARA COUNTY

Santa Clara County is one of nine counties in the San Francisco Bay Area. The 2017 estimated population was 1.94 million people, making it the sixth largest county in California. San Jose is the largest city in the county with more than 1.03 million residents (or 53 percent of the population).

Nearly 17 percent of the population in Santa Clara County is under the age of 18, and 12 percent is 65 years or older. The median age is 36.8 years. Santa Clara County is also

very diverse. Notably, people of "some other race"[14] make up the third largest racial group behind White and Asian, respectively, accounting for 11 percent of the population. Nearly 5 percent of the population is of two or more races. More than one quarter (26 percent) of residents have Latinx heritage.

RACE/ETHNICITY IN SANTA CLARA COUNTY

Race/Ethnicity	Total % of County (Race Alone)	Total % of County (Alone or in Combination with Other Races)*
White	46.9	50.8
Asian	34.4	37.2
Latinx (Any Race)	—	26.3
Some Other Race	10.6	11.7
Two or More Races	—	4.8
Black/African Ancestry	2.5	3.4
American Indian/Alaskan Native	0.5	1.3
Native Hawaiian/Pacific Islander	0.4	0.8

* Percentages do not total 100 percent because they overlap.
Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016.

Nearly four in 10 (38 percent) people in Santa Clara County were born outside the United States. This percentage is higher than the foreign-born populations statewide (27 percent) and nationwide (13 percent). In Santa Clara County, two-thirds (67 percent) of the Asian/Pacific Islander population and more than one-third (35 percent) of Latinxs are foreign-born. This compares with 15 percent of White residents and 17 percent of African ancestry residents.[15]

About one in 10 (11 percent) foreign-born residents in Santa Clara County is a recent immigrant, having arrived in the U.S. in 2010 or later. This includes 13 percent of the

[14] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.
[15] U.S. Census Bureau; 2011–2015 American Community Survey 5-Year Estimates, Selected Population Tables, Tables DP02; generated by Baath M. (Santa Clara County Public Health Department) using American FactFinder.

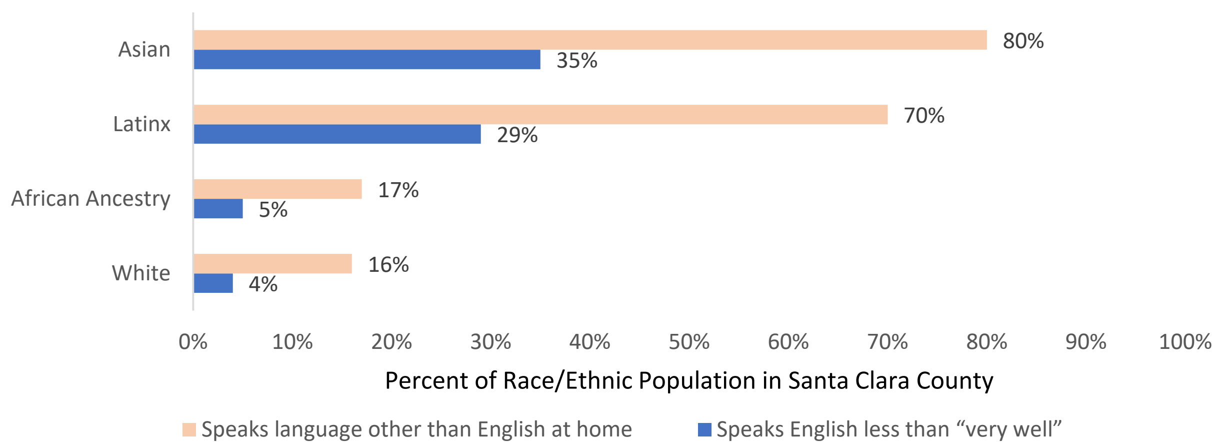
foreign-born Asian/Pacific Islander population. Among the Asian/Pacific Islander population, the subgroups with the highest proportions of foreign-born residents are Asian Indian (73 percent), Korean (71 percent) and Vietnamese (70 percent). Among foreign-born residents of Santa Clara County, the Asian Indian and Japanese subgroups are most likely (21 percent), and Latinxs are least likely (4 percent), to be recent immigrants. This compares with 15 percent of White residents and 13 percent of African ancestry residents who are foreign-born.

LANGUAGES SPOKEN AND LANGUAGE PROFICIENCY

Santa Clara County residents in total speak more than 100 languages and dialects. More than half (52 percent) of the population in the county speaks a language other than English at home. This percentage is higher than the state average (44 percent).

More than one in five (21 percent) county residents say that they do not speak English "very well," which exceeds the state benchmark (19 percent). In Santa Clara County, Asian/Pacific Islanders represent the highest percentage (80 percent) of people who speak a language other than English at home, followed by Latinxs (70 percent), residents of African ancestry (17 percent), and Whites (15 percent). Similarly, Asian/Pacific Islanders aged 5 and older represent the highest percentage (35 percent) of people who do not speak English "very well," followed by Latinxs (29 percent), residents of African ancestry (5 percent), and Whites (4 percent). Among Asian/Pacific Islander subgroups, Vietnamese residents represent the highest percentages of people aged 5 and older who speak a language other than English at home (91 percent) and who do not speak English "very well" (57 percent).

LANGUAGES SPOKEN BY ETHNICITY, SANTA CLARA COUNTY



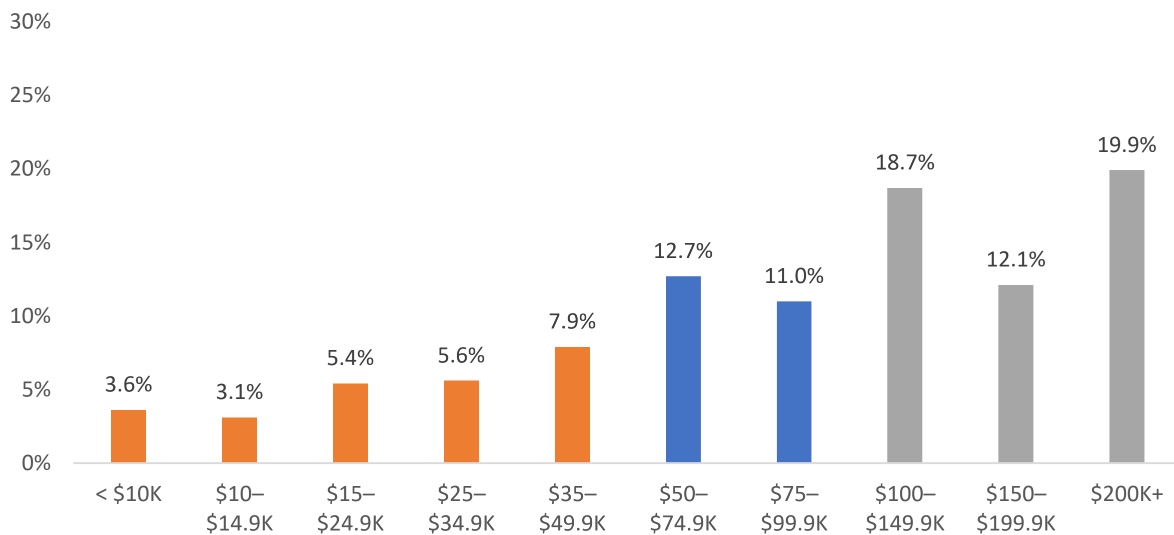
Source: Santa Clara County Public Health Department, 2017, Asian/Pacific Islander Health.

INCOME AND EDUCATION

Two key social determinants, income and education, are closely connected,[16] and have a significant impact on health outcomes, including poor birth outcomes, functional health (hearing, vision, and speech), asthma, obesity, mental health, and injuries.[17] 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 $101,173, which is far higher than California ($63,783) and higher than neighboring San Mateo County ($98,546).[18]

As shown in the chart below, about half of households in Santa Clara County earn annual incomes of $100,000 or more, about one-fourth earn between $50,000 and $100,000, and the rest earn less than $50,000. By comparison, the 2018 Self-Sufficiency Standard for a family of two adults, one infant, and one preschool-aged child is over $120,600.[19] This amount exceeds the county's median household income — and is more than four times higher than the Federal Poverty Level of $25,100.

PERCENT OF HOUSEHOLDS BY INCOME RANGE, SANTA CLARA COUNTY



Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016. Table S1901.

[16] Vilorio, D. (2016). Education Matters. Career Outlook. U.S. Bureau of Labor Statistics, March 2016.
[17] Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The Impact of Poverty on the Current and Future Health Status of Children. *Pediatric Child Health*. *12*(8): 667–672.
[18] U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016.
[19] The Insight Center for Community Economic Development. *Self-Sufficiency Standard Tool.* https://insightcced.org

Despite the fact that half of households earn more than $100,000 per year, there are indications that many residents of Santa Clara County are economically insecure:

- More than one in five (22 percent) residents lives below 200 percent of the Federal Poverty Level, which is better than the percentage of Californians overall (35 percent).[20]
- Nearly four in 10 children countywide are eligible for free or reduced-price lunch (38 percent).[21]
- Housing costs are high in Santa Clara County: The 2018 median home price is $1.3 million, and the median rent is $3,600 per month.[22]
- Approximately one in every 13 people (8 percent) is uninsured.[23]
- About one in 10 people (11 percent) has experienced recent food insecurity.
- More than 7,400 people in Santa Clara County are experiencing homelessness.

AREA DEPRIVATION INDEX

For 20 years, the U.S. Health Resources and Services Administration has used the Area Deprivation Index (ADI) to measure the lack of basic necessities in communities. The ADI measures social vulnerability. The ADI combines 17 indicators of socioeconomic status, such as income, employment, education, and housing conditions, and has been linked to health outcomes such as 30-day re-hospitalization rates, cardiovascular disease death, cervical cancer incidence, cancer deaths, and all-cause mortality.

The ADI score of 81.9 for El Camino Hospital's service area[24] was calculated using Census Block Group[25] level data. After the score was generated, the percentile of 18 was determined. In general, the greater the percentile number, the greater the deprivation.

The table below shows the 17 indicators that comprise the index, along with the value for the service area and for California. For most indicators, a lower score and percentile is desired. The arrow symbol preceding each indicator shows the desired direction for the percentile. Exceptions to the desired direction include median gross rent and monthly

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[20] U.S. Census Bureau, American Community Survey. 2012–2016.
[21] National Center for Education Statistics, NCES-Common Core of Data. 2015–2016.
[22] Zillow, data through May 31, 2018: https://www.zillow.com/santa-clara-county-ca/home-values/
[23] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016.
[24] The service area is comprised of the following cities: Alviso, Campbell, Cupertino, Los Altos, Los Altos Hills, Los Gatos, Loyola, Monte Sereno, Mountain View, San Jose, Santa Clara, Saratoga, and Sunnyvale.
[25] A Census Block Group is smaller than a Census Tract, but larger than a Census Block. In urban areas, a Census Block is generally equivalent to a city block, but in suburban and rural areas may be defined by the Census in other ways. A Census Block Group encompasses multiple, usually contiguous, Census Blocks. (U.S. Census Bureau. 2018. Geography Program Glossary.)

home cost, where lower percentiles indicate higher rent and housing costs. Area percentiles and indicator values that are worse than California are noted in red text.

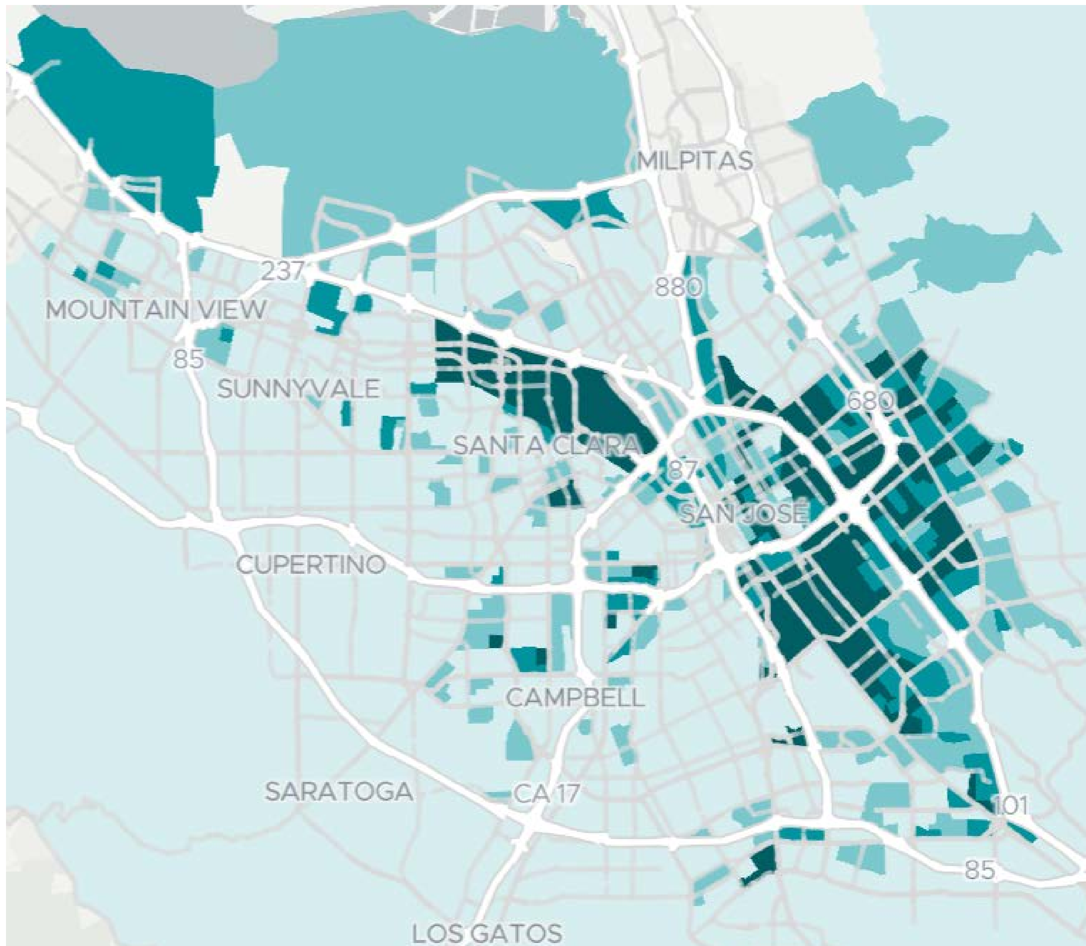
AREA DEPRIVATION INDEX, EL CAMINO HOSPITAL SERVICE AREA

Indicator Name	Service Area Percentile (out of 100)	Service Area Value	CA Percentile (out of 100)	CA Value
↓Area Deprivation Index	18	–	49	–
↓ Single parent households with children	56	19.8%	67	23.8%
↓ Less than high school education, aged 25+	76	7.4%	84	10.0%
↓ High school diploma/GED, adults ≥ aged 25	61	86.7%	74	81.9%
↓ Median family income	12	$115,600	32	$74,913
↓ Unemployment, ≥ aged 16	53	6.6%	68	8.9%
↓ Employed in white collar jobs, aged 16+	26	70.7%	47	60.5%
↓ Families below poverty level	46	6.3%	64	11.9%
↓ Population below 150% of poverty threshold	38	15.7%	59	25.9%
↓ Income disparity (index)	24	1.6	36	2.2
↓ Owner-occupied housing units	65	55.7%	68	54.1%
↑ Median home value	**3**	**$797,700**	11	$441,468
↑ Median gross rent	**6**	**$1,822**	17	$1,313
↑ Median monthly home cost	**7**	**$2,371**	20	$1,768
↓ Crowded households (>1 person per room)	**89**	**8.3%**	89	8.3%
↓ Households without complete plumbing	45	0.3%	52	0.4%
↓ Households without a telephone	53	1.8%	59	2.2%
↓ Households without a motor vehicle	51	5.1%	62	7.5%

Arrow indicates the desired direction of the percentile (not always the value) on a scale of 0 to 100. Percentages of total area population. Area percentiles are generated in comparison to U.S. values. Children refers to people under 18 years old. Sources: Community Commons, using U.S. Census Bureau, American Community Survey data (2013–2017) and Census Block Group level data (BroadStreet 2018).

The map below shows the ADI score by Census Block Group. Colors for the block groups are based on the percentile range into which the block group falls.

Area Deprivation Index Map, El Camino Hospital Service Area



Area Deprivation Index (%), ADI 2018 by Block Group

4. Assessment Team

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

The following organizations collaborated with El Camino Hospital to prepare the 2019 Community Health Needs Assessment (CHNA):

- Hospital Council of Northern and Central California
- Kaiser Permanente South Bay (San Jose and Santa Clara Kaiser Foundation Hospitals)
- Lucile Packard Children's Hospital Stanford
- Santa Clara County Public Health Department
- Stanford Health Care
- Sutter Health (Palo Alto Medical Foundation)
- Verity Health System (O'Connor and St. Louise Regional Hospitals)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

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

The project managers for this assessment were Jennifer van Stelle, Ph.D., and Melanie Espino, the cofounders and principals of Actionable Insights. They were assisted by Robin Dean, MA, MPH; Alexandra Fiona Dixon; Rebecca Smith Hurd; Franklin Hysten; Jenjii Hysten; Heather Imboden, MCP; Susana Morales, MA; Olivia Murillo; Kit Strong, MPH, MSW; and Margaret Tamisiea.

5. Process and Methods

The Coalition collaborated on the primary and secondary data requirements of the 2019 CHNA. The CHNA data collection process took place over seven months and culminated in this report, which was written for El Camino Hospital in the first half of 2019.

The Coalition contracted Actionable Insights (AI) to collect secondary quantitative (statistical) data, secondary statistical and survey data from Santa Clara County Public Health Department reports, and primary qualitative data through key informant interviews and focus groups.

SECONDARY DATA COLLECTION

More than 200 quantitative health indicators were analyzed to assist the Coalition with understanding the health needs in Santa Clara County and assessing the priority of those needs in the community. Data was collected from existing sources using the Community Commons CHNA Data Platform[26] and other online sources. Findings from CBHC member 2016 CHNA reports and collected sub-county data, where available, were also used.

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

- Status of African/African Ancestry Health: Santa Clara County 2014 Report
- Santa Clara County 2017 Asian and Pacific Islander Health Assessment
- Partners for Health Santa Clara County: Community Health Assessment-Community Health Improvement Plan 2015–2020
- Status of LGBTQ Health: Santa Clara County 2013

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

- 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?

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[26] Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system. https://www.communitycommons.org

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 national objectives or targets for improvement. The most recent set of objectives are for the year 2020 (HP2020). Year 2030 objectives are currently under development.[27]

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 ancestry (Black and African-American) communities. The Status of LGBTQ Health: Santa Clara County 2013 report studied key priority health issues for the county's diverse lesbian, gay, bisexual, transgender and queer communities. 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- and native-born. Both reports included findings from conversations with these populations, and they express a specific effort to understand the experiences of LGBTQ residents who are of African ancestry. In 2013, the lack of statistical data on these small populations was cited as an information gap. The inclusion of these two important reports fills that gap and contributes to the understanding of the health needs of residents who are LGBTQ and/or African ancestry.

INFORMATION GAPS AND LIMITATIONS

A lack of secondary data limited the Coalition in its ability to assess some health issues that were identified as community needs during the 2019 CHNA process. Statistical information related to these topics was scarce:

- Adult use of illegal drugs and misuse/abuse of prescription medications
- Alzheimer's disease and dementia diagnoses
- Diabetes among children
- Hepatitis B
- Health of undocumented immigrants (who do not qualify for subsidized health insurance and may be underrepresented in survey data)
- Mental health disorders
- Suicide among LGBTQ youth

[27] http://www.healthypeople.gov

PRIMARY QUALITATIVE DATA (COMMUNITY INPUT)

Primary research was conducted for this assessment. Two strategies were used for collecting community input: first, key informant interviews with local experts; second, focus groups with professionals who represent and/or serve the community or community members (residents) themselves.

The assessment included input from key informants and focus group participants representing these populations:[28]

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

The Coalition also sought to build upon prior CHNAs by focusing the primary research on the community's perception of mental health (identified as a major health need in the 2016 CHNA) and their experience with healthcare access and delivery (also identified as a major health need in 2016). Relatively little quantitative data exists on these subjects.

Each interview and focus group was recorded as a standalone piece of data. Recordings were transcribed, and then the research team used qualitative research software tools to analyze the transcripts for common themes. The team also tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. The Coalition used this tabulation to help assess community health priorities.

In all, the Coalition solicited input from more than 65 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. The Coalition also distributed a community priority survey to several organizations that did not participate in interviews or focus groups. Multiple community leaders participated from each of these agencies:

- Santa Clara County Public Health Department and Behavioral Health Services

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

- Hospitals, clinics and healthcare systems
- Mental/behavioral health or violence prevention providers
- County government departments
- City government departments
- School systems
- Nonprofit community-based organizations serving children, youth, seniors, parents, minorities, immigrants, those experiencing homelessness, and those suffering from dementia, mental health and substance use disorders

These leaders and representatives participated in key informant interviews or focus groups. *See Attachment 1: Community Leaders, Representatives and Members Consulted for the list of organizations that participated in the CHNA, along with their expertise and mode of consultation (focus group or key informant interview).*

KEY INFORMANT INTERVIEWS

Primary research was conducted between January and May 2018 via key informant interviews with eight Santa Clara County experts from various organizations in the health sector. Interviews were conducted in person or by telephone for approximately one hour. Key informants were asked:

- What are the most important health needs that you see in Santa Clara County? Which are the most pressing among the community? How are the needs changing?
- What drivers or barriers are impacting the top health needs?
- To what extent is healthcare access a need in the community? If certain groups are identified as having less access than others, what are the barriers for them?
- To what extent is mental health a need in the community? How do mental health challenges affect physical health?
- What policies or resources are needed to impact health needs?

DETAILS OF KEY INFORMANT INTERVIEWS

Name	Agency	Expertise	Date
Anne Ehresman	Project Cornerstone	Youth	1/30/18
Candace Roney	Dental Society	Oral health	1/30/18
Laura Brunetto	Santa Clara County Public Health Department	Maternal health	2/1/18

Name	Agency	Expertise	Date
Erin O'Brien	Community Solutions	Community safety and mental health	2/6/18
Dr. Peter Coehlo	Private practice	Southern Santa Clara County	2/27/18
Dr. Sara Cody	Santa Clara County Public Health Department	Public health	3/26/18
Bruno Pillet	Second Harvest Food Bank	Food insecurity	4/16/18
Camille Llanes Fontanilla	Somos Mayfair	Immigrant population	5/7/18

FOCUS GROUPS

Focus groups with community leaders and residents were convened in March and April 2018. A total of 46 professionals and 20 residents participated in various focus groups. Nonprofit hosts, such as the Community Health Partnership, recruited participants for the groups. These participants represented low-income, minority and/or medically underserved populations in the community. The focus group discussions centered on the same five questions asked of key informants; facilitators modified the questions appropriately for each audience.

Details of Focus Groups

Topic	Focus Group Host/Partner	Date	Number of Participants
Homelessness	Medical Respite Program, Santa Clara Valley Medical Center	3/7/18	8
Senior population, low socioeconomic status*	Portuguese Organization for Social Services and Opportunities	3/22/18	11
Healthcare safety net	Community Health Partnership	3/28/18	8
Substance use	Caminar for Mental Health	4/10/18	7
Senior population, middle-income socioeconomic status*	Avenidas	4/16/18	9
Social determinants of health	Stanford Health Care	4/20/18	6

Topic	Focus Group Host/Partner	Date	Number of Participants
Youth mental health	Community Health Awareness Council	4/25/18	7
Community and family safety	East San José PEACE Partnership	4/26/18	10

** Resident group.*

See Attachment 5: Qualitative Research Protocols for additional details.

PROCESS OF IDENTIFYING COMMUNITY HEALTH NEEDS

The Coalition began the 2019 CHNA planning process in the fall of 2017. The collective goal for the assessment was to gather community feedback and existing data about local health needs to inform how each member hospital would select specific issues to address with Community Benefit in its service area. The Coalition engaged Actionable Insights, a local consulting firm with expertise in community health needs assessments.

Community feedback was gathered between January and May 2018 via individual interviews with eight local experts and convening eight focus groups. The experts were asked to: identify and discuss the top needs of their constituencies, including barriers to health; give their perceptions of access to healthcare and mental health needs; and share which solutions may improve health (such as services and policies).

The focus group discussions centered on five questions (*see page 37*), which were modified appropriately for each audience. The focus groups comprised local residents and people who serve them. Participants included professionals in the fields representing low-income, minority, and/or medically underserved populations in the community.

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

Health needs described in this report fall into three categories (*see Definitions box at right*):

- Health conditions
- Health drivers
- Health outcomes

El Camino Hospital generated a list of health needs that reflects priorities in its service area based on community input and secondary data, which were filtered using the following criteria:

1. Must fit the definition of a "health need."
2. Is suggested or confirmed by more than one source of secondary and/or primary data.
3. Meets qualitative threshold:
   (a) Two of eight key informants identified the need, or
   (b) The community prioritized it over other health issues in at least two of eight focus groups.

In addition, available statistical data for some health needs failed benchmarks by 5 percent or more. The benchmarks used for comparison came from Healthy People 2020 or, when unavailable, California state averages. These data are described in the summary descriptions of each health need, which appear on the following pages.

DEFINITIONS

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

Health driver: A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes.

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

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

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

PROCESS OF PRIORITIZING HEALTH NEEDS

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

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

The Coalition used this input to identify the significant health needs; therefore, the 2019 health needs listed in this report reflect the health priorities of the community, as follows:

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

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

6. Prioritized 2019 Community Health Needs

The processes and methods described in Section 5: Process and Methods resulted in the prioritization of seven health needs (*see list on previous page*). Each description summarizes the statistical data and community input collected during the community health needs assessment. *For additional information, see Attachment 2: Secondary Data Tables.*

HOUSING AND HOMELESSNESS

More than half of all focus groups and key informants prioritized Housing and Homelessness as a health need. The community described stress about the high costs of housing and lack of affordable rent.

"We have multiple families or groups of people living in one unit, whether that's an apartment or a home or whatever. We have people renting out living rooms or backyards … or RVs and then paying people to take a shower in their home. Or we have five families living in a single-family unit where each family has a bedroom. That creates stress." —Focus group participant

Professionals who serve families report an increase in households seeking help from food banks and making difficult choices about how to spend remaining funds — healthy food, medicine, doctor visits, therapeutic services. The community reports that families are moving within or exiting the area due to increased cost of living.

More than one quarter (28 percent) of Santa Clara County residents live below the 2018 Self-Sufficiency Standard, and there are significant racial and ethnic disparities.[29] Santa Clara County has a much lower rate of available HUD-assisted housing units (374.3 units) than in the state (352.4). The number of those experiencing homelessness has recently increased by nearly 14 percent (to nearly 7,400 people in 2017, up from 6,500 in 2015), as has the proportion of them who are minors (15 percent in 2017, up from about 1 percent in 2015). The public health officer interviewed noted that a lack of stable housing can prolong recovery time from diseases and surgical procedures.

ACCESS AND DELIVERY

Healthcare Access and Delivery, which impacts various other community health needs, was identified as a top health need by half of focus groups and key informants.

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[29] Insight Center for Economic Development. (2018).

Although the county overall has high rates of health insurance (92 percent) and available providers (113 primary providers per 100,000 people), the community reports that healthcare is often unaffordable. Those who do not receive health insurance subsidies (such as undocumented immigrants) often lack insurance and the funds to pay for medical care without it. Health clinic professionals believe that undocumented immigrants have accessed healthcare less often in recent years due to the political climate and fear of being identified and subject to deportation. Latinxs, Pacific Islanders and those of “Other”[30] races have the highest rates of uninsured (15 percent, 9 percent, and 17 percent, respectively).

The rate of early and adequate prenatal care is above 75 percent in all cities of the county except for Milpitas (71 percent), Santa Clara (72 percent) and San Jose (73 percent).

Even for those individuals with healthcare insurance, medication often remains unaffordable. Several community members are concerned about the ability of older adults to pay for healthcare (including long-term care) if they are not Medi-Cal eligible. The county’s rates of Federally Qualified Health Centers (1.9 per 100,000 people) and access to mental-health care (272.4 providers per 100,000 people) fall below state averages (2.5 centers and 280.6, respectively).

As described on page 28, two in 10 Santa Clara County residents speak limited English, including 35 percent of Asian/Pacific Islander residents and 29 percent of Latinx residents. More than half of Vietnamese residents and four in 10 Korean residents report not speaking English well. Limited English proficiency can restrict healthcare access. Health clinic professionals expressed concern about attracting and retaining talent (especially bilingual staff) in the healthcare sector due to the high cost of living in the Bay Area.

BEHAVIORAL HEALTH

Behavioral Health, including mental health and substance abuse, ranked high as a health need, with the community prioritizing it in more than two-thirds of discussions.

The co-occurrence of mental health and substance use emerged as a common theme. The community cited a lack of services for behavioral health, including preventive mental-health care and detox centers, as a major concern. Professionals who work in behavioral health described experiencing challenges with health systems that were established to serve people with these conditions.

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[30] “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

"Basically, there's nowhere [for those with moderate to high mental health needs] to go because, the community is tapped out. ... So, our mental health programs end up managing them, and we don't get reimbursed from the county, from the health plans because, we're not, according to our contract, obligated to manage these patients. But, yet, somebody has to take care of these members. So, that's what's been happening." —Focus group participant

In focus groups and interviews, residents discussed economic security as a driver of poor mental health and substance use. Often, economic security was also cited as the result of not receiving treatment for behavioral health problems. Additionally, LGBTQ residents expressed a need for mental-health care and suicide prevention assistance.

Although data overall do not fail benchmarks, disparities are evident. Latinx residents experience levels of stress that are much higher than — and sometimes twice as high as — the overall county population in multiple areas (work, finances, food, health and rent). Asian residents report levels of stress about work (56 percent) and health (46 percent) that are each two to three percentage points higher than county residents overall. The percentage of the Medicare population with depression (11 percent) is trending up. Men are twice as likely as women to report being diagnosed with post-traumatic stress disorder (4 percent, compared with 2 percent).

Adult men are also more likely to binge drink than women (15 percent, compared to 13 percent), but adolescent females are more likely to binge drink than adolescent males. Latinx adults experience high rates of binge drinking (21 percent) compared with other populations (15 percent of Whites and 8 percent for other ethnic groups). (Geographically, Campbell has the highest rate of alcohol outlets per square mile of any city in Santa Clara County at 5.6, compared with 0.5 in Saratoga, and 2.7 countywide.)

Latinx and White adults are most likely to use marijuana (13 percent and 12 percent, respectively).[31] Almost one-fourth of African ancestry and Latinx students have misused cough and cold medicine, compared to 12 percent of White youth. Rates of other types of substance use among Latinx and African ancestry youth (cocaine, ecstasy, inhalants, and prescription pain medicine) are up to six percentage points higher than their White counterparts (whose rates are between 5 percent and 11 percent). About 15 percent of county adolescents have seriously considered suicide, with the highest percentages in the Filipino (21 percent) and Pacific Islander (19 percent) youth. Although nationwide

[31] This data was collected in 2014 (Santa Clara County Behavioral Risk Factor Survey), which is before California passed the Medical Cannabis Regulation and Safety Act (2015) and the Medicinal and Adult-Use Cannabis Regulation and Safety Act (2017), which is expected to increase the proportion of adults who use cannabis.

men are 3.5 times more likely to commit suicide than women,[32] Santa Clara County hospitalization rates for attempted suicide are 73 percent higher for females than males.

ECONOMIC SECURITY

Economic Security, including food security and education, was prioritized by one-third of all focus groups and key informants.

As described on page 29, although the poverty and income-inequality rates are lower than those of California's overall, research shows that the cost of living is very high in Santa Clara County. While median income seems relatively high in the county ($115,600), more than one quarter (28 percent) of Santa Clara County residents live below the 2018 Self-Sufficiency Standard, and significant racial and ethnic disparities exist.[33] The cost of living and the low-income population emerged as common themes of community input. Economic security is crucial to stable housing. (*See also the Housing and Homelessness health need description.*)

Rates of food insecurity are favorable (11 percent, compared to 14 percent), but the proportion of adults and children experiencing food insecurity who do not qualify for federal food assistance (39 and 46 percent, respectively) is higher in Santa Clara County than the state as a whole (22 percent and 29 percent). (*See also the Diabetes/Obesity health need description.*)

The focus group illuminated the great extent to which disparities exist. African ancestry residents and those of "Other"[34] races have rates of poverty that fail benchmarks (16.1 percent and 17 percent compared to 15.8 percent). More than one in 10 African ancestry and one in four Latinx households have received food from a food bank in recent years. The community mentioned people who are low-income in the majority of focus groups and key informant interviews. (*See the Area Deprivation Index Map, page 32.*)

The costs of long-term care for older adults with fixed incomes who are not eligible for Medi-Cal is a community concern. Mental-health care costs are also difficult for middle-income parents, as reported by youth mental-health providers. (*See also the Behavioral Health health need description.*)

Education is included in this category, as it is a predictor of economic security. Overall, the county high school graduation rate (percent of students who graduate in four years

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[32] American Foundation for Suicide Prevention. https://afsp.org/about-suicide/suicide-statistics/
[33] Insight Center for Economic Development. (2018).
[34] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

with a regular high school diploma) is high and stable (82 percent), but rates are lower among Latinx (70 percent), Native American (70 percent) and African ancestry (79 percent) residents than White residents (93 percent). Third- and fourth-grade reading levels are predictors of high school graduation.[35] Lack of fourth-grade reading proficiency among children of African (60 percent), Latinx (67 percent), Pacific Islander (61 percent) and Native American ancestry (58 percent) is significantly worse than among White children (27 percent).

DIABETES/OBESITY

Half of all key informant interviews and a third of focus groups identified Diabetes/ Obesity as a top health need. The community discussed environmental factors that contribute to diabetes and obesity such as the built environment, stress and poverty.

"[Obesity] usually has to do with very, very, very generally the environment, the neighborhoods where you have higher rates of obesity are also the neighborhoods where you have more disinvestments so you're not gonna have the same access to full grocery stores or you might just have smaller corner stores. Or less access to parks that are safe. There's usually kind of interacts with environmental conditions, that built support, physical activity and healthy eating." —Key informant

Data indicate that Santa Clara County has a significantly higher proportion of fast-food restaurants (86.7 per 100,000 people) than the state (78.7). Weekly fast food consumption is highest in Campbell (40 percent of city residents), San Jose (42 percent) and Los Gatos (38 percent). Conversely, the county also has lower proportions of grocery stores (19.5 per 100,000 people) and WIC-authorized stores[36] (9.5 per 100,000 people) than the state benchmark (21.8 grocery stores, 15.8 are WIC).

Among cities in the El Camino Hospital service area,[37] Campbell has the highest rate of fast food restaurants per mile at 5.9, exceeding that of the county overall and San Jose (2.8). However, it also has relatively better access to farmers' markets (at 1.1 miles, compared with 1.6 miles in the county overall and 1.6 miles in Santa Clara). The distance to fresh groceries is shortest in Mountain View, Sunnyvale and Los Altos (at 0.4 miles or

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[35] The Campaign for Grade-Level Reading. https://gradelevelreading.net
[36] The Women, Infants and Children (WIC) Program is a federally funded health and nutrition program that provides assistance to pregnant women, new mothers, and children aged 0–5. The California Department of Public Health approves the grocers and other vendors statewide who accept program vouchers. https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx
[37] Cities data spreadsheet provided by public health Dec 2016 Indicators from 2014, accessed January 2019. Excludes Gilroy and Morgan Hill, as well as Monte Sereno or Los Altos Hills, where data is unstable.

less) and farthest in Los Altos Hills, Monte Sereno and Morgan Hill (more than one mile). Diabetes prevalence is higher in the county than in the state — and is trending up both locally and statewide.

"The biggest coping strategy for people who are food insecure is to go for cheap food. Cheap food is usually unhealthy food. So, they go for processed food, McDonald's, things like that because it's less expensive. Therefore, there's a very high percentage of diabetes and prediabetes among the people we serve. We estimate that more than a third of the people we're serving are either diabetes or prediabetes." —Key informant

Overall obesity rates are high, but do not fail benchmarks. However, disparities were found: Latinx residents have the highest rate of overweight or obese adults (72 percent) compared to the county overall (54 percent). Pacific Islanders have high rates of overweight and obesity among adults (77 percent) and middle/high school youth (49 percent). This is possibly driven by physical inactivity; more than one in four (28 percent) of all youth are physically inactive in the county.

Latinx youth fail the benchmark for physical activity (42 percent are inactive compared to 38 percent in California). About six in 10 county youth have insufficient fruit and vegetable consumption, which is worse than the state average (47 percent). Although that benchmark is relatively high, Latinx youth are faring slightly better (46 percent) — and better than youth of other ethnicities (73 percent of African ancestry youth, 73 percent of youth of "Other"[38] ethnicities, and 61 percent of White youth.) Fruit and vegetable consumption data were unavailable for Asian/Pacific Islander youth.

Among cities in El Camino Hospital's service area, the hypertension death rate is highest in San Jose (18.3). Diagnosed high-blood pressure is highest among Campbell residents (33 percent) compared with other cities, such as Los Altos (15 percent) and San Jose (28 percent).

Males are much more likely than females to be obese (18 percent compared to 10 percent). One in four LGBTQ survey respondents report being overweight or obese. Obesity often coexists with food insecurity (a lack of available financial resources for food at the household level) because "both are consequences of economic and social disadvantage."[39] (*See also the Economic Security health need description.*)

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[38] Other" is a U.S. Census category for ethnicities not specifically called out in data sets.
[39] Food Research & Action Center. (2015). *Food Insecurity and Obesity.*

COGNITIVE DECLINE

Cognitive Decline and Dementia were mentioned in half of the focus groups and two interviews with experts. Serving individuals who are impaired is difficult for providers.

Professionals serving chronically homeless individuals and individuals who abuse substances report early onset dementias and difficulty treating and housing people with these impairments. Several community members are concerned about the ability of older adults to pay for healthcare, including long-term care, for those who are not Medi-Cal eligible. Professionals rely on family members to coordinate care for their loved ones, which can affect their health, well-being, and economic stability. Although county data on dementia are not available, one in nine Californians is experiencing subjective cognitive decline.

The county death rate due to Alzheimer's disease is significantly worse than the state's rate (35.9 per 100,000 compared to 30.1). The median age in Santa Clara County (36.8 years) is higher than that of California overall (35.8). In El Camino Health's service area, Los Altos and Los Altos Hills and Saratoga have the highest proportion of older adults (at 20 and 23 percent respectively) followed by Monte Sereno (19 percent) and Los Gatos (18 percent) compared to a mean of 12 percent in the service area overall.

ORAL/DENTAL HEALTH

Oral/Dental Health was prioritized as a health need in two interviews and in one focus group. Feedback related to oral/dental health usually concerned the perceived lack of access to dental insurance.

More than a third of adults (36 percent) in Santa Clara County do not have dental insurance, which is better than the California average (41 percent). However, significantly more children in Santa Clara County (30 percent) lack a recent dental exam than the state average (19 percent); the percentages are highest (worst) among White and Latinx children (31 percent and 52 percent, respectively).

Ethnic disparities exist. More than half of residents of African, Asian and Latinx ancestry have had dental decay or gum disease, which is worse than the county as a whole (45 percent).

For additional details, including statistical data and sources, see the data tables found in Attachment 3: Secondary Data Tables.

7. Evaluation of 2017–2019 Implemented Strategies Based on the 2016 CHNA

In 2015–16, El Camino Hospital participated in a Community Health Needs Assessment similar to collaborative 2019 effort.

The 2016 CHNA report is posted on the Community Benefit Page of the El Camino Hospital website.[40] IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years.[41]

After reviewing the findings of the 2016 CHNA, El Camino Hospital's Community Benefit Advisory Council (CBAC) identified 12 health needs to address in FY17 and the subsequent two fiscal years with community benefit grant funding.

The health needs fall under three health priority areas:

- Access to Healthcare & Delivery
- Cancer
- Cardiovascular (Heart) & Cerebrovascular (Stroke)
- Hypertension
- Obesity & Diabetes
- Oral & Dental Health
- Respiratory Conditions

- Alzheimer's Disease & Dementia
- Behavioral Health

- Economic Security
- Unintentional Injuries
- Violence & Abuse

Due to the timing of the CHNA publication and the submission of year-end data from grants, annual data for FY19 (January 1, 2019–June 30, 2019) is unavailable for inclusion. Each year, the Community Benefit Program publishes an Annual Report to the Community available on the Community Benefit page of the website.[24]

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[40] https://www.elcaminohospital.org/about-us/community-benefit
[41] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf

For additional details on El Camino Hospital's Community Benefit Program results in fiscal years 2017 and 2018 and the first six months of fiscal year 2019, see Attachment 7: FY17 – FY19 Year-over-Year Dashboard.

8. Conclusion

El Camino Hospital worked with its Community Benefit Hospital Coalition partners, pooling expertise and resources, to conduct the 2019 Community Health Needs Assessment in Santa Clara County.

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

The 2019 CHNA, which builds upon prior assessments, meets federal (IRS) and California state requirements.

Next steps for El Camino Hospital:

- After the CHNA is adopted by the hospital's board, make the CHNA report publicly available on the website (by June 30, 2019).[42]
- Monitor community comments on the CHNA report (ongoing) Select priority health needs to address.
- Develop strategies to address priority health needs (independently or with Coalition partner hospitals).
- Ensure Community Benefit Plan and Implementation Strategy is approved by the hospital board (by June 2019).

[42] https://www.elcaminohospital.org/about-us/community-benefit

9. List of Attachments

1. Community Leaders, Representatives and Members Consulted
2. Secondary Data Indicators
3. Secondary Data Tables
4. Community Assets and Resources
5. Qualitative Research Protocols
6. IRS Checklist
7. FY17 – FY19 Year-over-Year Dashboard

Attachment 1. Community Leaders, Representatives and Members Consulted

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including low-income populations, minorities and the medically underserved. The group included leaders from the Santa Clara County Health & Hospital System, nonprofit hospital representatives, local government employees and nonprofit organizations.

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Interview	1	Dr. Sara Cody, Public Health Officer, Santa Clara County Public Health Department	Youth health	1	Health department representative	Leader	1/30/18
Interview	2	Laura Brunetto, Maternal Health Director, Santa Clara County Public Health Department	Oral health	1	Health department representative	Leader	1/30/18
Interview	3	Candace Roney, Executive Director, Santa Clara County Dental Society	Public health	1	Medically underserved	Leader	2/1/18
Interview	4	Anne Ehresman, Executive Director, Project Cornerstone	Community Safety and mental health	1	Medically underserved	Leader	2/6/18
Interview	5	Erin O'Brien, President/CEO, Community Solutions	Community Safety and mental health	1	Medically underserved	Leader	4/16/18
Interview	6	Bruno Pillet, VP of Programs & Services, Second Harvest Food Bank of Santa Clara and San Mateo Counties	Food insecurity/ hunger	1	Low income	Leader	5/7/18
Interview	7	Camille Llanes-Fontanilla, Executive Director, Somos Mayfair	Immigrant population	1	Minority, low income	Leader	2/27/18
Interview	8	Dr. Peter Coehlo, Private practice	South County	1	Low income	Leader	3/26/18

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Focus Group	**1**	**Host:** Community Health Partnership	Safety net health services	8	Low income	Leader	3/28/18
		Kent Imai, Medical Director, Community Health Partnership			Low income	Leader	
		Lynn Liu, Associate Medical Director, Northeast Medical Services			Low income	Leader	
		Wangping Zhao, Physician-in-Charge, AACI Health Center			Low income	Leader	
		Anu Balabruan, CMU, Indian Health center			Low income	Leader	
		Claude Roge, Medical Director, School Health Clinic of SCC			Low income	Leader	
		Laura Dalton, CMO, PPMM			Low income	Leader	
		Ranjani Chandramouli, MD, Medical Director, Gardner Family Health			Low income	Leader	
		Ravenswood Family Health Center			Low income	Leader	
Focus Group	**2**	**Host:** Medical Respite Program	Homeless population	10	Low income	Leader	3/7/18
		Amber Frymier, Healthcare Program, Valley Homeless Clinic			Low income	Leader	
		Emma Vidal,Valley Homeless Clinic			Low income	Leader	
		Lorna Lindo, Valley Homeless Clinic			Low income	Leader	
		Marisela Villarreal,Valley Homeless Clinic			Low income	Leader	
		Sara Jeevanjee, Medical Director, Medical Respite Program			Low income	Leader	
		Vanessa Beretta, Development Officer, City of San Jose, Homeless Response Team			Low income	Leader	

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Malinda Mitchell, Hospital Council, Medical Respite Program			Low income	Leader	
		Aleksandra Ceprnic, Psychology, Medical Respite			Low income	Leader	
		Dana Schuster, Outreach Specialist, Home First			Low income	Leader	
		Linda Jones, Home First			Low income	Leader	
Focus Group	**4**	**Host:** Caminar	Substance use	7	Medically underserved	Leaders	4/10/18
		Cheryl Blankenship, Quality Improvement Coordinator, Santa Clara County Behavioral Health			Medically underserved	Leader	
		Michael Hutchinson, MFT, Executive Director, Family and Children Services, a Division of Caminar			Medically underserved	Leader	
		Neidy Lozada, Associate Director of Programs, Pathways Society			Medically underserved	Leader	
		Tianna Nelson, Ph.D., LMFT, Behavioral Health Division Director, Quality Improvement, Santa Clara County Behavioral Health Services			Medically underserved	Leader	
		Tina Sentner LAADC CA, Program Director, Mission Street Sobering Center			Medically underserved	Leader	
		Ursula King, SUTS Supervisor, LMFT			Medically underserved	Leader	
		Ashwini Gupta, Sr. Program Director, LMFT			Medically underserved	Leader	

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
Focus Group	**5**	**Host:** Stanford Health Care	Social determinants of health	6	Low income	Leaders	4/20/18
		Grace Benlice, Director of Care Coordination , El Camino			Low income	Leader	
		Karen Nelson, MSW, MBA, Director, Social Work, Case Management, Spiritual Care, Aging Adult Services, Stanford Healthcare			Low income	Leader	
		Michele Lew, CEO, The Health Trust			Low income	Leader	
		Nicole Fargo-Nosich, Associate Director, Community Services Agency of Mountain View and Los Altos			Low income	Leader	
		Rhonda McClinton-Brown, Executive Director, Office of Community Engagement - Stanford			Low income	Leader	
		Robert Mevicocci, Director, Santa Clara County Social Services Agency			Low income	Leader	
Focus Group	**6**	**Host:** Santa Clara County PEACE partnership		10	Minority	Leaders	4/26/18
		Kelsey Pennington, Program Officer, FIRST 5			Minority		
		Laura Buzo, Deputy Chief, FIRST 5			Minority		
		Lidia Doniz, Santa Clara County Violence Prevention			Minority		
		Malaya Arevalo, Wellness Services Manager, AACI Health & Wellness			Minority		

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Mariana Jimenez-Alvarez, Santa Clara County			Minority		
		Neil Kozuma, Public Affairs Director, Foothill Community Health Center			Minority		
		Vanessa Bolton, Health Education Specialist, Santa Clara County Public Health Department			Minority		
		Mario Maciel, City of San Jose, Mayor's Gang Prevention Task Force			Minority		
		Neil Rufino, City of San Jose, PRNS			Minority		
		René Santiago, Santa Clara County Executive's Office			Minority		
Focus Group	**7**	**Host:** Community Health Awareness Council (CHAC)	Youth mental health	8	Medically underserved	Leaders	4/25/18
		Kathleen King, CEO, Healthier Kids Foundation			Medically underserved	Leader	
		Katy Carter, Executive Director, Almaden Valley Counseling			Medically underserved	Leader	
		Tasha Dean, Assistant Superintendent, Sunnyvale			Medically underserved	Leader	
		Barbara Avery, Director of Community Benefit, El Camino Health			Medically underserved	Leader	
		Lauren Olaiz, Community Mental Health Relations, El Camino Health			Medically underserved	Leader	
		Marsha Deslauriers, Executive Director, CHAC			Medically underserved	Leader	

DATA COLLECTION METHOD	ID	NAME, TITLE, AGENCY	TOPIC	# OF PEOPLE	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP (LEADER, REPRESENTATIVE, MEMBER)	DATE INPUT WAS GATHERED
		Susan Flatmo, Clinical Services Coordinator, Mountain View/Los Altos School District			Medically underserved	Leader	
		Chris Barley, Licensed Alcohol & Drug Counselor, Family and Children Services, a Division of Caminar			Medically underserved	Leader	
RESIDENT FOCUS GROUPS (Attendee names not collected.)							
Focus Group	**3**	**Host:** POSSO	Senior health	11	Minority, medically underserved	Members	3/22/18
Focus Group	**8**	**Host:** Avenidas	Senior health	9	Medically underserved	Members	4/16/18

Attachment 2. Secondary Data Indicators, Santa Clara County

Category	Indicator	Indicator Variable	Data Source
Access	Absence of Dental Insurance Coverage	Percent Adults Without Dental Insurance	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Access	Access to Dentists	Dentists, Rate per 100,000 Pop.	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015.
Access	Access to Mental Health Providers	Mental Health Care Provider Rate (Per 100,000 Population)	University of Wisconsin Population Health Institute, County Health Rankings. 2018.
Access	Access to Primary Care	Primary Care Physicians, Rate per 100,000 Pop.	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014.
Access	Children Likely to Visit ED	The rate of emergency department visits for children ages 0 to 17 per 100,000 population. Available by race.	Office of Statewide Planning and Development, 2013 Emergency Department Data. Retrieved from 2016 Status of Children's Health Report.
Access	Children with Health Insurance by Region	Health insurance coverage among children (ages 0-17) in Santa Clara County by zip code.	U.S. Census Bureau, 2009-13 American Community Survey 5-Year Estimates. Retrieved from 2016 Status of Children's Health Report.
Access	Costs as a Barrier to Care	Percentage of adults who needed to see a doctor in the past 12 months but could not because of cost. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. 2017 Asian Pacific Islander Report.
Access	Difficulty Understanding Doctors	Percentage of adults who had a hard time understanding the doctor the last time they saw a doctor	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.

Category	Indicator	Indicator Variable	Data Source
Access	Federally Qualified Health Centers	Federally Qualified Health Centers, Rate per 100,000 Population	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. March 2018.
Access	Health Professional Shortage Area - Primary Care	Percentage of Population Living in a HPSA	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.
Access	Healthcare Discrimination for LGBTQ People	Percentage of LGTBQ survey respondents who have experienced healthcare discrimination in the past 5 years	Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey. Retrieved from 2013 Status of LGBTQ Health Report.
Access	Insurance - Uninsured Population	Percent Uninsured Population	US Census Bureau, American Community Survey. 2012-16.
Access	Lack of a Consistent Source of Primary Care	Percentage Without Regular Doctor	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Access	Limited English Proficiency	Percentage of population ages 5 years and older who do not speak English “very well.” Available by Asian subpopulation.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables. Retrieved from 2017 Asian Pacific Islander Report.
Access	Preventable Hospital Events	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Access	Routine Annual Check-Ups for Children	The percentage of children who saw a doctor in the past 12 months. Available by age group (0-5 and 6-11).	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey.
Asthma	Asthma - Hospitalizations	Age-Adjusted Discharge Rate	California Office of Statewide Health

Category	Indicator	Indicator Variable	Data Source
		(Per 10,000 Pop.)	Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Asthma	Asthma - Prevalence	Percent Adults with Asthma	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Asthma	Asthma among Children under Age 18 (p.20)	Children ages 0 to 17 who were ever diagnosed with asthma. Available by trend data.	2001-2014 California Health Interview Survey
Asthma	Asthma Attacks	Middle and high school students who had an asthma episode or attack in the past 12 months. Available by race/ethnicity and gender.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Asthma	Asthma Diagnoses among Asian Residents	Percentage of Asian/Pacific Islander survey respondents who were ever diagnosed with asthma	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.
Asthma	Asthma Prevalence	Children (ages 0-11) ever diagnosed with asthma. Available by gender.	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey. Retrieved from 2016 Status of Children's Health Report.
Asthma	Asthma-Related ED Visits	Asthma emergency department visit rate among children (ages 0-17), Santa Clara County, 2009-2013. Available by zip codes.	Office of Statewide Health Planning and Development, 2009-2013 Emergency Department Data. Retrieved from 2016 Status of Children's Health Report.
Behavioral Health	Adults Feeling Depressed	Percentage of adults who felt depressed 1 or more times in the past week	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.
Behavioral Health	Adults Prohibiting Smoking	Percentage of adults who live in	Santa Clara County Public Health

Category	Indicator	Indicator Variable	Data Source
		households that completely prohibit smoking in or around the home. Available by gender and race.	Department, 2000-2014 Behavioral Risk Factor Survey.
Behavioral Health	Alcohol - Access	Number of alcohol retail outlets per square mile	Santa Clara County Public Health Department, 2016 City Profiles; Department of Alcoholic Beverage Control (ABC), April 2016
Behavioral Health	Alcohol - Excessive Consumption	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Behavioral Health	Binge Drinking (Adults)	Percentage of adults who engaged in binge drinking in the past 30 days. Available by gender and race.	Santa Clara County Public Health Department, 2013 Behavior Risk Factor Survey; Centers for Disease Control and Prevention, 2012 Behavioral Risk Factor Surveillance System; Healthy People 2020. Retrieved from the 2015-20 Community Health Assessment-Community Health Improvement Plan Report.
Behavioral Health	Binge Drinking (Youth)	The percentage of middle and high school students drinking 5 or more drinks of alcohol in a row within a couple of hours in the past 30 days. Available by race and gender.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Behavioral Health	Cigarette Use (Adult)	Percentage of adults who are current smokers	Santa Clara County Public Health Department, 2013 Behavior Risk Factor Survey; Centers for Disease Control and Prevention, 2012 Behavioral Risk Factor Surveillance System; Healthy

Category	Indicator	Indicator Variable	Data Source
			People 2020. Retrieved from the 2015-20 Community Health Assessment-Community Health Improvement Plan Report.
Behavioral Health	Cigarette Use (Youth)	Percent of population who smoked at least one cigarette in the past 30 days. Available by age group.	California Healthy Kids Survey, 2015-2016. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Behavioral Health	Considered Suicide (LGBTQ)	Percentage of LGBTQ survey respondents who seriously considered attempting suicide or physically harming themselves during the past 12 months.	Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey. Retrieved from 2013 Status of LGBTQ Health Report, Santa Clara County Public Health.
Behavioral Health	E-cigarette Use	Percentage of population using an e-cigarette or other nicotine device 1 or more times in the past 30 days. Available by overall county rates, and year in school (i.e., 11th grade) or type of school (nontraditional).	California Healthy Kids Survey, 2015-2016. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Behavioral Health	Feeling Sad or Hopeless (Youth)	Percentage of middle and high school students who felt sad or hopeless for 2 weeks or more in the past 12 months. Available by Asian subpopulation.	California Healthy Kids Survey, 2015-16. Retrieved from 2016 Status of Children's Health Report.
Behavioral Health	Frequent Mental Distress	The percentage of adults in Santa Clara County who reported frequent mental distress (14 or more mentally unhealthy days) in the past 30 days. Available by race.	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Behavioral Health	High Schoolers Seriously Considering Suicide	The proportion of high school students who have ever	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of

Category	Indicator	Indicator Variable	Data Source
		seriously considered attempting suicide in the past 12 months. Available by gender. Trend data also available.	Children's Health Report.
Behavioral Health	Lack of Social or Emotional Support	Percent Adults Without Adequate Social / Emotional Support (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Behavioral Health	Leading Causes of Injury Deaths (Suicide)	Leading causes of injury deaths, including suicide. Available by Asian subpopulation.	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017. Retrieved from 2017 Asian Pacific Islander Report.
Behavioral Health	Liquor Store Access	Liquor Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
Behavioral Health	Mental Health - Depression Among Medicare Beneficiaries	Percentage of Medicare Beneficiaries with Depression	Centers for Medicare and Medicaid Services,2015.
Behavioral Health	Mental Health - Frequent mental distress	Percentage of adults who report frequent mental distress (14 or more mentally unhealthy days) in the past 30 days	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Behavioral Health	Mental Health - Needing Mental Health Care	Percentage with Poor Mental Health	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Behavioral Health	Mental Health - Poor Mental Health Days	Average Number of Mentally Unhealthy Days per Month	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
Behavioral Health	Mental Health - Suicidality	Percent of youth who seriously considered suicide in the past	California Healthy Kids Survey, 2013-14

Category	Indicator	Indicator Variable	Data Source
		year	
Behavioral Health	Mental Health - Suicide Attempts	Hospitalization discharge rate for suicide attempts	Office of Statewide Planning and Development, 2007-2014 Patient Discharge Data
Behavioral Health	Mental Health - Suicide Attempts	Rate of hospitalizations (per 100,000 people) due to suicide attempts and suicide ideation	Office of Statewide Planning and Development, 2007-2014 Patient Discharge Data.
Behavioral Health	Mental Health - Suicide Attempts Youth)	Percent of youth self-reported suicide attempts	California Healthy Kids Survey, 2013-14
Behavioral Health	Mortality - Suicide	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Behavioral Health	Need for Mental Health Providers (LGBTQ)	Percentage of LGBTQ survey respondents feeling that they might have needed to see a professional in the past 12 months because of concerns about mental health or substance use.	Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey. Retrieved from 2013 Status of LGBTQ Health Report, Santa Clara County Public Health.
Behavioral Health	PTSD Diagnoses	The percent of adults ever diagnosed with post-traumatic stress disorder (PTSD). Available by gender.	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey.
Behavioral Health	PTSD prevalence	Percent of adults who were ever diagnosed with Post Traumatic Stress Disorder	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Behavioral Health	Stress	Percentage of adults who are somewhat or very stressed about financial concerns. Percentage of adults who are somewhat or very stressed	Santa Clara County Community Assessment Project, August 2012. United Way Silicon Valley. Retrieved from the 2015-20 Community Health Assessment-Community Health

Category	Indicator	Indicator Variable	Data Source
		about work-related concerns. Percentage of adults who are somewhat or very stressed about health concerns. Available by race.	Improvement Plan Report.
Behavioral Health	Suicidality (High Schoolers)	High school students who had seriously considered attempting suicide in the past 12 months.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Behavioral Health	Suicide	Age-adjusted rate of suicide by race/ethnicity and Asian/Pacific Islander subgroups. Data for Japanese and Pacific Islanders are not presented due to small numbers.	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017. U.S. Census Bureau; 2010 Census. Retrieved from 2017 Asian Pacific Islander Report.
Behavioral Health	Suicide Mortality/Attempts	Middle and high school students who attempted suicide in the past 12 months. Available by race.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Behavioral Health	Tobacco - Smoking (adult)	Percentage of adults who are current smokers	UCLA Center for Health Policy Research, AskCHIS 2007-2015.
Behavioral Health	Tobacco - Smoking (youth)	Cigarette use (youth) 1+ days in the past 30 days	California Healthy Kids Survey, 2006-2016.
Behavioral Health	Tobacco - Smoking (youth)	E-Cigarette use (youth) 1+ times in the past 30 days	California Healthy Kids Survey, 2013-2016.
Behavioral Health	Tobacco Usage	Percentage of Adults Smoking Cigarettes	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Cancer	Cancer Incidence - All Sites	Annual Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry

Category	Indicator	Indicator Variable	Data Source
			(Oct 2016 Extract.)
Cancer	Cancer Incidence - Breast	Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Cancer Incidence - Cervical	Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.) Healthy People 2020 (benchmark).
Cancer	Cancer Incidence - Colon and Rectum	Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.) Healthy People 2020 (benchmark).
Cancer	Cancer Incidence - Lung	Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Cancer Incidence - Prostate	Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Cancer Incidence & Mortality (Asian Residents)	Cancer incidence and mortality for all sites (colorectal, liver, lung female breast, male prostate). Available by site and Asian subgroup.	Greater Bay Area Cancer Registry, 2010-2014; U.S. Census Bureau; 2010 Census.
Cancer	Cancer Screening - Mammogram	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2014.
Cancer	Cancer Screening - Pap Test	Percent Adults Females Age 18+ with Regular Pap Test (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Category	Indicator	Indicator Variable	Data Source
Cancer	Cancer Screening - Sigmoid/Colonoscopy	Percent Adults Screened for Colon Cancer (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Cancer	Mortality - Breast Cancer	Cancer, Age-Adjusted Mortality Rate (per 100,000 Female Population)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Mortality - Cancer (All Sites)	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Greater Bay Area Cancer Registry, 1995-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Mortality - Cervical	Cancer, Age-Adjusted Mortality Rate (per 100,000 Female Population)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.) Healthy People 2020 (benchmark).
Cancer	Mortality - Colon and Rectum	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Mortality - Lung	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cancer	Mortality - Prostate	Cancer, Age-Adjusted Mortality Rate (per 100,000 Male Population)	Greater Bay Area Cancer Registry, 2010-2014; California Cancer Registry (Oct 2016 Extract.)
Cognitive Decline	Causes of Death	Percentage and ranking of total deaths by cause.	Santa Clara Public Health Department, 2016. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018
Cognitive Decline	Mortality – Alzheimer's	Alzheimer's disease deaths per 100,000 people	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health

Category	Indicator	Indicator Variable	Data Source
			Department, 2009-2013 Death Statistical Master File; U.S. Census Bureau, 2010 U.S. Census
Communicable Diseases	Flu vaccinations (Adults)	Percent of adults who received flu shot	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Communicable Diseases	Flu vaccinations (Children)	Percent of children who received flu shot or nasal vaccine	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Communicable Diseases	Mortality – Influenza and pneumonia	Influenza and pneumonia deaths per 100,000 people	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2009-2013 Death Statistical Master File; U.S. Census Bureau, 2010 U.S. Census
Communicable Diseases	Personal Belief Exemptions	Percentage of incomplete immunizations at kindergarten entry due to personal exemptions.	California Department of Public Health, School Assessments Unit, Immunization Branch, 2014-15. Retrieved from 2016 Status of Children's Health Report.
Communicable Diseases	Pertussis Incidence	Pertussis rates per 100,000 people, 2007-2016	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2007-2011) & California Reportable Disease Information Exchange (CalREDIE) (2011-2016), data are provisional as of 1/4/2018.
Communicable Diseases	Senior Pneumonia Vaccinations	Percent Population Age 65+ with Pneumonia Vaccination (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Category	Indicator	Indicator Variable	Data Source
Communicable Diseases	Stayed Home Due to Flu (Adults)	Percent of adults who stayed home due to flu	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Communicable Diseases	Tuberculosis Incidence	Tuberculosis rates per 100,000 people, 2008-2017	Santa Clara County Public Health Department, California Reportable Disease Information Exchange, 2017, data as of February 12, 2018, and are provisional.
Communicable Diseases	Tuberculosis Incidence Rates	Incidence rates of tuberculosis. Available by county and country of origin.	Santa Clara County Public Health Department, California Reportable Disease Information Exchange, 2017, data as of February 12, 2018, and are provisional; State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010–2017. Sacramento, California, December 2017. Santa Clara Public Health Department, 2016. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Community & Family Safety	Homicide Rate	Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Community & Family Safety	Students Cyberbullied	Cyberbullying is defined as the percentage of students who reported that other students spread mean rumors or lies about them on the Internet 1 or more times in the past 12 months. Available by race and gender.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.

Category	Indicator	Indicator Variable	Data Source
Community & Family Safety	Students Physically Bullied on School Property	Physical bullying is defined as the percentage of students who reported being pushed, shoved, hit or kicked by someone who wasn't kidding around 1 or more times in the past 12 months. Available by race and gender.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Community & Family Safety	Students Psychologically Bullied on the School Property	Psychological bullying is defined as the percentage of students who reported being afraid of being beat up or had mean rumors or lies spread about them on school property in the past 12 months.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Community & Family Safety	Substantiated Child Maltreatment	Rate of substantiated child maltreatment per 1,000 children. Available by race and age group.	University of California, Berkeley, Center for Social Sciences Research, 2014. Retrieved from 2016 Status of Children's Health Report.
Community & Family Safety	Violence - All Violent Crimes Rate	Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
Community & Family Safety	Violence - Assault (Crime)	Assault Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
Community & Family Safety	Violence - Assault (Injury)	Assault Injuries, Rate per 100,000 Population	California Department of Public Health, California EpiCenter. 2013-14.
Community & Family Safety	Violence – Average Violent Crimes	Average number of violent crimes within 1 mile	Santa Clara County Public Health Department, 2016 City Profiles; Public

Category	Indicator	Indicator Variable	Data Source
			Engines, Inc., January 2012 to December 31, 2012
Community & Family Safety	Violence - Domestic Violence	Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	California Department of Public Health, California EpiCenter. 2013-14.
Community & Family Safety	Violence - Rape (Crime)	Rape Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
Community & Family Safety	Violence - Robbery (Crime)	Robbery Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
Community & Family Safety	Violence - School Expulsions	Rate of Expulsions (per 100 Students)	California Department of Education, 2014-15.
Community & Family Safety	Violence - School Suspensions	Rate of Suspensions (per 100 Students)	California Department of Education, 2014-15.
Community & Family Safety	Violence - Youth Intentional Injury	Intentional Injuries, Rate per 100,000 Population (Youth Age 10 - 19)	California Department of Public Health, California EpiCenter. 2013-14.
Community & Family Safety	Youth Assault Rate	Non-fatal assault rates per 100,000 children (ages 0-17). Available by race.	Office of Statewide Health Planning and Development, 2013 Emergency Department Data and 2009-2013 Patient Discharge Data. Retrieved from 2016 Status of Children's Health Report.
Community & Family Safety	Youth Taking Guns to School Rate	This indicator is defined as the percentage of students who reported carrying a gun on	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.

Category	Indicator	Indicator Variable	Data Source
		school property 1 or more times in the past 12 months. Available by race.	
Demographics	Change in Total Population	Percent Population Change, 2000-2010	US Census Bureau, Decennial Census. 2000 - 2010.
Demographics	Female Population	Percent Female Population	US Census Bureau, American Community Survey. 2012-16.
Demographics	Hispanic Population	Percent Population Hispanic or Latino	US Census Bureau, American Community Survey. 2012-16.
Demographics	Households by Income Range	Income in the past 12 months	U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-16. Table S1901.
Demographics	Insurance - Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid	US Census Bureau, American Community Survey. 2012-16.
Demographics	Male Population	Percent Male Population	US Census Bureau, American Community Survey. 2012-16.
Demographics	Median Age	Median Age	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 0-4	Percent Population Age 0-4	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 18-24	Percent Population Age 18-24	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 25-34	Percent Population Age 25-34	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 35-44	Percent Population Age 35-44	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 45-54	Percent Population Age 45-54	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 5-17	Percent Population Age 5-17	US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Variable	Data Source
Demographics	Population Age 55-64	Percent Population Age 55-64	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population Age 65+	Percent Population Age 65+	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population in Limited English Households	Percent Linguistically Isolated Population	US Census Bureau, American Community Survey. 2012-16.
Demographics	Population with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency	US Census Bureau, American Community Survey. 2012-16.
Demographics	Total Population	Population Density (Per Square Mile)	US Census Bureau, American Community Survey. 2012-16.
Diabetes & Obesity	Commute Over 60 Minutes	Percentage of Workers Commuting More than 60 Minutes	US Census Bureau, American Community Survey. 2012-16.
Diabetes & Obesity	Commute to Work - Alone in Car	Percentage of Workers Commuting by Car, Alone	US Census Bureau, American Community Survey. 2012-16.
Diabetes & Obesity	Commute to Work - Walking/Biking	Percentage Walking or Biking to Work	US Census Bureau, American Community Survey. 2012-16.
Diabetes & Obesity	Diabetes Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diabetes & Obesity	Diabetes Management (Hemoglobin A1c Test)	Percent Medicare Enrollees with Diabetes with Annual Exam	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2014.
Diabetes & Obesity	Diabetes Prevalence	Percent Adults with Diagnosed Diabetes (Age-Adjusted)	UCLA Center for Health Policy Research, AskCHIS 2007-2016
Diabetes & Obesity	Diabetes Prevalence	Percentage of adults who were ever diagnosed with diabetes	UCLA Center for Health Policy Research, AskCHIS 2007-2016
Diabetes & Obesity	Farmer’s Market Access	Average distance (miles) to nearest farmers’ market	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Information Services

Category	Indicator	Indicator Variable	Data Source
			Department Farmers Market 2016
Diabetes & Obesity	Fast food consumption	Percent of adults who ate fast food at least weekly in the past 30 days	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2013-14, Behavioral Risk Factor Survey
Diabetes & Obesity	Fast Food Consumption (Ages 2-11)	Children (ages 2-11) who ate fast food 1 or more times in the past 7 days. Available by race.	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey. Retrieved from 2016 Status of Children's Health Report.
Diabetes & Obesity	Fast Food Consumption (Middle/High School)	Middle and high school students who ate fast food 1 or more times in the past 7 days. Available by race.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Diabetes & Obesity	Fast Food Restaurants per Square Mile	Average distance (miles) to nearest full-service grocery store	Santa Clara County Public Health Department, 2016 City Profiles; InfoUSA 2014
Diabetes & Obesity	Fast Food Restaurants Rate	Fast Food Restaurants, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
Diabetes & Obesity	Food Desert Population	Percent Population with Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.
Diabetes & Obesity	Grocery Stores (distance)	Average distance (miles) to nearest full-service grocery store	Santa Clara County Public Health Department, 2016 City Profiles; InfoUSA 2014
Diabetes & Obesity	Grocery Stores Rate	Grocery Stores, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
Diabetes & Obesity	Health Risk Zone for Body Composition (5th, 7th, and 9th Graders)	Percentage of 5th, 7th, and 9th graders in the county who are obese or in the "health risk"	California Department of Education, FITNESSGRAM, 2013-14. Retrieved from 2016 Status of Children's Health

Category	Indicator	Indicator Variable	Data Source
		zone according to body composition. Body composition was assessed by FITNESSGRAM, a measure of aerobic capacity and body composition. Available by region and school district.	Report.
Diabetes & Obesity	Low Fruit/Vegetable Consumption (Adult)	Percent Adults with Inadequate Fruit / Vegetable Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09.
Diabetes & Obesity	Low Fruit/Vegetable Consumption (Youth)	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Diabetes & Obesity	Obese (Middle/High School)	Percentage of middle and high school students who are obese. Available by gender.	California Healthy Kids Survey, 2013-14. Retrieved from 2016 Status of Children's Health Report.
Diabetes & Obesity	Obese Youth (Grades 5, 7 ,9)	Percentage of middle and high school students who are obese	California Healthy Kids Survey, 2006-2016; Healthy People 2020 (benchmark).
Diabetes & Obesity	Overweight or Obese (Adults)	Percentage of adults in Santa Clara County who are overweight or obese. Available by race.	Santa Clara County Public Health Department, 2013-2014 Behavioral Risk Factor Survey.
Diabetes & Obesity	Overweight or Obese (Youth)	Percentage of middle and high school students who are overweight or obese. Available by Asian subpopulation.	California Healthy Kids Survey, 2015-16. Retrieved from 2017 Asian Pacific Islander Report.
Diabetes & Obesity	Overweight or Obese Adults	Percentage of adults who are overweight or obese	UCLA Center for Health Policy Research, AskCHIS 2007-2016.

Category	Indicator	Indicator Variable	Data Source
Diabetes & Obesity	Overweight or Obese Youth	Percentage of middle and high school students who are overweight or obese	California Healthy Kids Survey, 2006-2015; retrieved from kidsdata.org.
Diabetes & Obesity	Overweight Youth (Grades 5, 7 ,9)	Percentage of middle and high school students who are overweight	California Healthy Kids Survey, 2006-2016
Diabetes & Obesity	Park Access	Percent Population Within 1/2 Mile of a Park	US Census Bureau, Decennial Census. ESRI Map Gallery. 2010.
Diabetes & Obesity	Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.
Diabetes & Obesity	Physical Inactivity (Youth)	Percent Physically Inactive	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes & Obesity	Recreation and Fitness Facility Access	Recreation and Fitness Facilities, Rate (Per 100,000 Population)	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
Diabetes & Obesity	Walking/Biking/Skating to School	Percentage Walking/Skating/Biking to School	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Diabetes & Obesity	WIC-Authorized Food Stores Rate	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Economic Security	Adults with Health Insurance	Percentage of adults who had health insurance. Available by Asian subgroup.	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.
Economic Security	Bachelor's Degree or Higher (Hispanic/Latino)	Percentage of adults ages 25 years and over with their education attainment. Available by race/ethnicity and degree type.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables, Tables DP02; generated by Baath M.; using American FactFinder; Accessed

Category	Indicator	Indicator Variable	Data Source
			July 14, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Economic Security	Bachelor's Degree or Higher in the API Population	Percentage of adults ages 25 years and over with their education attainment. Available by Asian subgroup.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables. Retrieved from 2017 Asian Pacific Islander Report.
Economic Security	Children Eligible for Free/Reduced Price Lunch	Percent Students Eligible for Free or Reduced-Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Economic Security	Economic Security - Households with No Vehicle	Percentage of Households with No Motor Vehicle	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Economic Security - Unemployment Rate	Unemployment Rate	US Department of Labor, Bureau of Labor Statistics. 2018 - March.
Economic Security	Education - Head Start Program Facilities	Head Start Programs Rate (Per 10,000 Children Under Age 5)	US Department of Health & Human Services, Administration for Children and Families. 2018.
Economic Security	Education - High School Graduation Rate	Cohort Graduation Rate	California Department of Education,2014-15.
Economic Security	Education - Less than High School Diploma (or Equivalent)	Percent Population Age 25+ with No High School Diploma	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Education - Reading Below Proficiency	Percentage of Grade 4 ELA Test Scores Below Standard	California Department of Education, 2015-16.
Economic Security	Education - School Enrollment Age 3-4	Percentage of Population Age 3-4 Enrolled in School	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Food Security - Food Insecurity Rate	Percentage of Total Population with Food Insecurity	Feeding America.,2014.
Economic Security	Food Security - Population Receiving SNAP	Percent Population Receiving SNAP Benefits	US Census Bureau, Small Area Income & Poverty Estimates. 2015.

Category	Indicator	Indicator Variable	Data Source
Economic Security	Higher Educational Attainment	Percentage of adults ages 25 years and over with their education attainment. Available by race/ethnicity.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables, Tables DP02; generated by Baath M.; using American FactFinder; Accessed July 14, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Economic Security	Homelessness	Total number of homeless individuals enumerated during the point-in-time homeless census with trend, Santa Clara County. Percentage of homeless individuals enumerated during the point-in-time count.	Applied Survey Research. (2017). Santa Clara County Homeless Census and Survey.
Economic Security	Housing - Assisted Housing	HUD-Assisted Units, Rate per 10,000 Housing Units	US Department of Housing and Urban Development, 2016.
Economic Security	Housing - Cost Burdened Households	Percentage of Households where Housing Costs Exceed 30% of Income	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Housing - Substandard Housing	Percent Occupied Housing Units with One or More Substandard Conditions	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Housing - Vacant Housing	Vacant Housing Units, Percent	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Income Inequality	Gini Index Value	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Poverty - Children Below 100% FPL	Percent Population Under Age 18 in Poverty	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Poverty - Population Below 100% FPL	Percent Population in Poverty	US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Variable	Data Source
Economic Security	Poverty - Population Below 200% FPL	Percent Population with Income at or Below 200% FPL	US Census Bureau, American Community Survey. 2012-16.
Economic Security	Preschool Enrollment	Percentage of children ages 3 and 4 who are enrolled in a preschool or nursery school. Available by Asian subgroup. Data are not presented for Pacific Islanders due to small sample size.	U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables and U.S. Census Bureau, 2010 Census. Retrieved from 2017 Asian Pacific Islander Report.
Economic Security	Rate of Receiving Food from a Church or Food Bank/Food Pantry	The percentage of adults or another adult in the family who received food from a church, food pantry or food bank in the past 12 months. Available by race.	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey.
Economic Security	Received Food	Percent of families that received food from a church, food pantry, or food bank in previous 12 months	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Economic Security	Residents Age 5 and Older Who Do Not Speak English Very Well	Percentage of population ages 5 years and older who do not speak English 'very well.' Available by Asian subgroup.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables. Retrieved from 2017 Asian Pacific Islander Report.
Economic Security	Seniors Living in Poverty	The rate of seniors ages 65 years and over living below the 100% Federal Poverty Level. Available by Asian subgroup.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables. Retrieved from 2017 Asian Pacific Islander Report.
Economic Security	Unemployment	Percentage of the population ages 16 years and older who are unemployed. Available by Asian subgroup.	U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables. Retrieved from 2017 Asian Pacific Islander Report.

Category	Indicator	Indicator Variable	Data Source
General Health/ Mortality	Death - Causes	Percent of deaths by cause	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017
General Health/ Mortality	Death Rate	Age-adjusted death rates (all causes) per 100,000 people. Available by gender, ethnicity, and trends over time.	Santa Clara County Public Health Department, VRBIS, 2014-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
General Health/ Mortality	Death Rate among Asian Residents	Age-adjusted death rates (all causes). Available by Asian subgroup.	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census. Retrieved from 2017 Asian Pacific Islander Report.
General Health/ Mortality	Life expectancy	Years	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2009-2013 Death Statistical Master File; U.S. Census Bureau, 2010 U.S. Census
General Health/ Mortality	Life Expectancy	Life expectancy (in number of years) at birth among residents in Santa Clara County. Available by race/ethnicity.	Santa Clara County Public Health Department, VRBIS, 2014-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.

Category	Indicator	Indicator Variable	Data Source
General Health/ Mortality	Life Expectancy among Asian Residents	Life expectancy (in number of years) at birth among residents in Santa Clara County.	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census. Retrieved from 2017 Asian Pacific Islander Report.
General Health/ Mortality	Mortality - Premature Death	Years of Potential Life Lost, Rate per 100,000 Population	University of Wisconsin Population Health Institute, County Health Rankings. 2014-16.
General Health/ Mortality	Poor General Health	Percent Adults with Poor or Fair Health (Age-Adjusted)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
General Health/ Mortality	Population with Any Disability	Percent Population with a Disability	US Census Bureau, American Community Survey. 2012-16.
Heart & Stroke	Causes of Death	Percentage and ranking of total deaths by cause.	Santa Clara Public Health Department, 2016. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018
Heart & Stroke	Heart Disease Prevalence	Percent Adults with Heart Disease	University of California Center for Health Policy Research, California Health Interview Survey. 2011-12.
Heart & Stroke	High Blood Pressure	Percentage of Asian/Pacific Islander survey respondents who were ever diagnosed with high blood pressure. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.
Heart & Stroke	High Blood Pressure - Unmanaged	Percent Adults with High Blood Pressure Not Taking Medication	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Category	Indicator	Indicator Variable	Data Source
Heart & Stroke	High Cholesterol	Percentage of Asian/Pacific Islander survey respondents were ever diagnosed with high blood cholesterol. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2017 Asian/Pacific Islander Health Survey. Retrieved from 2017 Asian Pacific Islander Report.
Heart & Stroke	Hypertension	Adults who were ever diagnosed with high blood pressure (hypertension)	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2013-14, Behavioral Risk Factor Survey
Heart & Stroke	Mortality – Hypertension Deaths	Hypertension deaths per 100,000 people	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2009-2013 Death Statistical Master File; U.S. Census Bureau, 2010 U.S. Census.
Heart & Stroke	Mortality - Ischaemic Heart Disease	Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Heart & Stroke	Mortality - Stroke	Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Maternal & Infant Health	Breastfeeding (Any)	Percentage of Mothers Breastfeeding (Any)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Maternal & Infant Health	Breastfeeding (Exclusive)	Percentage of Mothers Breastfeeding (Exclusively)	California Department of Public Health, CDPH - Breastfeeding Statistics. 2012.
Maternal & Infant Health	Inadequate Prenatal Care	Percentage of mothers who received inadequate prenatal care. Inadequate prenatal care is defined as receiving less than	Santa Clara County Public Health Department, 2015 Birth Statistical Master File. Retrieved from 2017 Asian Pacific Islander Report.

Category	Indicator	Indicator Variable	Data Source
		50% of expected prenatal care visits and/or initiating prenatal care after the fourth month of pregnancy. Available by Asian subpopulation.	
Maternal & Infant Health	Infant Mortality	Infant Mortality Rate (Per 1,000 Births)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2006-10.
Maternal & Infant Health	Infant Mortality	Infant Mortality Rate (Per 1,000 Births)	Santa Clara County Public Health Department, VRBIS, 2007-2015. Data as of 05/26/2017; Santa Clara County Public Health Department, Birth Statistical Master File, 2007-2015
Maternal & Infant Health	Infant Mortality Rate	Infant mortality rate is the number of deaths occurring in infants younger than one year per 1,000 live births. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2007-2015 Birth Statistical Master File; Santa Clara County Public Health Department, VRBIS, 2007-2015. Data as of 05/26/2017. Retrieved from the 2017 Asian Pacific Islander Report.
Maternal & Infant Health	Infant Outcomes among Mothers Ages 45+	Percentage of mothers who are 45 years and over who received prenatal care in their first trimester; percentage of mothers who are 45 years and over who gave birth to preterm babies; percentage of mothers who gave birth to low birthweight babies.	Santa Clara County Public Health Department, 2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal & Infant Health	Low Birth Weight	Percentage of live births with birth weight of less than 2,500 grams (5 lbs, 8oz), 2006-2015	Santa Clara County Public Health Department, Birth Statistical Master File, 2006-2015
Maternal & Infant Health	Low Birthweight	Percentage of low birthweight among Santa Clara County	Santa Clara County Public Health Department, Birth Statically Master

Category	Indicator	Indicator Variable	Data Source
		residents. Low birthweight is percentage of live births with birth weight of less than 2,500 grams (5 lbs, 8oz). Available by age group.	File, 2006-2015; Kidsdata.org. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Maternal & Infant Health	Prenatal Care	Mothers who received early and adequate prenatal care	Santa Clara County Public Health Department, 2016 City Profiles; Santa Clara County Public Health Department, 2009-2013 Birth Statistical Master File
Maternal & Infant Health	Prenatal Care in First Trimester	Percentage of mothers receiving prenatal care in the first trimester. Available by race.	Santa Clara County Public Health Department, 2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal & Infant Health	Preterm Births	The percentage of births classified as preterm. A preterm birth occurs when children are born before 37 weeks of gestation. Available by mother who did not receive prenatal care and by race.	Santa Clara County Public Health Department, 2009-2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal & Infant Health	Preterm Births (Asian residents)	The percentage of births classified as preterm. A preterm birth occurs when children are born before 37 weeks of gestation. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2015 Birth Statistical Master File. Retrieved from the 2017 Asian Pacific Islander Report.
Maternal & Infant Health	Preterm Births among Mothers who did Receive Prenatal Care	Percentage of preterm births among mothers who did not receive prenatal care.	Santa Clara County Public Health Department, 2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal & Infant Health	Teen Births (API Populations)	Teenage (ages 15-19) birth rate per 1,000 females. Available by Asian subpopulation.	Santa Clara County Public Health Department, 2006-2015 Birth Statistical Master File; U.S. Census Bureau; 2010

Category	Indicator	Indicator Variable	Data Source
			Census. Retrieved from 2017 Asian Pacific Islander Report.
Maternal & Infant Health	Teen Births (Under Age 20)	Teen birth rate is number of births per 1,000 females ages 15 to 19 years	Santa Clara County Public Health Department, Birth Statistical Master File, 2006-2015
Maternal & Infant Health	Teen Births by Region	Teen live birth per 1,000 females (ages 15-19) in Santa Clara County. Available by zip code.	Santa Clara County Public Health Department, 2009-2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal & Infant Health	Teens Receiving Early Prenatal Care	Percentage of mothers under age 15 who received prenatal care in their first trimester.	Santa Clara County Public Health Department, 2013 Birth Statistical Master File. Retrieved from 2016 Status of Children's Health Report.
Maternal/Infant Health	Teen Births	Teenage (ages 15-19) live birth rate per 1,000 females. Available by race.	California Department of Public Health, 2004-2013 Vital Statistics
Natural Environment	Air Quality - Ozone (O3)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012.
Natural Environment	Air Quality - Particulate Matter 2.5	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012.
Natural Environment	Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Natural Environment	Drought Severity	Percentage of Weeks in Drought (Any)	US Drought Monitor, 2012-14.
Natural Environment	Exposed to Unsafe Drinking Water	Percentage of Population Potentially Exposed to Unsafe Drinking Water	University of Wisconsin Population Health Institute, County Health Rankings. 2012-13.
Natural Environment	Heat Index Days	Percentage of Weather	National Oceanic and Atmospheric

Category	Indicator	Indicator Variable	Data Source
		Observations with High Heat Index Values	Administration, North America Land Data Assimilation System (NLDAS). Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
Natural Environment	Heat Stress Events	Heat-related Emergency Department Visits, Rate per 100,000 Population	California Department of Public Health, CDPH - Tracking. 2005-12.
Oral Health	Dental Care - Lack of Affordability (Youth)	Percent Population Age 5-17 Unable to Afford Dental Care	University of California Center for Health Policy Research, California Health Interview Survey. 2009.
Oral Health	Dental Decay/Gum Disease (Adult)	Dental Decay/Gum Disease (Adults 45-64	Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
Oral Health	Living in Dental Health Professional Shortage Area	Percentage of Population Living in a HPSA	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.
Oral Health	No Recent Dental Exam (Adult)	Percent Adults Without Recent Dental Exam	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Oral Health	No Recent Exam (Children)	Percent Youth Without Recent Dental Exam	University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.
Oral Health	Poor Dental Health (Adult)	Percent Adults with Poor Dental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Sexually Transmitted Infections	Chlamydia	Chlamydia rates per 100,000 people, 2007-2016, Santa Clara County	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2007-2011) &

Category	Indicator	Indicator Variable	Data Source
			California Reportable Disease Information Exchange (CalREDIE) (2011-2016), data are provisional as of 5/5/2017. STD Control Branch, California Department of Public Health.
Sexually Transmitted Infections	Chlamydia Rate (Ages 0-17)	The rate of chlamydia per 100,000 children (ages 0-17). Trend data available. Available by gender.	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2009-2011) & California Reportable Disease Information Exchange (CalREDIE) (2011-2014). Retrieved from 2016 Status of Children's Health Report.
Sexually Transmitted Infections	Early syphilis	Early syphilis rates (per 100,000 people)	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2007-2011) & California Reportable Disease Information Exchange (CalREDIE) (2011-2016), data are provisional as of 5/5/2017. STD Control Branch, California Department of Public Health, Sexually Transmitted Diseases in California 2016 Executive Summary.
Sexually Transmitted Infections	Gonorrhea	Gonorrhea rates per 100,000 people, 2007-2016, Santa Clara County	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2007-2011) & California Reportable Disease Information Exchange (CalREDIE) (2011-2016), data are provisional as of 5/5/2017. STD Control Branch, California Department o
Sexually Transmitted Infections	Gonorrhea Rate (Ages 0-17)	The rate of gonorrhea per 100,000 children (ages 0-17). Trend data available. Available by gender.	Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2009-2011) & California Reportable Disease Information Exchange (CalREDIE)

Category	Indicator	Indicator Variable	Data Source
			(2011-2014). Retrieved from 2016 Status of Children's Health Report.
Sexually Transmitted Infections	HIV	HIV rates (Per 100,000 Pop.)	Santa Clara County Public Health Department, enhanced HIV/AIDS reporting system (eHARS), 2007-2016, data are provisional as of April 30, 2017 and subject to change;
Sexually Transmitted Infections	HIV Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Sexually Transmitted Infections	No HIV Screening	Percent Adults Never Screened for HIV / AIDS	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Transportation & Traffic	Public Transit within 0.5 Miles	Percentage of Population within Half Mile of Public Transit	Environmental Protection Agency, EPA Smart Location Database. 2011.
Transportation & Traffic	Road Network Density	Total Road Network Density (Road Miles per Acre)	Environmental Protection Agency, EPA Smart Location Database. 2011.
Unintentional Injury	Causes of All Death among Older Adults	Percentage of all deaths among residents ages 65 and older by cause (i.e., accidental falls).	Selected Santa Clara County Public Health Department data provided via e-mail, July 31, 2018.
Unintentional Injury	Causes of Injury Death among Older Adults	Percentage of injury deaths among residents ages 65 and older by cause (i.e., unintentional injuries).	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.
Unintentional Injury	Deaths due to Falls among Older	Age-adjusted death rate due to	Santa Clara County Public Health

Category	Indicator	Indicator Variable	Data Source
	Adults	unintentional falls among seniors ages 65 and older per 100,000 population. Available by Asian subpopulation.	Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census.
Unintentional Injury	Fatal Motor Vehicle Accident Rate	Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Unintentional Injury	Fatal Pedestrian Accident Rate	Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data. 2010-12.
Unintentional Injury	Motor Vehicle Hospitalization Rate	Motor Vehicle Hospitalization Rate (per 100,000 Population)	Office of Statewide Health Planning and Development, 2014 Patient Discharge Data; State of California, Department of Finance, State and County Population Projection, 2010-2060. Sacramento, California, February, 2017
Unintentional Injury	Senior Falls Mortality Rate	Age-Adjusted Rate of deaths due to falls (per 100,000 aged 65 and older)	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census.
Unintentional Injury	Unintentional Injury Mortality	Age-adjusted rate of unintentional injury deaths among residents in Santa Clara County per 100,000 population. Trend data available. Available by age group.	Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017. Selected Santa Clara County Public Health Department data provided via e-mail, January 2018.

Category	Indicator	Indicator Variable	Data Source
Unintentional Injury	Unintentional Injury Rate (Children)	The age-adjusted rate of emergency department visits due to non-fatal unintentional injury per 100,000 children (ages 0-17). Available by ethnicity.	Office of Statewide Health Planning and Development, 2013 Emergency Department Data; Office of Statewide Health Planning and Development, 2013 Patient Discharge Data. Retrieved from 2016 Status of Children's Health Report.

Attachment 3. Secondary Data Tables, Santa Clara County

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Introduction

Health needs data found in the following tables were collected primarily from the publicly available Community Commons data platform.[i] Other Santa Clara County Public Health Department data were reviewed and are noted in the report. Pertinent data points on health needs from these sources are included in the following data tables:

- 2017 Asian Pacific Islander report (API)
- 2016 Status of Children's Health Report (CR)
- 2015-20 Community Health Assessment-Community Health Improvement Plan (CHA)
- Behavioral Risk Factor Survey (BRFS)
- Status of African/African Ancestry Health: Santa Clara County 2014 Report (AAH)
- Selected public health statistics provided via email, January 2018 (PHD)

Statistical data tables compare Santa Clara County data to California state benchmarks or Healthy People 2020 aspirational goals, whichever is more stringent.

Definitions:

Incidence rate	Rate of new cases within a specific time period
Mortality rate	Rate of deaths from a given condition compared with a specified population
Prevalence	Proportion of a population with the aforementioned condition
Age-adjusted rate	Statistically modified rate that eliminates the effect of different age distributions in the populations

Conventions:

- Core indicators are separated from drivers by a heavy border.
- Certain indicators are available by ethnicity, which shows disparities in certain populations. Those tables follow each of the overall health need tables if available.
- Rates are per 100,000 unless otherwise noted.
- If available, data are rounded to the nearest tenth – unless the data point is less than 1.0, in which case it is rounded to the nearest hundredth.
- Data in tables that are worse than benchmarks are in **bold type.**
- Data that are 5% worse (not five percentage points, but 5 percent) than benchmarks are marked with a diamond (◆).
- Data where trends are available are denoted with the dagger (†) symbol.

- Indicator details, including the year and original source, may be found in “List of Data Indicators” (provided separately).
- In keeping with the 2015 African/African Ancestry report, we use the term “African/ African Ancestry” or “of African descent” to refer to all African people. Please note that the data sources from which ethnicity data are provided may use the terms “Black” and/or “African-American” in their surveys and studies. The term African/African Ancestry is more inclusive and emphasizes the connectedness of all African people.

Social Determinants of Health

Health needs in the social determinants of health category are those which impact our health by way of our social and physical environments. The Healthy People 2020 framework organizes its research on social determinants of health in five domains: 1. Economic Stability, 2. Education, 3. Health and Health Care, 4. Neighborhood and Built Environment, and 5. Social and Community Context. The data tables found in this section all pertain to domains 1-4.

Figure 1, Social Determinants of Health Domains

Source: HealthyPeople.gov

Healthcare Access & Delivery

Table 1, Statistical Data for Healthcare Access & Delivery

Indicators	SCC	Benchmark	Desired ↑↓
Access to Dentists Rate[†]	109.0	80.2	↑
Access to Primary Care Rate[†]	112.9	86.7	↑
Lack of Consistent Source of Primary Care	11.6%	14.3%	↓
Access to Mental Health Care Providers Rate	**272.4**	**280.6**	↑
Uninsured Population (2012—2016)	7.7%	12.6%	↓
Federally Qualified Health Centers Rate	**♦1.9**	**2.5**	↑
Living in Health Professional Shortage Area - Primary Care	0.0%	5.1%	↓
Preventable Hospital Events Rate (per 1,000 Medicare Beneficiaries)	27.7	35.9	↓
Population Receiving Medicaid	17.5%	25.6%	↓
Health Professional Shortage Area - Dental	0.0%	26.1%	↓
Cancer Screening - Mammogram	62.1%	59.7%	↑
Cancer Screening - Pap Test	78.5%	78.3%	↑
Cancer Screening - Sigmoid/Colonoscopy	65.2%	57.9%	↑
Population with Any Disability	7.8%	10.6%	↓
Limited English Speaking Households	**♦10.6%**	**9.2%**	↓
Population with Limited English Proficiency	**♦21.1%**	**18.8%**	↓
Linguistically Isolated Households	**♦9.9%**	**8.6%**	↓

Rates are per 100,000 population unless otherwise noted.

- Rates for access to dentists and access to primary care have both been increasing in the county.

Table 2, Statistical Data for Healthcare Access & Delivery by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Pac Isl	Other	Multi Race	Hispanic/ Latino (Any Race)
Lack of consistent source of primary care	14.3%	8.4%	**♦23.5%**			11.6%		**14.5%**
Uninsured Population (2012-2016)	12.6%	4.5%	8.4%	5.6%	9.1%	**♦16.8%**	6.2%	**♦14.8%**
Limited English Speaking Households	9.4%				**26.5%**			**17.9%**

Other key findings related to healthcare access were found in the Santa Clara County Public Health Department reports. No comparisons were provided for this data.

- Children of African descent were most likely to visit the emergency department.
- Fewer children from East Side San Jose and South County have health insurance compared to children in other sub-county areas.
- The 2014 Santa Clara County Behavioral Health Risk Survey found that while 99% of children aged 0-5 had routine annual check-ups, that proportion dropped to 91% for children aged 6-11.[CHA]
- The 2013 Status of LGBTQ Health report cited problems with discrimination within healthcare settings and a shortage of LGBTQ-competent providers, which can lead to suboptimal health outcomes for LGBTQ people.[LH]
- Four in ten (41%) Chinese residents do not speak English very well.[API]
- More than a third each of Chinese, Korean, and Vietnamese survey respondents reported having a hard time understanding their doctors.[API]
- Costs are a barrier to care for some Asian subpopulations: 35% of Pacific Islanders surveyed reported not seeing their doctors due to cost and 17% of Vietnamese residents do not take medicines as prescribed due to cost.[API]

Community & Family Safety

Community & Family Safety refers to data about neighborhood and family safety including crime, violence, and abuse. See Unintentional Injuries for data regarding accidents.

Table 3, Statistical Data for Community Safety

Indicators	SCC	Bench-mark	Desired ↑↓
Homicide Rate	2.8	5.2	↓
Youth Intentional Injury (assault and self-harm)	168.6	209.7	↓
Violent Assault Injury Rate	181.4	289.4	↓
Domestic Violence Injuries Rate (Females)	3.2	4.9	↓
Violent Assault Crime Rate	144.5	249.4	↓
Robbery Rate	84.0	149.5	↓
All Violent Crimes Rate	253.9	425.0	↓
Rape Rate	**◆22.8**	**21.0**	**↓**
Alcohol - Excessive Consumption	14.7%	17.2%	↓
Liquor Store Access Rate	8.9	10.6	↓
School Suspensions Rate (per 100 students)	4.2	6.8	↓
School Expulsions Rate (per 100 students)	0.07	0.09	↓

Rates are per 100,000 population unless otherwise noted.

Other findings from the Children's Report[CR]:

- One in five (19%) middle and high school students were physically bullied on school property in the past 12 months, higher than the Healthy People 2020 target of 17.9%. Students of African Ancestry were more likely to be physically bullied.
- 37% of students were psychologically bullied on school property in the past 12 months.
- 18% of students reported they experienced cyberbullying in the past 12 months, similar to CA (22%). Females were psychologically bullied and cyberbullied at higher percentages (41% and 22%, respectively) than males.
- Males (23%) were physically bullied more than females (15%).
- The percentage of middle and high school students who were physically bullied on school property in the past 12 months declined from 32% to 19% since 2007. The percentage of middle and high school students who were psychologically bullied on school property in the past 12 months declined from 48% to 37% since 2007.

- The rate of substantiated child maltreatment was higher among African Ancestry children than other racial/ethnic groups and higher among children ages 0 to 5. Research suggests an association between poverty and child maltreatment; African and Latino Ancestry children experienced higher rates of poverty and higher rates of maltreatment nationwide.
- Youth assault and youth taking weapons to school was higher among students of African Ancestry and Latinos.
- 2014 data by city show that violent crime rate was highest in the cities of San Jose and Sunnyvale, at 21.8 and 20.3 average number of violent crime within one mile respectively.

Table 4, Statistical Data for Community Safety by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Multi Race	Hispanic/ Latino (Any Race)
Homicide Rate	5.2	1.6	◆**7.2**	0.0	3.4	5.1
Youth Intentional Injury (assault and self-harm)	209.7	◆**300.4**	◆**258.4**	85.2		163.5
Violent Assault Injury Rate	289.4	175.1	◆**640.4**	49.3		◆**330.9**
Domestic Violence Injuries Rate (Females)	4.9	3.3		1.6		**5.0**
School Suspensions Rate (per 100 students)	6.8	2.9	◆**11.6**	0.85	3.6	◆**7.1**
School Expulsions Rate (per 100 students)	0.09	0.05	◆**0.20**	0.02	0.04	◆**0.11**

Rates are per 100,000 population unless otherwise noted. There were no ethnicity data for those of "other" race/ethnicity.

Economic Stability

Table 5, Statistical Data for Economic Security

Indicators	SCC	Bench-mark	Desired ↑↓
Unemployment Rate	2.6	5.6	↓
Income Inequality (Gini Coefficient)	0.47	0.49	↓
Population Below 200% FPL	21.7%	35.2%	↓
Population Below 100% FPL	9.3%	15.8%	↓
Children Below 100% FPL	10.5%	21.9%	↓
Less than High School Diploma (or Equivalent)	12.9%	17.9%	↓
High School Graduation Rate†	83.6	H82.4	↑
Reading Below Proficiency	**42.0%**	**H36.3%**	**↓**
Children Eligible for Free/Reduced Price Lunch	37.5%	58.7%	↓
Population Receiving SNAP†	5.1%	9.4%	↓
Population Receiving Medicaid	17.5%	25.6%	↓
Uninsured Population (2012-2016)	7.7%	12.6%	↓
School Enrollment Age 3-4	56.9%	48.6%	↑
Head Start Program Facilities Rate (per 10,000 children 0-5)	**◆2.7**	**6.3**	**↑**
Food Insecurity Rate	11.0%	13.9%	↓
Food Insecurity Rate – Children under 18	19.3%	**25.3%**	↓
Food Insecure Population Ineligible for Assistance	**◆39%**	**22%**	**↓**
Food Insecure Population Ineligible for Assistance - Children	**◆46%**	**29%**	**↓**
Commute Over 60 Minutes	8.4%	10.9%	↓
Households with No Vehicle[1]	5.1%	7.8%	↓

Rates are per 100,000 population unless otherwise noted.

In addition:

- The 2014 Santa Clara County Behavioral Risk Survey found that 16% of African/African Ancestry and 25% of Latinos had received food from a church or food bank/food pantry.[BRFS]

Please see Table 7 for data on **Housing & Homelessness.**

[1] This indicator is relevant because individuals from households without access to a vehicle may lack access to healthcare, child care services, and employment opportunities.

Table 6, Statistical Data for Economic Security by Ethnicity

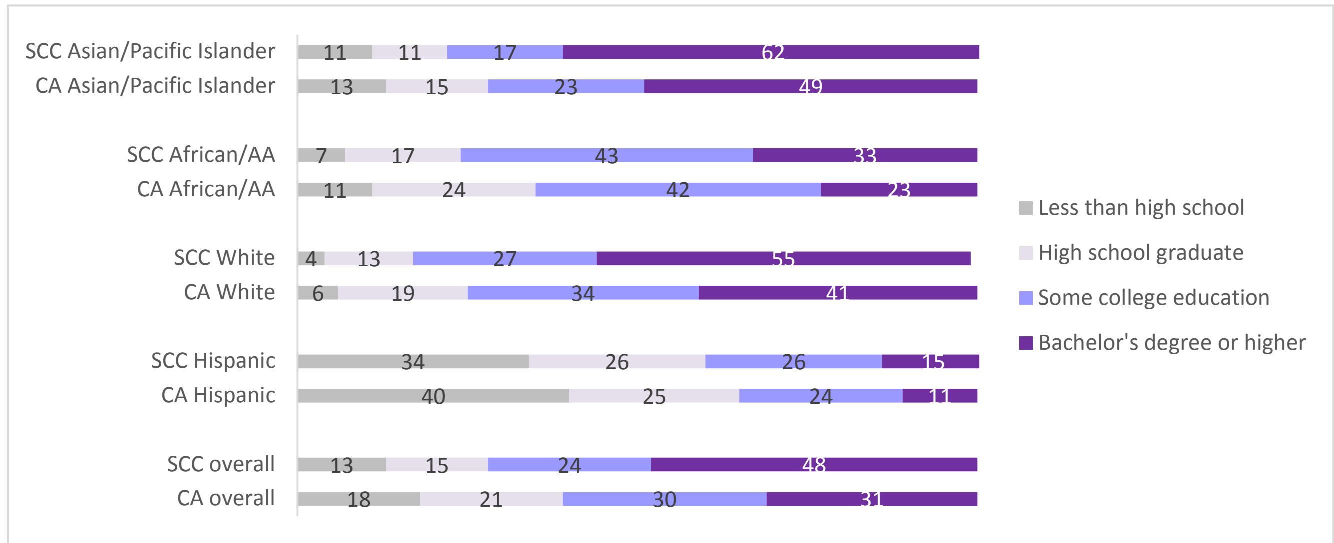
Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other	Multi Race	Hispanic/ Latino (Any Race)	Pac Isl	Native Am
Population Below 100% FPL (%)	15.8	6.0	**16.1**	7.7	**◆17.0**	8.6	15.0	7.8	14.1
Children Below 100% FPL (%)	21.9	10.8	**◆24.8**	16.6	**◆38.9**	**◆40.3**	**◆40.3**	7.9	**◆32.8**
High School Graduation Rate (percent of cohort)	82.4	92.5	78.8	95.2		91.0	**◆70.0**		**◆69.8**
Reading Below Proficiency 4th Grade	36.3	27.0	**◆60.0**	19.0		24.0	**◆67.0**	**◆61.0**	**58.0**
Less than Percent with High School Diploma or Equivalent (%)	17.9	3.9	8.8	10.2	**◆39.0**	9.8	**◆33.9**	12.9	**◆22.7**
Uninsured Population (2012-2016) (%)	12.6	4.5	8.4	5.6	**◆16.8**	6.2	**◆14.8**	9.1	11.2

Rates are per 100,000 population unless otherwise noted.

Additional statistical data about education:

- The county is much more educated than California overall; rates of higher education attainment are higher overall and higher for every ethnic group.[PHD]
- The high school graduation rate trend is flat.
- Hispanic/Latino residents are far less likely to have a bachelor's degree or higher (15%) than the county overall (48%).[PHD]
- Pacific Islanders are the least likely Asian subgroup to have a bachelor's degree or higher (19%) among the API population.[API]
- The population receiving SNAP is higher than California overall since 2006 and has been stable above 5.4% between 2010-2015.
- The proportion of residents five years and older who do not speak English very well:[API]
    - 35% of Asians/Pacific Islanders
    - Asian subgroups: Chinese (41%), Korean (43%), and Vietnamese (57%).
    - 29% of Latinos
    - 5% of African/African Ancestry residents
    - 4% of White residents
- Filipino (43%) and Vietnamese children (40%) have the lowest rates of preschool enrollment compared to other Asian/Pacific Islanders.[API]

Figure 2, Educational Attainment by Ethnicity (Percent)



Source: U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates, Selected Population Tables, Tables DP02; generated by Baath M.; using American FactFinder; Accessed July 14, 2017.

Additional statistical data about economic security and poverty:

- Almost one in five (18%) of Korean seniors are living at or below 100% of FPL.[API]
- Among Asian residents, Pacific Islanders have the highest rate of unemployment (16%) compared to the county overall (4%).[API]
- The 2017 Asian/API report specifies that, among Asian residents surveyed, Pacific Islanders reported having insurance less often (79%) than API respondents overall (91%).[API]

Housing & Homelessness

Table 7, Statistical Data for Housing & Homelessness

Indicators	SCC	Benchmark	Desired ↑↓
Vacant Housing Units	3.9%	8.2%	↓
Cost Burdened Households	37.3%	43.9%	↓
Median Rent, 2-Bedroom Unit	**◆$2,930**	**$2,150**	**↓**
Substandard Housing Units	40.4%	46.5%	↓
HUD-Assisted Housing Units Rate (per 10,000)	374.3	352.4	↑

Note: Rates above are for 2016.

- The Santa Clara County 2017 Point-in-Time Count reported that almost 7,400 people are experiencing homelessness. Nearly three-quarters of them (74%) are unsheltered. Minors comprise 15% of the homeless population, young adults aged 18-24 comprise 28%, and the majority (57%) are 25 years old and over.
- Housing and homelessness are related to economic security. See Tables 5 and 6 for data on economic security, which includes income, employment, and poverty.

Natural Environment

Table 8, Statistical Data for Natural Environment

Indicators	SCC	Benchmark	Desired ↑↓
Air Quality - Particulate Matter 2.5	0.00%	0.46%	↓
Exposed to Unsafe Drinking Water	0.0%	2.7%	↓
Air Quality - Ozone (O3)	0.0%	2.7%	↓
Climate & Health - Heat Index Days	0.00%	0.60%	↓
Climate & Health - Drought Severity	**93.7%**	**92.8%**	**↓**
Climate & Health - Heat Stress Events Rate	5.8	11.1	↓
Asthma Hospitalizations Rate (Age-Adjusted per 10,000)	6.6	8.9	↓
Asthma Hospitalizations Percent of Total Discharges	0.80%	0.88%	↓
Under Age 1	**◆0.14%**	**0.13%**	**↓**
Age 1-19	**◆4.47%**	**4.27%**	**↓**
Age 65+	**◆0.88%**	**0.77%**	**↓**
Asthma - Prevalence	13.5%	14.2%	↓
Road Network Density Rate (Acres)	**◆5.2**	**2.0**	**↓**
Living Within Half Mile of Public Transit	**◆4.4%**	**15.5%**	**↑**
Percent of Area with Tree Canopy Cover (population-weighted)	**◆9.8%**	**15.1%**	**↑**
Diabetes Hospitalizations Rate	7.9	10.4	↓
Diabetes Discharges (of Total Discharges)Error! Bookmark not defined.	0.69%	0.86%	↓
Average Days/Month with Poor Mental Health	2.7	3.6	↓
Heart Disease Mortality Rate	65.0	94.3	↓
Commute to Work - Alone in Car	**75.5%**	**73.4%**	**↓**

Rates are per 100,000 population unless otherwise noted. Note: No natural environment data are available by race/ethnicity.

Transportation & Traffic

Table 9, Statistical Data for Traffic & Transportation

Indicators	SCC	Benchmark	Desired ↑↓
Road Network Density (Acres)	◆5.2	2.0	↓
Living Within Half Mile of Public Transit	◆4.4%	15.5%	↑
Percent of Area with Tree Canopy Cover (population-weighted)	◆9.8%	15.1%	↑
Commute to Work - Alone in Car	75.5%	73.4%	↓

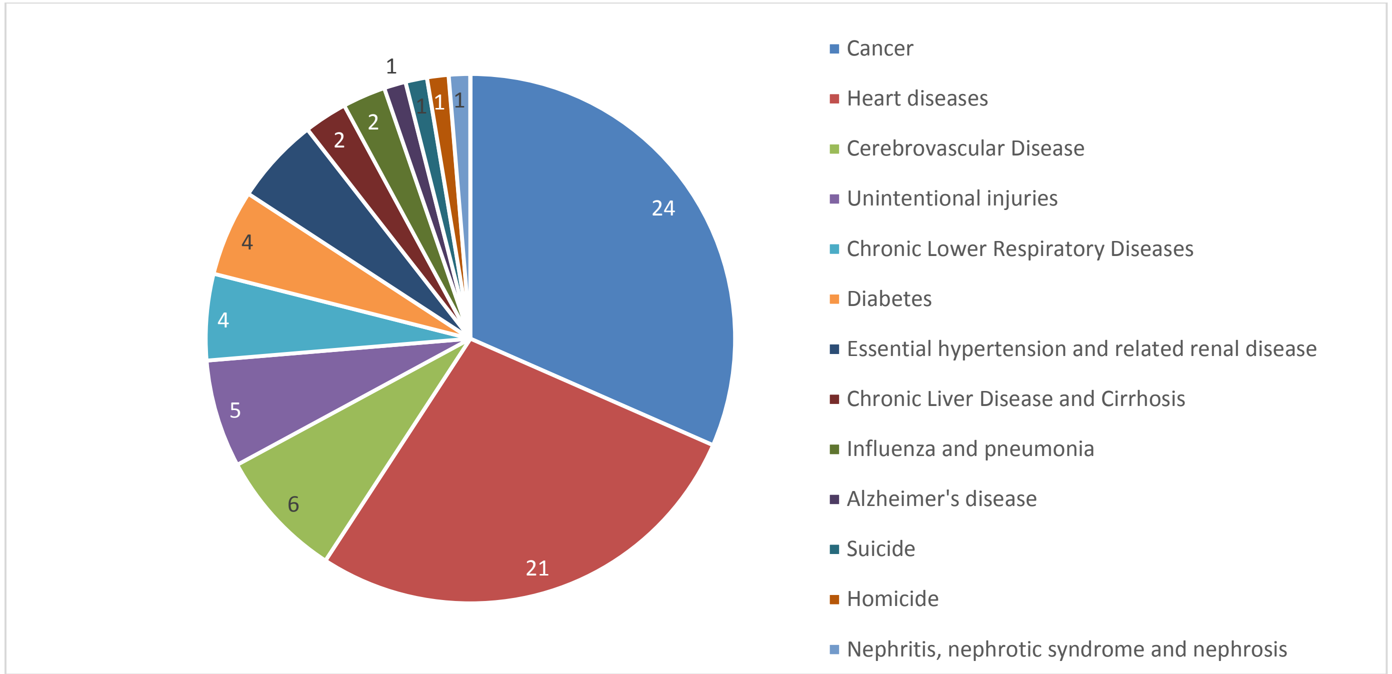
Please also see Table 8, Natural Environment, for conditions and drivers related to clean air.

Health Conditions

Health conditions are those topics that impact individual health, including health behaviors such as tobacco use, alcohol and drug use, mental health, and diseases or conditions.

General Health

Figure 3, Santa Clara County Percent of Causes of Death, 2016



Sources: Santa Clara County Public Health Department, VRBIS, 2014-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017; National Center for Health Statistics. Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD. 2017.

Table 10, Data Related General Health/Mortality

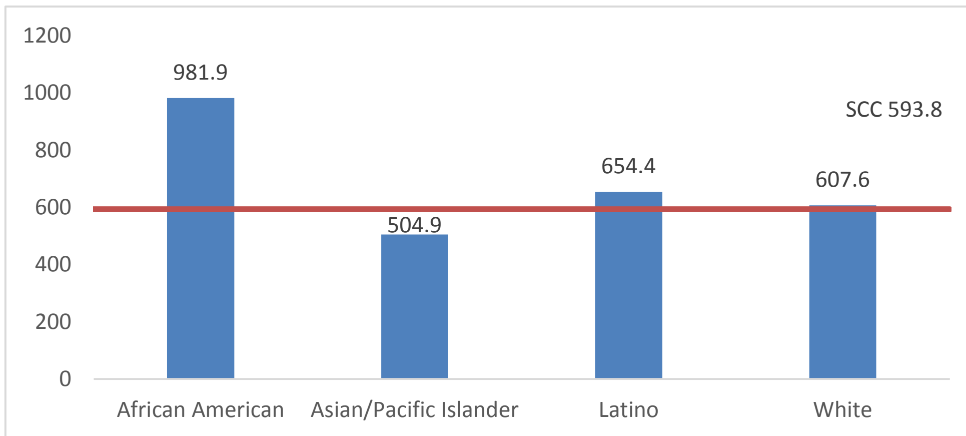
Indicators	SCC	Benchmark	Desired ↑↓
Poor General Health	13.5%	18.4%	↓
Premature Death (Years per 100,000)	3,622	5,308	↓
Life Expectancy at Birth (Years)[PHD]	82.3	78.8	↑
Population with Any Disability	7.8%	10.6%	↓

In addition, the death rate (due to all causes) has risen steadily from 2007, when it was 519.6 deaths per 100,000 people, to 593.8 in 2016. The death rate for males is 1.5 times as high as it is for women.[PHD]

Certain indicators are available by ethnicity, which shows disparities in certain populations:

- Residents of African or Native American descent are much more likely to be disabled than their white counterparts (89.4% and 14.9% respectively compared to 9.5%).◆ [PHD]
- ◆ Residents of African descent have a death rate that is 1.7 times as high as the county overall.[PHD] (See chart.)
- 2016 life expectancy for people of African descent is 75.7 years, 6.3 years less than their white counterparts (82.0). ◆ [PHD] Pacific Islanders have the lowest life expectancy among Asian residents at 78.7 years.[API]
- The Asian India age-adjusted death rate is 625.4, higher than the county overall at 593.8 and the API rate overall (504.9).
- In 2014, life expectancy was lowest in Gilroy (79 years) and Morgan Hill (80 years). Mortality rates were also highest in these two cities for cancer, heart disease, stroke, lower respiratory disease, and diabetes.

Figure 4, Death Rate (All Causes) by Ethnicity



Source: Santa Clara County Public Health Department, VRBIS, 2014-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017; National Center for Health Statistics. Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD. 2017

Asthma

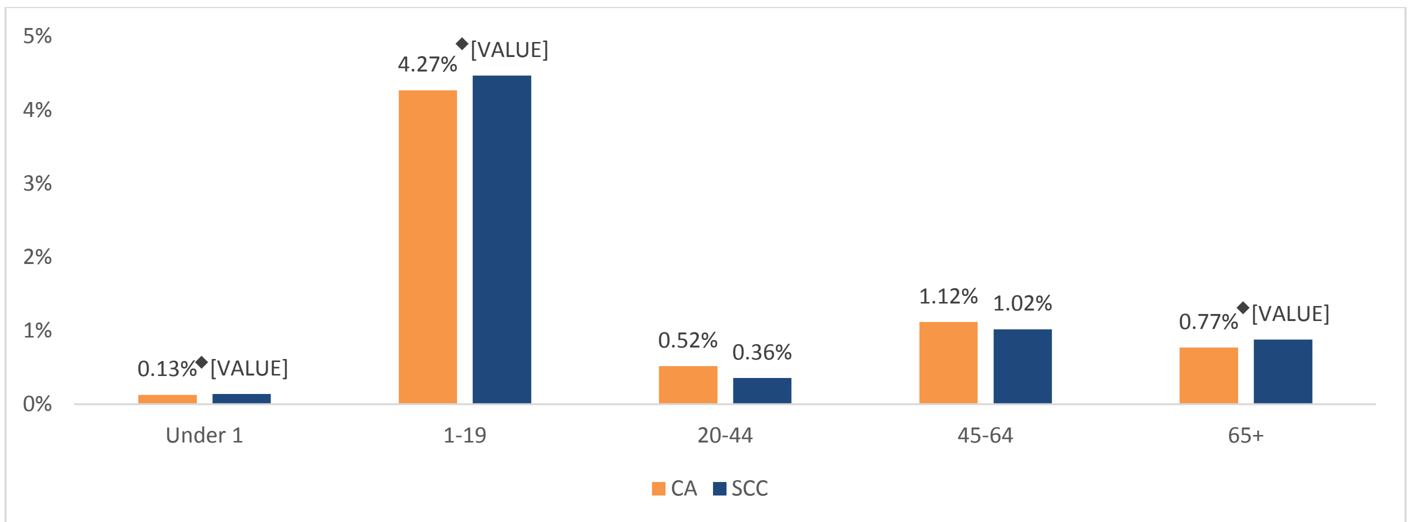
Table 11, Statistical Data Related to Asthma

Indicators	SCC	Bench-mark	Desired ↑↓
Asthma Prevalence	13.5%	14.2%	↓
Asthma Hospitalization Rate (Age-Adjusted per 10,000)	6.6	8.9	↓
Asthma Hospitalizations Percent of Total Discharges) (see chart)	0.80%	0.88%	↓
Under Age 1	**◆0.14%**	**0.13%**	**↓**
Age 1-19	**◆4.47%**	**4.27%**	**↓**
Age 65+	**◆0.88%**	**0.77%**	**↓**
Tobacco Usage	10.2%	12.8%	↓
Youth Cigarette Use[PHD]	3%	16%	↓
Youth E-Cigarette Use[PHD]	6%	N/A	↓
Air Quality - Particulate Matter 2.5	0.00%	0.46%	↓
Air Quality - Ozone (O3)	0.00%	2.65%	↓

Rates are per 100,000 population unless otherwise noted.

Obesity is also a driver of asthma. See Tables 21-22 (Diabetes & Obesity) for those data. Asthma hospital discharge data are available for other age groups; they were not worse than the benchmarks.

Figure 5, Asthma Hospitalizations Rate by Age



Retrieved from Community Commons. Source: CARES, 2011.

Table 12, Statistical data for Asthma by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other	Multi Race
Asthma Hospitalizations Percent of Total Discharges	0.88%	0.67%	◆**1.65%**	0.66%	0.87%	0.87%

Additional data are available in the 2017 Status of Children's Health report (Santa Clara County Public Health Department):

- Asthma trends for children under 18 were stable between 2001-2014 and are better than the rates seen in California.
- African/African Ancestry adolescents are more likely to report asthma attacks.
- Among Asian subpopulations, asthma diagnoses are most common for Filipinos (72%).
- Boys have higher asthma prevalence than girls.
- Adolescent girls are more likely to report having asthma attacks than adolescent boys.
- Emergency department visits for asthma are worst in East Palo Alto and Gilroy zip codes.

Behavioral Health

Below are statistical data for behavioral health (both mental health and substance use) in SCC.

Table 13, Statistical Data for Behavioral Health

Indicators	SCC	Benchmark	Desired ↑↓
Suicide Rate	8.1	10.3	↓
Suicide Attempt Hospitalizations Rate[PHD]	27.8	N/A	↓
Suicide Attempts (Self-Report – Youth) [CR]	11%	N/A	↓
Considered Suicide (High School Youth)[† CR]	**20%**	**19%**	**↓**
PTSD diagnosed [BRFS]	3%	N/A	↓
Frequent mental distress [BRFS]	9%	N/A	↓
Average Days/Month with Poor Mental Health	2.7	3.6	↓
Depression Among Medicare Beneficiaries[†]	10.6%	14.3%	↓
Tobacco Usage (2006-2012)[†]	10.2%	12.8%	↓
Youth Cigarette Use[† PHD]	3%	[H]16%	↓
Youth E-Cigarette Use[† PHD]	6%	10%	↓
Alcohol - Excessive Consumption	14.7%	17.2%	↓
Liquor Store Access	8.9	10.6	↓
Access to Mental Health Providers Rate	272.4	280.6	↑
Needing Mental Health Care	14.1%	15.9%	↓
Lack of Social or Emotional Support	22.2%	24.6%	↓

Rates are per 100,000 population unless otherwise noted.

Table 14, Statistical Data for Behavioral Health by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other or Multi Race	Hispanic/ Latino (Any Race)	Pacific Islander
Suicide Rate (Age-Adjusted)	10.3	**◆12.7**		4.8		4.7	
Suicide Attempt Hospitalizations Rate[PHD]	27.8	**◆39.9**	**◆52.0**	15.6 API		22.0	
Attempted Suicide (Self-Report MS/HS) [CR]	11% SCC	10%*	11%	7%		**◆13%**	
Considered Suicide (High School Youth)[CR †]	20% SCC	16%	19%	19%		**◆22%**	

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other or Multi Race	Hispanic/ Latino (Any Race)	Pacific Islander
PTSD diagnosed BRFS	3% SCC	5%				3%	
Frequent mental distress BRFS	9% SCC	10%	11%	7% API		11%	
Needing Mental Health Care	15.9%	10.4%	**◆32.2%**		9.8% Other	**◆22.9%**	
Youth Cigarette Use† PHD	16%	3%	5%	1%		4%	
Youth E-Cigarette Use† PHD	6% SCC	6%	**◆7%**	4%		**◆9%**	

Rates are per 100,000 population unless otherwise noted.

- Koreans have the highest suicide rate among Asian/Pacific Islander subgroups (8.0) [API]
- 11% of Vietnamese reported frequent mental distress.[BRFS]
- 43% of Pacific Islander survey respondents reported feeling depressed.[API]
- Among API subgroups, suicide was the leading cause of injury deaths among Korean (40%), Chinese (32%), and Vietnamese (24%) residents.[API]

Other key findings related to behavioral health were found in Santa Clara County Public Health Department. No comparisons were provided for this data unless otherwise noted.

Tobacco/smoking:

- Cigarette use is declining and is far below HP benchmarks (3% among adults and under 5% for adolescents).[PHD]
- E-cigarette use in SCC is at 6%, lower than it was in 2013-15. Higher proportions of 11th graders (9%) and non-traditional students (26%) use e-cigarettes.[CHA]
- Males (adult and youth) in the county are almost two times more likely to be smokers than women.[CHA CR]
- White and multiracial adults are less likely to prohibit smoking in their homes compared to females and their peers. Men are less likely to prohibit smoking in their homes compared to women.[BRFS]
- African/African Ancestry and Latino students in middle school/high school are most likely to smoke.[CR]

Drinking:

- Campbell has the highest rate of alcohol outlets per square mile of any city in the county at 5.6 (compared to 0.5 in Saratoga and 2.7 in the county). [PHD]
- Adult drinking is highest among White and multiracial populations.[CC]
- Latinos and men are more likely to engage in adult binge drinking.[CHA]
- Latino middle school/high school students most likely to binge drink.[CR]
- Middle school/high school girls more likely to binge drink than boys. [CR]

- Among Asian residents, Filipinos have the highest rates of binge drinking.[API]

Other substances (from the 2015 CHA report):

- Adult marijuana use was highest among Latino and White residents (13% and 12% respectively). Data are not available for African/African Ancestry adults.
- Latino misuse of prescription medicine (5%) is more than twice as high as the county overall (2%). Data are not available for African/African Ancestry or Asian adults.
- Students of African or Latino Ancestry are most likely to take certain substances compared with their peers of other races/ethnicities:
  - Middle school/high school marijuana use (also white students)
  - High school misuse of prescription meds
  - High school misuse of cold/cough meds
  - High school cocaine use
  - High school ecstasy use
  - High school inhalant use
- Boys more likely to use other substances than girls except for cold/cough medicines.

Mental Health

For more bullying data, see the Community Safety data (Table 8) or the Children's Report.[CR]

- The percentage of the Medicare population with depression is trending up.[CC]
- Suicidality among middle school/high school students is at 20%.
- Among Asian middle school/high school students, Filipinos reported feeling sad and hopeless most often (34%), followed by Pacific Islanders (34%) and Vietnamese students (33%).
- Latinos report higher levels of stress than in the overall county in all areas (about work, finances, food, health, and rent).[CHA]
- Asian residents report higher levels of stress about work and health than county residents overall.[CHA]
- Men are twice as likely as women to report being diagnosed with PTSD (4% compared to 2%).[BRFS]
- Suicide attempt hospitalization rates are higher among women (35.6) than men (20.6) (73% higher). By age, between 2007-2014, those aged 15 to 24 were hospitalized at the highest rate (56.3).
- Latino youth have the highest rates of suicide mortality and suicide attempts compared to youth of other races/ethnicities.[CR]
- The proportion of high school students who have ever seriously considered attempting suicide in the past 12 months increased from 17% in 2008-10 to 20% in 2013-14.[CR]
- Female students reported higher percentages of suicidal ideation than male students (25% vs. 15%, respectively).[CR]
- 37% of middle school/high school students report being psychologically bullied (37%).

- Nearly half of LGBTQ survey respondents felt they might have needed to see a mental health professional in the previous year.[LH]
- Nearly one quarter of LGBTQ survey respondents seriously considered suicide in the past year.[LH]

Cancers

Table 15, Statistical Data for Cancers

Indicators	SCC	Benchmark	Desired ↑↓
Cancer Incidence Rate (All Types)[PHD]	**426.6**	**409.2**	**↓**
Cancer Mortality Rate (All Types) [† PHD]	130.1	149.0	↓
Breast Cancer Incidence Rate[PHD]	**125.3**	**120.6**	**↓**
Breast Cancer Mortality Rate[† PHD]	18.0	20.4	↓
Cervical Cancer Incidence Rate[PHD]	5.0	7.3	↓
Cervical Cancer Mortality Rate[† PHD]	1.4	2.2	↓
Colon and Rectum Cancer Incidence Rate [PHD]	38.0	[H]38.7	↓
Colon and Rectum Mortality Rate[† PHD]	12.4	13.4	↓
Lung Cancer Incidence Rate[PHD]	43.4	44.5	↓
Lung Cancer Mortality Rate[† PHD]	29.5	33.2	↓
Prostate Cancer Incidence Rate[PHD]	**◆127.3**	**109.2**	**↓**
Prostate Cancer Mortality Rate[† PHD]	18.2	19.9	↓
Alcohol - Excessive Consumption	14.7%	17.2%	↓
Liquor Store Access	8.9	10.6	↓
Overweight (Adult)	32.9%	35.8%	↓
Obesity (Adult)	19.3%	22.4%	↓
Physical Inactivity (Adult)	15.2%	17.3%	↓
Low Fruit/Vegetable Consumption (Adult)	69.2%	71.5%	↓
Food Security - Food Desert Population	8.3%	13.4%	↓
Tobacco Usage	10.2%	12.8%	↓
Cancer Screening - Pap Test	78.5%	78.3%	↑
Cancer Screening – Mammogram (age 67-69) [†]	62.1%	59.7%	↑
Cancer Screening - Sigmoid/Colonoscopy	65.2%	57.9%	↑
Air Quality - Particulate Matter 2.5	0.00%	0.46%	↓

Rates are per 100,000 population unless otherwise noted.

- Between the periods of 1995-1999 and 2010-2014, mortality rates for all types of cancer listed in the table trended down.

Table 16, Statistical Data for Cancers by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Hispanic /Latino (Any Race)
Cancer Incidence Rate (All Types)PHD	409.2	**◆484.1**	**◆522.3**	345.4	**395.9**
Cancer Mortality Rate (All Types)† PHD	149.0	**154.0**	**◆201.4**	120.5	139.5
Breast Cancer Incidence RatePHD	120.6	**◆147.5**	**◆160.7**	102.1	110.6
Breast Cancer Mortality Rate† PHD	20.4	**◆21.7**	**◆33.6**	11.8	15.5
Cervical Cancer Incidence RatePHD	7.3	4.6	--	4.7	**◆8.0**
Cervical Cancer Mortality Rate†	2.2	0.9	--	1.5	--
Colon and Rectum Cancer Incidence Rate PHD	38.7	**38.9**	**◆54.6**	37.3	37.3
Colon and Rectum Mortality Rate† PHD	13.4	12.6	**◆23.5**	11.5	12.6
Lung Cancer Incidence RatePHD	44.5	**◆47.6**	**◆54.4**	42.4	30.2
Lung Cancer Mortality Rate† PHD	33.2	**33.5**	**◆38.5**	27.0	19.7
Prostate Cancer Incidence RatePHD	109.2	**◆138.1**	**◆210.9**	81.5	**◆129.9**
Prostate Cancer Mortality Rate† PHD	19.9	**◆21.5**	**◆34.2**	10.0	18.1

Rates are per 100,000 population unless otherwise noted. Source: Community Commons data platform 2010-2014 except cervical cancer incidence (20019-2013). Note: No data for Pacific Islanders or those of "other" race/ethnicity are available.

Additional data from the Asian/Pacific Islander Report:

- Filipino cancer incidence (all sites) is 353.3, the highest among Asian subpopulations.
- Korean cancer mortality rate (all sites) is 155.3, the highest among Asian subpopulations.
- The report contains additional data on incidence and mortality by site and subgroup.

Cardiovascular Disease/Stroke

Table 17, Statistical Data for Cardiovascular Disease/Stroke

Indicators	SCC	Bench-mark	Desired ↑↓
Heart Disease Prevalence	5.3%	6.3%	↓
Heart Disease Mortality	65.0	94.3	↓
Stroke Mortality Rate	26.1	35.4	↓
Physical Inactivity (Adult)	15.2%	17.3%	↓
Park Access	71.4%	58.6%	↑
Recreation and Fitness Facility Access†	14.7	10.2	↑
Tobacco Usage	10.2%	12.8%	↓
Alcohol - Excessive Consumption	14.7%	17.2%	↓
Liquor Store Access	8.9	10.6	↓
Fast Food Restaurants Rate†	**◆86.7**	**78.7**	**↓**
Overweight (Adult)	32.9%	35.8%	↓
Obesity (Adult)	20.6%	26.5%	↓
Diabetes Prevalence	8.2%	8.3%	↓
Diabetes Hospitalizations Rate (per 10,000)	7.9	10.4	↓
Medicare Patients with Hemoglobin A1c Test	85.4%	81.8%	↑
High Blood Pressure - Unmanaged	26.9%	30.3%	↓

Rates are per 100,000 population unless otherwise noted.

- Heart Diseases are the second leading cause of death in the county (21%). Cerebrovascular Diseases (including stroke) are the third (6%).[PHD]
- Access to recreation and fitness opportunities has increased since 2010.
- The 2014 hypertension death rate was highest in San Jose (18.3) and Morgan Hill (17.3). However, diagnosed high-blood pressure was county except for Milpitas highest among Palo Alto residents (36%) and Morgan Hill (38%) compared to other cities, such as Los Altos (15%) and San Jose (28%).[PHD]
- In 2014, life expectancy was lowest in Gilroy (79 years) and Morgan Hill (80 years). Mortality rates were also highest in these two cities for cancer, heart disease, stroke, lower respiratory disease, and diabetes.[PHD]

Table 18, Statistical Data for Cardiovascular Disease/Stroke by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Multi Race	Hispanic Latino (Any Race)	Pac Isl	Native Am
Heart Disease Prevalence	6.3%	**6.5%**	4.2%			5.0%		
Heart Disease Mortality Rate	99.5	78.3	78	43.5		63.0		40.3
Stroke Mortality Rate	35.4	25.0	33.6	25.0		29.2		

Japanese residents have the highest rate of high blood pressure (48%) and high cholesterol (43%) among Asian/Pacific Islander subpopulations.[API]

Cognitive Decline

Subjective Cognitive Decline (SCD) is self-reported memory problems. One in nine people in California are experiencing SCD. In 2015, it is estimated that between 12.7-16.7% of Californians aged 65 and older reported worsening SCD.[2]

- In the U.S. one in ten people aged 65 and older have Alzheimer's disease.[3]
- 2011 Age-Adjusted Mortality Rate due to Alzheimer's disease is 35.9, worse than California in 2010 (30.10) by 19%.◆
- Alzheimer's disease accounted for 1% of deaths in each of the years between 2014 and 2016.[PHD]
- Median age in the county is 36.8 years (2015), 2.8% higher than that of the state, a driver of Alzheimer's rates.[CCDP]
- The greatest proportion of those aged 65 and older are in Palo Alto, Los Altos Hills, Saratoga, South San José, and rural far East San José.[CCDP]
- 2014 rates of deaths due to Alzheimer's disease was highest in Campbell (52.8), Gilroy (53.9), and Morgan Hill (55.3). Overall county rate is 34.6.[PHD]
- Note: Per the 2016 CHNA, Santa Clara County Alzheimer's disease mortality rate data was considered unreliable.

[2] CDC BRFSS. Retrieved April 2018 from https://www.cdc.gov/aging/agingdata/index.html
[3] Alzheimer's Association. (2017). *Alzheimer's Disease Facts and Figures.*

Communicable Diseases

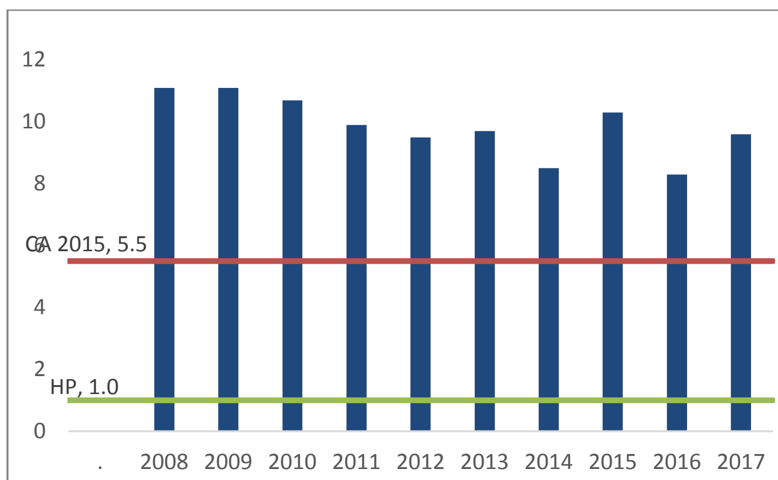
Table 19, Statistical Data for Communicable Diseases

Indicators	SCC	Benchmark	Desired ↑↓
Pertussis Incidence Rate PHD	**◆12.1**	**4.7**	↓
Tuberculosis Incidence Rate† PHD	**◆9.6**	**H1.0**	↓
Stayed Home Due to Flu (Adults) BRFS	17%	N/A	↓
Senior Pneumonia Vaccinations	66.7%	63.4%	↑
Flu vaccinations (adults) BRFS	42%	N/A	↑
Flu vaccinations (children) BRFS	60%	N/A	↑
Kindergarten Immunizations CR	**93%**	**H95%**	↑

Rates are per 100,000 population unless otherwise noted.

- 2% of parents received personal belief exemptions from immunizations, compared to 3% in the state. CR
- TB Rates have consistently failed HP benchmarks and California rates since 2008 (see chart).
- The 2014 death rate from the flu and pneumonia was highest in the cities of Gilroy (20.1) and Campbell (18.7) compared to 14.3 overall in the county.

Figure 6, TB Incidence Rates by Year



Source: Santa Clara County Public Health Department, Tuberculosis Information Management System, 2000-2009; California Reportable Disease Information Exchange, 2010-2017, data as of February 12, 2018, and are provisional; Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2010. Sacramento, California, September 2012; State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010–2017. Sacramento, California, December 2017.

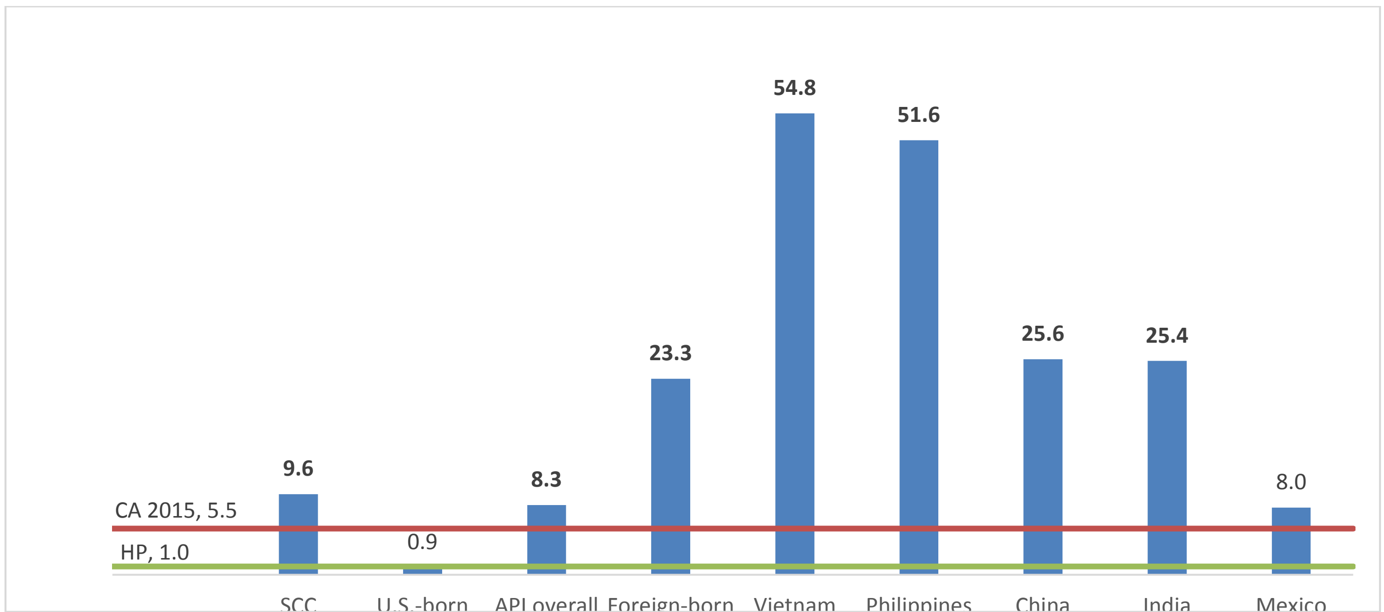
Table 20, Statistical Data for Communicable Diseases by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Multi Race	Hispanic /Latino (Any Race)
Pertussis Rate[PHD]	4.7	**◆13.7**	**4.4***	**◆7.7**		**◆11.7**
Stayed Home Due to Flu (Adults)[BRFS]	17% SCC	16%	17%	**◆21%**		16%
Flu vaccinations (adults)[BRFS]	42% SCC	47%	**◆34%**	42% API	45%	**◆37%**

Rates are per 100,000 population unless otherwise noted.
Note: No data are available for Pacific Islanders specifically or Native Americans or those of "Other" races.

TB rates in Santa Clara County are higher among those born outside of the U.S., as shown in the chart below. All rates shown except U.S. born citizens fail the benchmark by more than 5%.[PHD]

Figure 7, TB Incidence Rates by Country of Birth



Sources: Santa Clara County Public Health Department, California Reportable Disease Information Exchange, 2017, data as of February 12, 2018, and are provisional; State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010–2017. Sacramento, California, December 2017; U.S. Census, American Community Survey 1-Year Estimate, 2016. (2017 data not available when the report was generated).

Diabetes & Obesity

Table 21, Statistical Data for Diabetes & Obesity

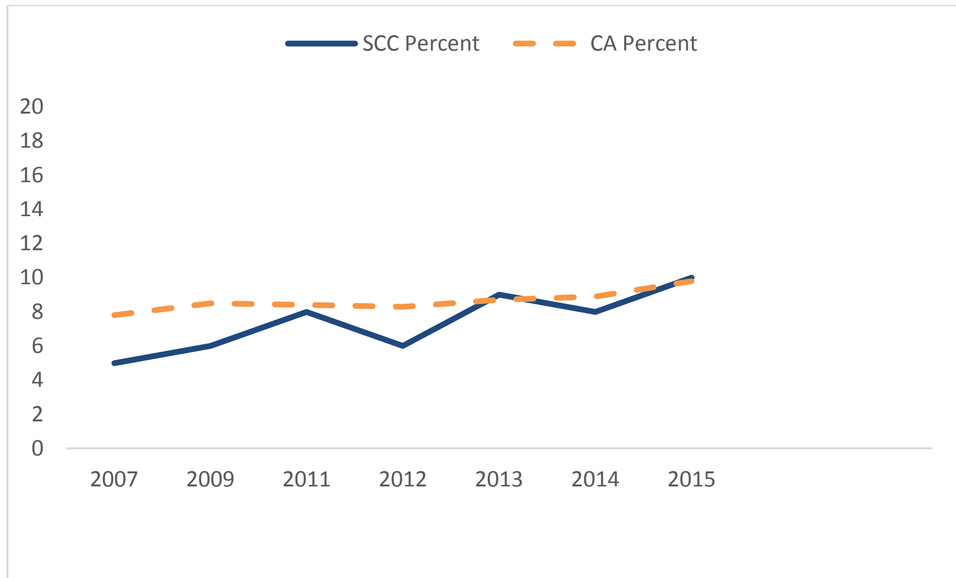
Indicators	SCC	Bench-mark	Desired ↑↓
Overweight or Obese Adults PHD	55%	63%	↓
Overweight or Obese Youth (Grades 5, 7, 9)[4]	31-35% by grade	36-40% by grade	↓
Overweight Youth (Grades 5, 7, 9) PHD	17%	N/A	↓
Obese Youth (Grades 5, 7, 9) PHD	14%	H16%	↓
Diabetes Prevalence† PHD	**◆9.8%**	**9.1%**	↓
Diabetes Hospitalizations Rate (per 10,000)	7.9	10.4	↓
Low Fruit/Vegetable Consumption (Adult)	69.2%	71.5%	↓
Low Fruit/Vegetable Consumption (Youth)	**◆59.8%**	**47.4%**	↓
Fast Food Restaurants Rate†	**◆86.7**	**78.7**	↓
Grocery Stores Rate	**◆19.5**	**21.8**	↑
WIC-Authorized Food Stores Rate	**◆9.5**	**15.8**	↑
Food Desert Population	8.3%	13.4%	↓
Physical Inactivity (Adult)	15.2%	17.3%	↓
Physical Inactivity (Youth)	28.1%	37.8%	↓
Park Access	71.4%	58.6%	↑
Recreation and Fitness Facility Access	14.7	10.2	↑
Breastfeeding (Any)	96.5%	93.0%	↑
Breastfeeding (Exclusive)	77.2%	64.8%	↑
Commute >60 Min.	8.4%	10.9%	↓
Food Insecurity Rate	11.0%	13.9%	↓
Exposed to Unsafe Drinking Water	0.0%	2.7%	↓
Commute to Work - Walking/Biking	3.8%	3.8%	↑
Medicare Patients with Hemoglobin A1c Test	85.4%	81.8%	↑
Commute to Work - Alone in Car	**75.5%**	**73.4%**	↓
Walking/Biking/ Skating to School	48.1%	43.0%	↑

Rates are per 100,000 population unless otherwise noted.

[4] CHKS. (2015). Retrieved July 2018 from kidsdata.org

As shown in the chart below, the prevalence of diabetes is increasing, a trend that is also seen at the state level according to the UCLA Center for Health Policy Research California Health Information Survey.[5]

Figure 8, Percent Ever Diagnosed with Diabetes by Year



Source: UCLA Center for Health Policy Research, AskCHIS 2007-2016

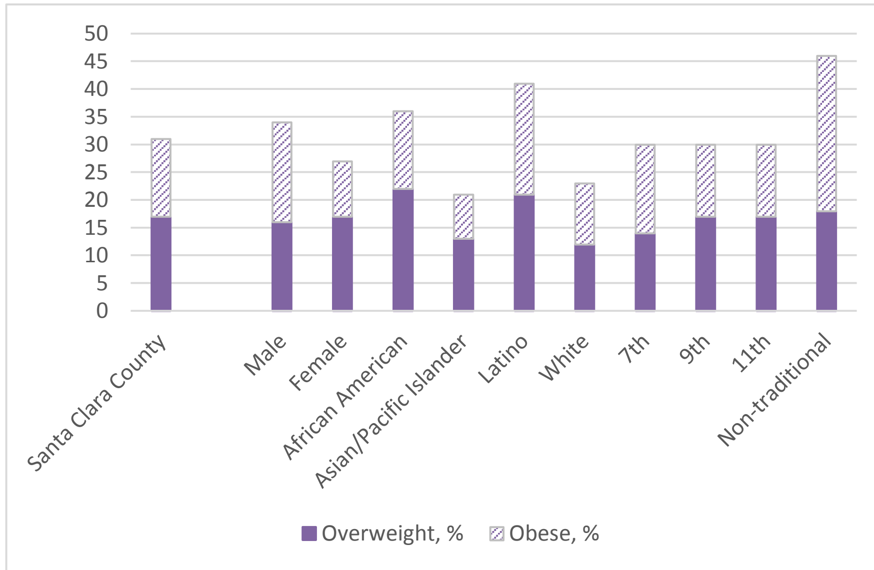
Table 22, Statistical Data for Diabetes & Obesity by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other	Multi Race	Hispanic/ Latino (Any Race)
Overweight Youth PHD (See chart)	17% SCC	12%	22%	13%			◆21%
Obese Youth PHD (See chart)	16%	11%	14%	8%			◆20%
Obese Youth CR	11% SCC	7%	◆12%	7%			◆19%
Low Fruit/Vegetable Consumption (Youth)	47.4%	◆60.6%	◆73.1%		◆72.8%		45.5%
Physical Inactivity (Youth)	37.8%	21.9%	33.2%	15.6%		28.5%	◆41.8%
Breastfeeding (Any)	93.0%	97.1%	94.3%	97.4%	97.2%	96.6%	95.4%
Breastfeeding (Exclusive)	64.8%	86.0%	69.5%	74.3%	76.6%	82.6%	74.2%
Walking/Biking/Skating to School	43.0%	46.8%			41.1%		59.1%

[5] http://ask.chis.ucla.edu

- Latinos have the highest rate of overweight or obese adults (72%) compared to the county overall (54%).
- Pacific Islanders have high rates of overweight and obesity among adults (77%) and middle school/high school youth (49%).

Figure 9, Percent Overweight and Obese Students, 2015-16



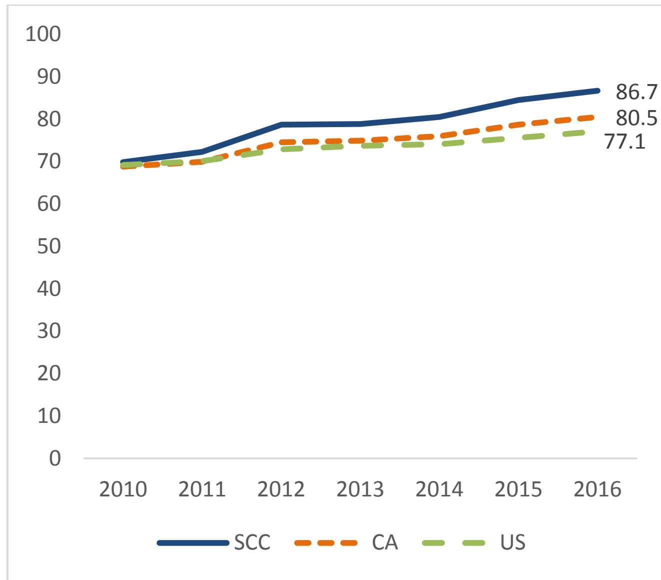
Source: California Healthy Kids Survey, 2006-2016

Other key findings related to obesity were found in the Santa Clara County Public Health Department's Child Health Assessment. No comparisons were provided for this data unless otherwise noted.

- Youth fruit and vegetable consumption is worse in Gilroy and East Side Union High School District compared to students in other districts.
- Latino children had the highest rates of fast food consumption, both among children under 12 years of age and middle/high school students.
- Males (both adults and middle/high school students) are almost twice as likely to be obese than females.

As shown in the chart below, the rate of fast food restaurants in the county has substantially increased since 2010 (from 69.8 to 86.7) which far outpaces the increase in the state and the U.S.

Figure 10, Fast Food Restaurants Rate per 100,000 People by Year



Source: U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography:ZCTA.

2014 Sub-county data: PHD

- Among SCC cities, Campbell has the highest rate of fast food restaurants per mile at 5.9, exceeding that of the county overall and San Jose (2.8). However, it also has relatively good access to farmer's markets (at 1.1 miles) compared to 1.6 miles in the county overall and 1.6 miles in Santa Clara. (See fast food consumption data point below.)
- Weekly fast food consumption is highest in Morgan Hill (56%), Campbell (40%), San Jose (42%), and Los Gatos (38%).
- The distance to fresh groceries is lowest in Mountain View, Sunnyvale, and Los Altos (at 0.41 miles or less) and worst in Los Alto Hills, Monte Sereno, and Morgan Hill (more than one mile).

Maternal/Infant Health

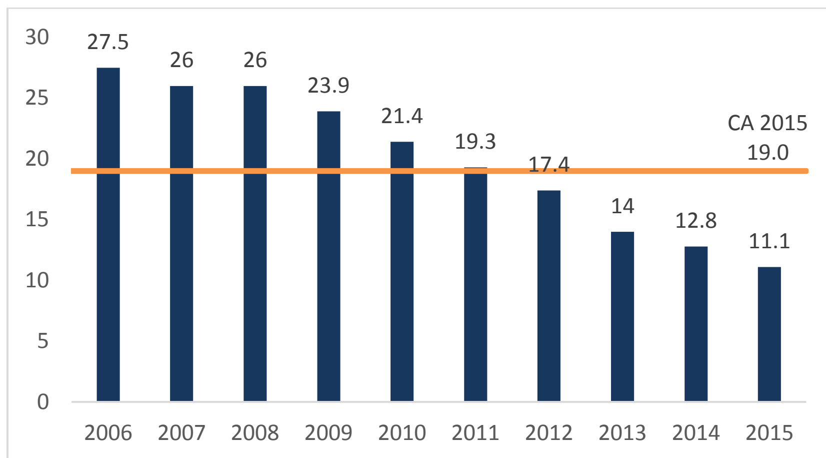
Table 23, Statistical Data for Maternal/Infant Health

Indicators	SCC	Bench-mark	Desired ↑↓
Low Birth Weight [PHD]	**7.0%**	**6.8%**	**↓**
Infant Mortality Rate (per 1,000 births) [PHD]	3.1	4.6	↓
Teen Births Rate (per 1,000 Under Age 20) [† PHD]	11.1	19.0	↓
Breastfeeding (Any)	96.5%	93.0%	↑
Breastfeeding (Exclusive)	77.2%	64.8%	↑
Head Start Program Rate (per 10,000 kids aged 0-5)	◆2.7	6.3	↑
Education - School Enrollment Age 3-4	56.9%	48.6%	↑
Food Security - Food Insecurity Rate	11.0%	13.9%	↓
WIC-Authorized Food Stores Rate	**◆9.5**	**15.8**	**↑**

Rates are per 100,000 population unless otherwise noted.

Teen births are trending down since 2006 for all ethnic groups (see chart). Ethnic disparities in teen births are seen in the Latina population (25.3 per 1,000)[CR] and the Pacific Islander Population (20.3 per 1,000, the highest among Asian subpopulations).[API]

Figure 11, Teen Births by Year

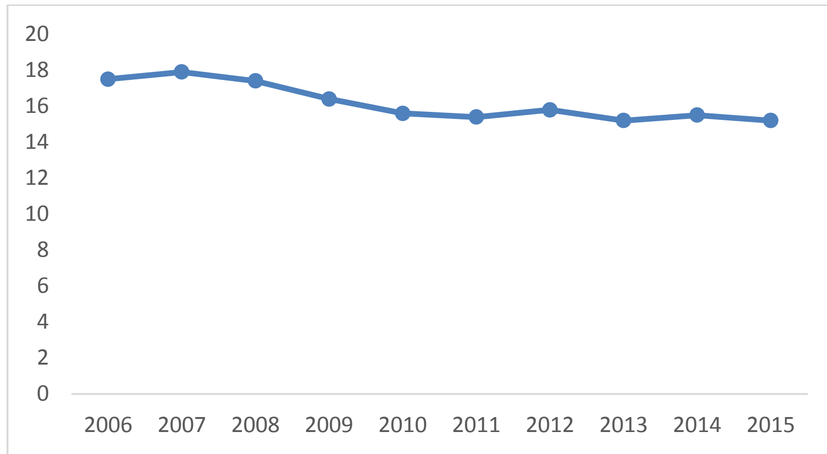


Source: Santa Clara County Public Health Department, Birth Statistical Master File, 2006-2015.

The county birthrate has declined slightly since 2006 (as show in the chart below), which is consistent with trends seen in the U.S. overall. In addition to ethnic disparities in low

birthweight, low birthweight percentage among mothers who are aged 45 and older (18%) is three times as high as that for mothers aged 20-24 (6%).[PHD]

Figure 12, Birth Rate per 1,000 people, 2006-2015



Source: Santa Clara County Public Health Department, Birth Stastical Master File, 2006-2015; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017. Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National vital statistics report; vol 66, no 1. Hyattsville, MD: National Center for Health Statistics. 2017.

Table 24, Statistical Data for Maternal/Infant Health by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other	Multi Race	Hispanic/ Latino (Any Race)
Teen Births (per 1,000 under 20) [PHD]	19.0	2.1	7.0	1.5			◆**25.3**
Infant Mortality Rate (per 1,000 births) [PHD]	4.6	2.8	◆**8.7**	2.1 API	◆**10.5 PI**		3.7
Low Birthweight [PHD]	6.8%	6.3%	◆**10.4%**	◆**7.8%**			6.1%
Breastfeeding (Any)	93.0%	97.1%	94.3%	97.4%	97.2%	96.6%	95.4%
Breastfeeding (Exclusive)	64.8%	86.0%	69.5%	74.3%	76.6%	82.6%	74.2%

Note: "API"= Asian/Pacific Islander. "PI"=Pacific Islander. There were no data available for the Native American population.

Other findings from Santa Clara County Public Health Reports:

- African/African Ancestry (81%) and Latina mothers (79%) are least likely to have prenatal care in their first trimesters.[CR] Among Asian subpopulations, Pacific Islander mothers have the highest rate of inadequate prenatal care (21%).[API] Preterm births are high among those women who did not receive prenatal care (45%).
- Infant mortality in the pooled years of 2007-2015 for Asian/Pacific Islanders, as a whole, is 2.4 per 1,000 live births, which is the lowest rate for any ethnic group. However, the rate of infant mortality for Pacific Islanders is 10.5, which misses the HP2020 benchmark of 6.0 by 75%.[API]

- Only 56% of expectant mothers under age 15 receive early prenatal care.[CR] Teen births (under age 20) are highest in East San José and Central San José.
- 2014 data by city shows that the rate of early and adequate prenatal care was above 75% in all cities of the county except for Milpitas (71%), Santa Clara (72%), San Jose (73%), and Gilroy (73%).[PHD]
- Babies who are born preterm (before 37 weeks of gestation) are at increased risk for health problems, which can become long-term.[6] Preterm births overall are low (8%) compared to the state (9%). However, preterm births are high among mothers who have not received prenatal care (45%). More than one in ten of African/African Ancestry mothers (11%) and Filipina mothers have preterm births (11%).[CR, API]
- Although mothers aged 45 and older have high rates of early prenatal care (93%), when compared to younger mothers, they still have higher rates of preterm births (20%) and low birthweight babies (18%).

[6] Preterm Birth and Low Birth Weight. Child Health USA 2014. Available at: http://mchb.hrsa.gov/chusa14/health-status-behaviors/infants/preterm-birth-low-birth-weight.html. Accessed October 28, 2015.

Oral Health

Table 25, Statistical Data for Oral Health

Indicators	SCC	Benchmark	Desired ↑↓
Poor Dental Health (Adult)	7.8%	11.3%	↓
No Recent Dental Exam (Adult)	18.8%	30.5%	↓
No Recent Exam (Children Age 2-11)	**◆29.8%**	**18.5%**	**↓**
Dental Decay/Gum Disease (Adult) [BRFS]	45%	N/A	↓
Absence of Dental Insurance (Adult)	36.0%	40.9%	↓
Access to Dentists Rate	109.0	80.1	↑
Living in Dental Health Professional Shortage Area	0.0%	26.1%	↓
Exposed to Unsafe Drinking Water	0.0%	2.7%	↓
Dental Care - Lack of Affordability (Age 5-17)	4.2%	6.3%	↓

Rates are per 100,000 population unless otherwise noted.

Table 26, Statistical Data for Oral Health by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Other	Hispanic/ Latino (Any Race)
Dental Decay/Gum Disease (Adult)[BRFS]	45% SCC	31%	**◆50%**	**◆61%**		**◆60%**
No Recent Dental Exam (Children Age 2-11)	18.5%	**◆31.0%**			16.3%	**◆51.8%**
Absence of Dental Insurance (Adult)	40.9%	25.3%		30.3%		32.1%

Note: No data are available for African/African Ancestry. No data are available for Pacific Islander or Native American populations.

Sexually Transmitted Infections

Table 27, Statistical Data for Sexually Transmitted Infections

Indicators	SCC	Benchmark	Desired ↑↓
Chlamydia† PHD	361.8	504.4	↓
HIV Prevalence† PHD	6.9	12.7	↓
HIV Hospitalization Discharge Rate per 10,000 (2011)	0.87	1.98	↓
Early Syphilis† PHD	18.2	28.5	↓
Gonorrhea Rate† PHD	100.6	164.3	↓
No HIV Screening	**◆64.0%**	**60.8%**	↓

Rates are per 100,000 population unless otherwise noted.

- Gonorrhea among female minors has risen 61% between 2013 and 2014 and is five times as high as that of males.[CR]
- The rate of chlamydia infections among females (450.4) is 1.6 times that of males (273.3).[CR]
- 2016 STI rates in Santa Clara County are favorable compared to California. However, syphilis, gonorrhea and chlamydia rates are all trending up since 2007 (see chart).

Figure 13, HIV & Early Syphilis Rates by Year

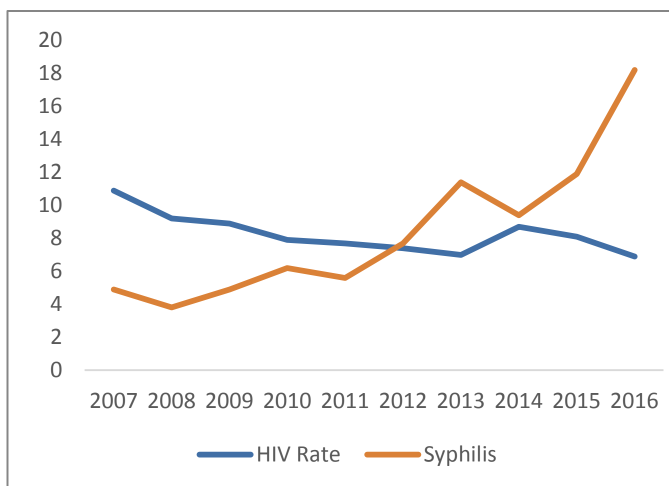
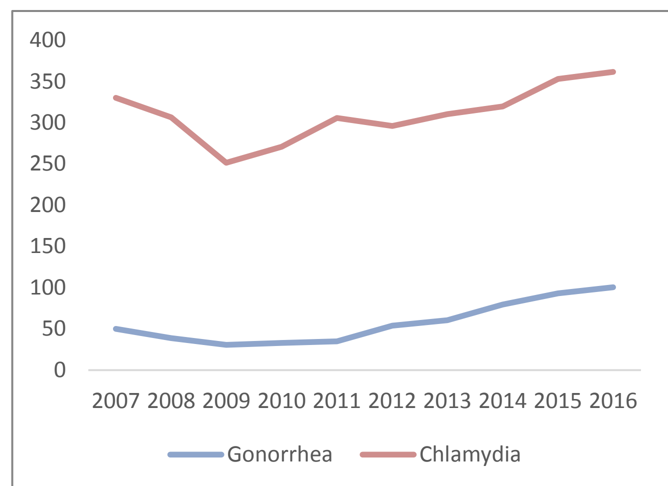


Figure 14, Gonorrhea and Chlamydia Rates by Year



Sources: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2016. Atlanta: U.S. Department of Health and Human Services; 2017; Santa Clara County Public Health Department, Automated Vital Statistics System (AVSS) (2007-2011) & California Reportable Disease Information Exchange (CalREDIE) (2011-2016), data are provisional as of 5/5/2017; State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2010. Sacramento, California, September 2012State of California, Department of Finance, State and County Population

Projections by Race/Ethnicity and Age, 2010-2060, Sacramento, California, February 2017; STD Control Branch, California Department of Public Health, Sexually Transmitted Diseases in California 2016 Executive Summary

Table 28, Statistical Data for Sexually Transmitted Infections by Ethnicity

Indicators	Bench-mark	White	African/ African Ancestry	Asian	Multi Race	Hispanic/ Latino (Any Race)
HIV Prevalence[PHD]	12.7	4.5	◆**34.9**	3.8		11.1
Early Syphilis[† PHD]	28.5	14.1	◆**39.3**	3.8		27.7
No HIV Screening	60.8%	51.1%	37.0%	◆**71.4%**	38.9%	47.6%

Note: STI rates for Pacific Islander, Native American, and populations of other race/ethnicity are not available,

Unintentional Injury

Table 29, Statistical Data for Unintentional Injury

Indicators	SCC	Benchmark	Desired ↑↓
Unintentional Injury Mortality Rate† PHD	26.9	36.4	↓
Motor Vehicle Hospitalization Rate PHD	49.7	N/A	↓
Fatal Motor Vehicle Accident Rate	6.2	8.6	↓
Fatal Pedestrian Accident Rate	**◆1.5**	**H 1.3**	**↓**
Senior Falls Mortality Rate (Age-Adjusted) API	40.7	H 47.0	↓
Alcohol - Excessive Consumption	14.7%	17.2%	↓
Liquor Store Access Rate	8.9	10.6	↓

Rates are per 100,000 population unless otherwise noted.

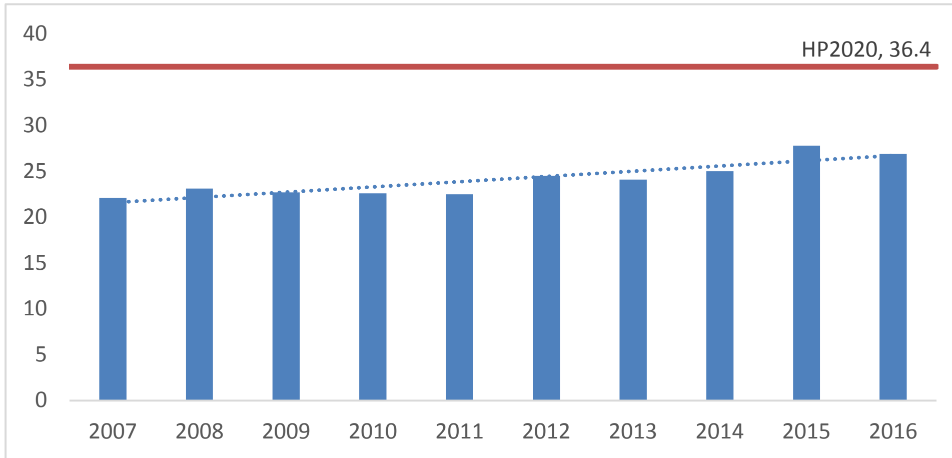
Other findings:

- 5% of deaths in the county are due to accidents, compared with 4% in the state. ◆
- Male mortality rates due to unintentional injury are 90% worse than that of females. ◆
- The unintentional injury mortality rate has increased slightly from 2007. PHD (See chart.)
- Campbell has the highest rate of alcohol outlets per square mile of any city in the county at 5.6 (compared to 0.5 in Saratoga and 2.7 in the county). PHD
- In 2014, unintentional injury deaths were highest in Los Altos (28.7) and Los Gatos (29.3). Morgan Hill and Gilroy also had high rates of unintentional injury deaths (both at 28.0) compared to the county (23.4).

Older Adults:

- Unintentional injuries are among the top 10 causes of deaths among adults ages 65 years and older.
- Among adults ages 65 years and older, deaths due to accidental falls accounted for 2% of all deaths. PHD
- Deaths due to accidental falls among adults ages 65 years and older accounted for two in three (67%) deaths due to unintentional injuries. This is higher compared to deaths due to accidental falls among the total population (31%). PHD
- The rate of unintentional injury deaths is five times higher for adults aged 75-84 compared to those aged 25-34. PHD

Figure 15, Unintentional Injury Mortality Rate by Year



Source: Santa Clara County Public Health Department, VRBIS, 2007-2016. Data as of 05/26/2017; U.S. Census Bureau; 2010 Census, Tables PCT12, PCT12H, PCT12I, PCT12J, PCT12K, PCT12L, PCT12M; generated by Baath M.; using American FactFinder; Accessed June 20, 2017.

Table 30, Statistical Data for Unintended Injury by Ethnicity

Indicators	Bench-mark	White	African/African Ancestry	Asian	Multi Race	Hispanic/ Latino (Any Race)
Unintentional Injury Mortality Rate[PHD]	36.4	29.4	**◆43.0**	16.0 API		32.8
Motor Vehicle Fatal Accident Rate	8.6	5.9	7.0	3.9		**9.4**
Motor Vehicle Hospitalization Rate[PHD]	49.7 (SCC)	**52.5**	**◆61.6**	28.2 API		**◆60.2**
Fatal Pedestrian Accident Rate	1.3	**1.4**	0	0	0	**◆2.2**

Rates are per 100,000 population unless otherwise noted.
Note: No data are available for the population of "other" race/ethnicity.

- African/African Ancestry children under 18 are 65% more likely to suffer an unintentional injury (3,554 per 100,000) compared to the county overall (2,150).◆ [CR]
- Japanese seniors have the highest rate of falls deaths among Asian subpopulations (41.6).[API]

References and Sources

AAH Status of African/African Ancestry Health: Santa Clara County 2014 Report. (2015, September 15). Santa Clara County Public Health Department. Retrieved from https://www.sccgov.org/sites/opa/nr/Documents/AFRICAN%20ANCESTRY%20REPORT.pdf

API Santa Clara County 2017 Asian and Pacific Islander Health Assessment. (n.d.). Santa Clara County Public Health Department. Retrieved from https://www.sccgov.org/sites/phd/hi/hd/Documents/AsianHealth/aha-report.pdf

BRFS Santa Clara County Behavioral Risk Factor Survey. (2013-14.) Santa Clara County Public Health Department. Retrieved from Santa Clara County Health Status Quick Facts, https://www.sccgov.org/sites/phd/hi/hd/Pages/data-home.aspx.

CC Community Commons CHNA Data Platform, Kaiser Permanente hub. https://www.communitycommons.org/groups/community-health-needs-assessment-chna

CR Status of Children's Health: Santa Clara County 2016. (2017). Santa Clara County Public Health Department. Retrieved from https://www.sccgov.org/sites/phd/hi/hd/reports/child-health/Pages/child-health-home.aspx

CHA Partners for Health Santa Clara County: Community Health Assessment-Community Health Improvement Plan 2015-2020. (2015). Santa Clara County Public Health Department. Retrieved from https://www.sccgov.org/sites/phd/collab/chip/Documents/cha-chip/cha-chip.pdf

LH Status of LGBTQ Health: Santa Clara County 2013. (2013, December 20). Santa Clara County Public Health Department. Retrieved from https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBTQ_Report_WEB.pdf

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[i] https://www.communitycommons.org/maps-data/

Attachment 4. Community Assets and Resources

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

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

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COGNITIVE DECLINE 180
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DIABETES & OBESITY 181
ORAL/DENTAL HEALTH 183

General Resources

- 211 (United Way). A free, confidential referral and information service that helps people find local health and human services by web, phone, and text.
- Community Health Partnership
- FIRST 5 Santa Clara County (children aged 0-5)
- The Health Trust
- Listing of Santa Clara County programs and services
- Santa Clara County Public Health Department

Community Health Needs

ACCESS TO HEALTHCARE & DELIVERY

Resources

Healthcare Facilities and Systems

- El Camino Health–Los Gatos
- El Camino Health–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 Health & Hospital System
- 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)

Community Clinics

- Asian Americans for Community Involvement
- Cardinal Free Clinics
- Foothill Community Health Centers
- Gardner Health Services
- Indian Health Center
- Mar Monte Community Clinic
- MayView Community Health Centers

- Medical Respite Program
- Planned Parenthood Mar Monte
- Peninsula Healthcare Connection
- Ravenswood Family Health Center
- RotaCare Bay Area–RotaCare San Jose
- School Health Clinics of Santa Clara County

Mobile Health Services

- Gardner Mobile Health Center
- Lucile Packard Children's Hospital Teen Van
- Santa Clara Valley Homeless Health Care Program Van
- Health Mobile (dental)

ECONOMIC STABILITY

Education, employment, and poverty

(See Housing & Homelessness for additional assets and resources.)

Resources

- CalFresh
- Catholic Charities
- Center for Employment Training (CET)
- Bay Area Legal Aid
- Occupational Training Institute
- City of San José employment resource center
- Community Service Agencies (Mountain View/Los Altos, Sunnyvale, West Valley)
- Connect Center CA (Pro-match and Nova job centers)
- Emergency Assistance Network of Santa Clara County
- Veterans Administration employment center
- Women, Infants, and Children (WIC) Nutrition Services
- Work 2 Future
- Day Worker Center (Mountain View)
- United Way Bay Area
- Social Services Agency of Santa Clara County
- SparkPoint

Food Resources

- Fresh Approach mobile food pantry
- Hope's Corner
- Loaves and Fishes

- The Food Connection
- Meals on Wheels (The Health Trust and Sourcewise)
- Salvation Army
- St. Joseph's Cathedral
- St. Joseph's Family Center—food bank and hot meals (Gilroy)
- Second Harvest Food Bank
- St. Vincent De Paul
- Santa Maria Urban Ministries
- Valley Verde

HOUSING & HOMELESSNESS

Assets

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

Resources

- American Vets Career Center
- Bill Wilson Center emergency shelter for youth
- Casa de Clara (Catholic volunteer group—services to women and children in downtown San 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 Service Agency Homeless Prevention Services (and emergency shelter)
- Destination Home
- Downtown Streets Team
- Dress for Success—interview suits and job development

- EHC Life Builders Emergency Housing Consortium
- Foster youth group home providers
- Gilroy Compassion Center
- Goodwill Silicon Valley
- The Health Trust Housing for Health
- HomeFirst
- Hope Services—employment for adults with developmental disabilities
- Housing Opportunities for Persons with AIDS
- InnVision the Way Home
- Life Moves (homeless housing)
- Love Inc.
- New Directions
- New Hope House
- NOVA Workforce development
- Rebuilding Together (repairs to keep people in homes)
- Sacred Heart Community Services (including emergency assistance)
- St. Joseph emergency assistance
- Salvation Army
- Senior Housing Solutions
- Sunnyvale Community Services—housing and emergency assistance
- Unity Care—foster youth housing and employment assistance
- West Valley Community Services emergency assistance

NATURAL ENVIRONMENT

Assets

- Acterra
- Audubon Society of Santa Clara County
- California League of Conservation Voters
- Canopy
- Committee for Green Foothills
- Midpeninsulsa Regional Open Space District
- Peninsula Open Space Trust
- San Francisquito Watershed Council
- Santa Clara Valley Open Space Authority
- Sierra Club–Loma Prieta Chapter

TRANSPORTATION & TRAFFIC

Assets

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

Resources

- Avenidas
- City Team Ministries
- Community Services Agency
- El Camino Hospital Roadrunners
- Heart of the Valley Escorted Transportation (nonprofit)
- Love Inc.
- Mountain View Community Shuttle
- Outreach & Escort, Inc.
- Peninsula Family Services – Ways to Work

BEHAVIORAL HEALTH

Assets

- ASPIRE youth mental health program
- HEARD (Health Care Alliance for Response to Adolescent Depression) is a community alliance of health care professionals, including primary care and mental health providers working in various settings including clinics, hospitals, private practices, schools, government, and private organizations.
- Project Safety Net (Palo Alto) youth suicide prevention coalition
- Tobacco Free Coalition Santa Clara

Resources

- 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)
- Bay Area Children's Association (BACA)
- Bill Wilson Center

- Billy DeFrank LGBT Community Center
- California Department of Rehabilitation, San Jose District
- Caminar
- Casa de Clara, a Catholic volunteer group, offers services to women and children in downtown San José 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 (Gilroy)
- Child Advocates of Silicon Valley
- Community Health Awareness Council (CHAC)
- Community Solutions
- Crestwood Behavioral Health
- Discovery Counseling Center (Morgan Hill)
- Eastern European Services Agency
- Eating Disorder Resource Center of Silicon Valley
- El Camino Hospital Behavioral Health
- Ethnic Cultural Community Advisory Committees (ECCAC)
- Grace Community Center
- In-Home Supportive Services (IHSS)
- Jewish Family Services of Silicon Valley
- Josefa Chaboya de Narvaez Mental Health
- Kaiser San Jose Behavioral Health Inpatient Hospital
- Law Foundation of Silicon Valley Mental Health Advocacy Project — legal services for people with mental health or developmental disabilities
- LGBT Youth Space Drop-In Center
- LifeMoves counseling
- Mekong Community Center
- Mental Health Urgent Care
- Momentum for Mental Health (includes psychiatric care, medication management, and medications)
- Momentum-Alliance for Community Care
- NAMI (National Alliance on Mental Illness) Warmline: namisantaclara.org/classes/warmline/ for behavioral health including veterans' services, senior services, and homeless services
- Parents Helping Parents
- Rebekah's Children's Services (Gilroy)
- Recovery Café
- San Jose Behavioral Health Hospital
- Santa Clara Valley Medical Center Sunnyvale Behavioral Health Center
- Santa Clara County Behavioral Health Department Zephyr and Esparanza Self-Health Centers

- Santa Clara County Behavioral Health Department REACH Psychosis Early Intervention Program
- Services for Brain Injury
- Silicon Valley Independent Living Center (SVILC)
- Sourcewise
- Stanford Hospital Psychiatry
- Uplift Family Services
- YMCA Silicon Valley Project Cornerstone
  - Santa Clara County 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 José)
  - Department of Alcohol & Drug Services Gateway program
  - Behavioral Health Department (suicide and crisis services)
  - Behavioral Health Department barbara Arons Pavilion, VMC
  - Behavioral Health Department Office of Family Affairs
  - Behavioral Health Department Office of Consumer Affairs
  - Department of Family & Children Services
  - Early Head Start Program provides access to mental health services for families of children 0-5

Other County MH Contract Agencies:

- Corporation/El Centro de Bienestar
- Gardner Family Care, Susanna Farina, Behavioral Health Coordinator
- Hope Counseling Center Services, Susan Detrick, Manager
- Gilroy Behavioral Health
- UJIMA Adult & Family Services, Yvonne Maxwell, Executive Director
- Young Adult Transition Team, Las Plumas Mental Health Center

Other Peer-Based MH Organizations:

- Depression and Bipolar Support Alliance (DBSA)
- NAMI
- South Bay Project Resource

COGNITIVE DECLINE

Including dementia and Alzheimer's disease

Assets

- Alzheimer's Association 24/7 Helpline
- El Camino Hospital's Chinese Health Initiative, Asian Dementia Initiative and Latino Family Connections in partnership with the Alzheimer's Association
- Family Caregiver Alliance
- Respite and Research for Alzheimer's Disease

- Sourcewise Community Resource Solutions
- Stanford/Veteran's Administration Alzheimer's Research Center
- United Way 211

Resources

- Adult day care and respite programs such as Avenidas Rose Kleiner Center, Alzheimer's Activity Center, and Catholic Charities Senior Activity Centers (Daybreak)
- Alzheimer's Association of Northern California and Northern Nevada information, support groups, Chinese Learning Circle, and Community Resource Finder
- Catholic Charities John XXIII Multi-Service Center Alzheimer's Program for Asian seniors and families

COMMUNICABLE DISEASES

Pertussis, tuberculosis

Assets

- Santa Clara County Hepatitis B Free Initiative
- Vietnamese Reach for Health Coalition

Resources

- Santa Clara County Needle Exchange Program
- Santa Clara County Pediatric TB Clinic
- Santa Clara County TB/Refugee Health Clinics School-Based Services

DIABETES & OBESITY

See Economic Stability for free food resources.

Assets

- Bay Area Nutrition and Physical Activity Collaborative (BANPAC)
- California WALKS Program
- Community Alliance with Family Farmers (CAFF) Foundation: 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)
- Green Belt Alliance (collaborative)
- Pacific Institute (public health & environmental justice in land use and transportation planning
- Santa Clara County Diabetes Prevention Initiative
- Santa Clara County Office of Education's Coordinated School Health Advisory Council
- Santa Clara County Office of Education's Coordinated School Health Advisory Council
- Sunnyvale Collaborative (obesity focused)
- YMCA National Diabetes Prevention Program (health education)

Resources

- Asian Americans for Community Involvement Clinic—diabetic case management
- Boys and Girls Clubs of Silicon Valley (FitKidz: Mind Body and Soul)
- Breathe CA: Let's Get Moving to School (at five schools, increasing number of students who walk and bicycle to school)
- Challenge Diabetes Program – Community Service Agencies (Sunnyvale, Mountain View & West Valley)
- Children's Discovery Museum: Rainbow Market Project (new exhibit to support children and families in exploring healthy eating)
- Children's Health Plan (diabetic services)
- 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
- County of Santa Clara Parks and Recreation Department—Healthy Trails Program, bilingual outreach
- Departments of Parks, Recreation, & Neighborhood Services exercise programs
- FIRST 5 Family Resource Centers (nutrition and physical activity programming)
- Fit Kids Foundation (Fit Kids Program)
- Gardner Clinic—Down with Diabetes program
- 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)
- The Health Trust (Food is Medicine)
- Healthier Kids Foundation—10 Steps to a Healthier You parent education series
- Healthy Kids weight management classes
- 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 Children's Hospital Pediatric Weight Control Program – tuition scholarships for low-income families
- Nutrition education in the School Health Clinics of Santa Clara County
- Nutrition education through Santa Clara County Public Health Department
- Our City Forest fruit tree stewardship programs (benefits community by promoting growing one's own food and giving away food)
- Playworks

- Project Access (Health & Wellness Program for low-income Families)
- San Francisco Planning & Urban Research (SPUR) Double Up Food Bucks
- Santa Clara County Public Health Department Breastfeeding Program (education, training public educators, and lactation consultant)
- Second Harvest Food Bank (Nutrition Education)
- 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 José Mayfair neighborhood)
- Stanford Hospital and Clinics Strong for Life—free exercise classes at senior centers
- Sunnyvale Community Services: Fresh From the Farm (provides low-income families fresh produce, nutrition education, farm and gardening experiences, and community-building activities)
- THINK Together (Healthy Living Program Alum Rock and San Jose School Districts)
- 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 José neighborhoods)
- West Valley Community Services (includes the Raising a Healthy Eater Program) Hospitals and Community Clinics

ORAL/DENTAL HEALTH

Assets

- Child Health and Disability Program–trains pediatric primary care providers on applying fluoride varnish and provides referrals for care
- First Five–oral health education and referral services
- Santa Clara County Dental Society–supports local dentists and partners with community agencies, including schools, to improve oral health through screenings and education
- Women, Infants, and Children (WIC)–oral health education in 13 WIC centers

Resources

- Children's Dental Center – locations in Sunnyvale and East San Jose providing full range of preventive and restorative services
- Dental and Oral Hygienist schools –2 dental hygiene programs provide free and low cost cleanings (Foothill College and Carrington College)
- Foothill Community Health Center – full range of preventive and restorative services
- Gardner Family Health –3 locations and mobile program providing a full range of preventive and restorative services
- Head Start–provides referrals and connects families with dental homes, exams and follow-up treatment

- Health Mobile–general dental services for homeless and low-income families in Mountain View, Sunnyvale and at many preschools in Santa Clara County
- Healthier Kids Foundation–screens children and youth and assists with follow-up care in school, resource centers and day care
- Indian Health Center–two locations providing preventive and restorative services
- Santa Clara Valley Health and Hospital System Dental Services – services include 6 dental clinics and mobile dental services; full range of services including specialty and urgent care
- School Nurses—coordinates dental screenings on school sites and connect families to resources
- STD/HIV Prevention and Control Program via Onsite Dental Foundation–provides mobile oral health services on weekends
- Superior Court of California, Santa Clara County–orthodontic care for foster youth school-based services

Attachment 5. Qualitative Research Protocols, Santa Clara County

Prior to key informant interviews, professionals were provided with the 2016 CHNA health needs list to consider.

Table 1, 2016 Health Needs List

2016 Priority Health Need	Examples
Alzheimer's Disease & Dementia	
Behavioral Health	Anxiety, depression, drug/alcohol addiction, stress
Mental Health	
Substance Abuse	
Birth Outcomes	Premature births, infant mortality
Cancers	Breast cancer, leukemia
Cerebrovascular Diseases	Heart attack, stroke
Climate Change	Global warming, drought
Communicable Diseases	TB, hepatitis, flu, pertussis (separate from STIs)
Community & Family Safety	Domestic violence, crime, child abuse
Diabetes	
Diet/Fitness/Nutrition	Nutritious food, safe places to exercise
Economic Security	Education, employment, poverty, cost of living
Healthcare Access & Delivery	Health insurance, costs of medicine, availability of providers, getting appointments, patients being treated with respect
Housing & Homelessness	
Obesity	
Oral/Dental Health	
Respiratory Conditions	Asthma, COPD
Sexual Health	Sexually-transmitted infections, teen births
Tobacco Use	Smoking, vaping, chewing tobacco
Transportation & Traffic	Public transportation, safe roads
Unintentional Injuries	Car accidents, falls, drownings

Key Informant Protocol – Professionals

Introduction – 5 mins

- Welcome and thanks
- What the project is about:
  - Identifying health needs in our community
    (called the Community Health Needs Assessment or CHNA)
  - Required of all non-profit hospitals in the U.S. every three years
  - Here in Santa Clara County, the Community Benefit Hospital Coalition is working together to meet this requirement
  - Will inform the investments that hospitals make to address community needs
- Scheduled for one hour - does that still work for you?
- Today's questions:
  - Most pressing health needs in Santa Clara County
  - Your perspective on [expertise area]
  - How access to care and mental health play a part in those needs
  - Which populations may have different or worse needs or experiences
  - Your suggestions for improvement
- What we'll do with the information you tell us today
  - Notes will go to hospitals
  - Would like to record so that we can get the most accurate record possible
  - Will not share the audi itself
  - Can keep anything confidential – even the whole interview. Let me know at any time.
  - Permission to record?
- Any questions before I begin? *[If interviewer does not have the answer, commit to finding it and sending later via email.]*

Health Needs Prioritization – 6-10 min.

Part of our task today is to find out which health needs you think are most important. You may want to take a look at the list we sent you of the most common needs from the 2016 CHNAs. You can see that some of them are health conditions, and others reflect the social determinants of health (housing, education, cost of living, environment, etc.).

Thinking specifically about Santa Clara County …

1. Are there any needs that should be added to the list?

Expertise Area – 20 mins

You are here to share your expertise/experience about [e.g., senior health].

2. **Which three needs do you believe are the most *important* to address here in the next few years for the population you serve?** [See table above.]

I am going to take you through a few questions about each of these needs.

3. **When you think about [health need 1]…**
   - What are people struggling with?
   - What barriers exist to seeing better health in this area?
4. **Are some people better or worse off?**
   Prompts: Differences by age, education level, disability status, income (affecting housing and transportation), etc.

[Repeat 3-4 for each health need they prioritized.]

5. **Lastly, are you seeing any trends related to these needs in the last three years?**

Access to Care – 5 mins

We know that access to care impacts all aspects of health.

6. **Would you say that health access [related to your specific expertise] is sufficient or not?**
7. **Do you see differences among any particular groups in your work?**
   Prompts: Differences by age, education level, disability status, language, those experiencing homelessness

Mental health – 5 mins

In recent assessments, mental health arose as a top health need. (By mental health, we mean everything ranging from anxiety to mental illness.)

8. **Do you agree? In your opinion, what are the specific mental health needs in our community?** (Conditions like depression/outcomes like suicide)
9. **In what ways are people struggling with mental health issues doing worse than others when it comes to health?** (Drivers)

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

10. **Do you have any opinions on what should be in place in our community to address these needs?**

a. **What types of services would you like to see in the community, that aren't already in place?**
    Prompt: Preventative care? Deep-end services? Workforce changes?

b. **Are there new/revised policies or other public health approaches that are needed?**
   Prompt: program models

[Time permitting] Additional comments

We thank you so much for answering our questions. In the few minutes we have left, is there anything else you would like us to add regarding community health needs?

Closing

OK, if anything occurs to you later that you would like to add to this interview, please just let us know. Thank you for contributing your expertise and experience to the CHNA. You can look for the hospital CHNAs to be made publicly available in 2019.

Focus Group Protocols

During focus groups, facilitators presented the 2016 CHNA List (**Table 1** of this attachment). Questions found in these protocols refer to that list.

Focus Groups with Professional or Community Representatives

Introduction – 6 mins

- Welcome and thanks
- What the project is about:
  - Santa Clara County Community Health Needs Assessment
  - Identifying unmet health needs in our community
  - Ultimately, to plan on how to address health needs now and in future
- Today's questions (refer to agenda flipchart page):
- Introductions (name and organization)
- Confidentiality:
  - When we are finished with all of the focus groups, we will look at all of the transcripts and summarize the things we learn.
  - Would like to record so that we can be sure to get your words right.
  - Now that we have introduced ourselves, we will only use first names here to preserve your anonymity. However, if you want to keep a comment anonymous, you may not want to name your organization.
  - We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
  - Transcripts will go to hospitals if that is OK with you
  - Permission to record?
- What we'll do with the information you tell us today
  - Hospitals will report the assessment to the IRS
  - Hospitals will use information for planning future investments
- Logistics
  - We will end at ___:___.
  - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.
  - Cell phones: On vibrate; please take calls outside.
  - Bathroom location
- Guidelines: Be respectful, it's ok to disagree. We want to hear from everyone.

Health Needs Prioritization – 10 min.

You are here to share your experience as a professional serving [e.g. seniors, persons experiencing homelessness, young adults, etc.].

Part of our task today is to find out which health needs you think are most important for the population you serve. This poster has a list of the health needs that the community came up with when we did the Community Health Needs Assessment for Santa Clara County in 2016. Many of these we have already talked about.

[Read aloud from flipchart and define (e.g. "Access and Delivery" means insurance, having a primary care physician, prevention care instead of ED, being treated with dignity and respect, wait times, etc.).]

1. **Are there any that should be added to the list?**
2. **Please think about the three from the list you believe are the most *important* to address here in the next 3-4 years.**
    a. What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important to address in the next few years. There may be some needs that are very dire – like ones that cause death. But you are voting on the things that you think may not be well-addressed now. In other words, some health needs may have a lot of people working on them, and plenty of treatments and medicines to address them. Others we may not understand as well, or there may not be enough doctors or facilities out there to help people. Then we will discuss the results of your votes.
3. **Summarize voting results.** Explain that we will spend the rest of our time reflecting on these top priorities.

Expertise Area – 20 mins

You are here to share your expertise/experience about [e.g. substance abuse, senior health, or homelessness].

4. **When you think about this health need…**
    - What are people struggling with?
    - What barriers exist to seeing better health in this area?
5. **Which groups, if any, are better or worse off than others?**
   Prompts: Differences by age, education level, disability status, income (affecting housing and transpo), etc.
6. **What trends, if any, have you seen in the last three years?**

Access to Care – 5 mins

We know that access to care impacts all aspects of health.

7. **Would you say that health access [related to the specific population you serve] is sufficient? Why or why not?**
8. **What differences do you see, if any, among various groups in your work?** Prompts: Differences by age, education level, disability status, language, those experiencing homelessness, immigration status, sexual orientation (i.e., LGBTQ).

Mental health – 5 mins

In recent assessments, mental health arose as a top health need. (By mental health, we mean everything ranging from stress to mental illness.)

9. **Do you agree? In your opinion, what are the specific mental health needs in our community?** (Conditions like depression/outcomes like suicide)
10. **In what ways might people who are struggling with mental health issues be doing worse than others when it comes to health?** (Drivers)

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

11. **What opinions, if any, do you have on what should be in place in our community to address these needs?**
    a. **What types of services would you like to see in the community, that aren't already in place?**
       Prompts:
       - Preventative care? Deep-end services?
       - Workforce changes?
       - Are there any quick wins or low-hanging fruit?

    b. **What new/revised policies or other public health approaches are needed, if any?**

IF TIME ALLOWS:

Cultural Competency – 5 mins

12. **To what extent do you think healthcare providers are culturally competent for the diverse population of Santa Clara County?** By "cultural competence" we mean that

people who are providing healthcare know how to provide healthcare in a respectful way to everyone.

Closing – 5 mins

- Thank you
- Repeat - What we will do with the information
- Look for CHNA reports to be publicly available in 20

Focus Groups with Santa Clara County Residents

Introduction – 6 mins

- Welcome and thanks
- Conducting a Community Health Needs Assessment
  - Non-profit hospitals in Santa Clara County hired us
  - Identify unmet health needs in our community
  - Helps those hospitals to plan on how to invest their resources to address community health needs
- Today's questions are… (refer to agenda flipchart page)
- We would like to record
  - Important to get your words right.
  - We will only use first names here to preserve your anonymity
  - Transcripts will go to hospitals if that is OK with you
  - When we are finished with all of the focus groups, we will look at all of the transcripts and **summarize** the things we learn. We also will pull out some **quotes** so that the hospitals can hear your own words. We will not use your name when we give them those quotes.
- Logistics
  - We will end at ___:___.
  - Cell phones: On vibrate; please take calls outside.
  - Bathroom location
  - Incentives – please sign the sheet
- Guidelines: Be respectful, it's ok to disagree. We want to hear from everyone.
- Speaking of that… it is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time.

Health Needs Prioritization – 10 min.

You are here to share your experience as a [e.g., young adult].

Part of our task today is to find out which health needs you think are most important. This poster has a list of the health needs that the community came up with when we did the Community Health Needs Assessment for Santa Clara County in 2016.
[Read aloud from flipchart and define (e.g., "Access and Delivery" means insurance, having a primary care physician, prevention care instead of ED, being treated with dignity and respect, wait times, etc.).]

1. **Are there any that should be added to the list?**
2. **Please think about the three from the list you believe are the most *important* to address here in the next few years.**

a. What we would like you to do is to take the three sticky dots you have there and use them to vote for three health needs that you think are the most important to address in the next 3-4 years. There may be some needs that are very dire – like ones that cause death. But you are voting on the things that you think may not be well-addressed now. In other words, some health needs may have a lot of people working on them, and plenty of treatments and medicines to address them. Others we may not understand as well, or there may not be enough doctors or facilities out there to help people. Then we will discuss the results of your votes.

3. **Summarize voting results.** Explain that we will spend the rest of our time reflecting on these top priorities.

Understanding the Needs – 15 mins

4. **When you think about this health need…**
    - What are people struggling with?
    - What barriers exist to people getting healthy or staying healthy?
5. **What about healthcare access?**
    - Is everyone able to get health insurance for their needs?
    - Is everyone able to afford to pay for health services and medication?
    - Is everyone able to get to the doctors they need when they need to?
6. **What about mental health?** Mental health was one of the top health needs last time. (By mental health, we mean everything ranging from stress to mental illness.)
    a. **In your opinion, what are the specific mental health needs in our community?** (Conditions like depression/outcomes like suicide)
    b. **Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how?** (Drivers)
7. **Do you think that things have been getting better, or worse, in the last three years or so? How?**

Equity & Cultural Competency – 15 mins

8. **Do you think that everyone in our community is getting the same health care, and has the same access to care? If not, what are the barriers for them?** Think about all of the people in our community… some have different ethnicities, languages, sexual orientations, and religions. They may be disabled or be low-income or be experiencing homelessness.

OPTIONAL IF TIME:

We also want to know about cultural competency. That means that people who are providing healthcare know how to provide healthcare in a respectful way to everyone.

9. To what extent do you think healthcare providers have this knowledge?

Suggestions/Improvements/Solutions – 5-10 mins

In addition to what we have already talked about…

10. What types of services, if any, does the community need more of?
Prompt: Preventative care? Deep-end services? Workforce changes?

11. What kinds of changes could those in charge here in Santa Clara County make to help all of us stay healthy?

Closing – 5 mins

- Thank you
- Repeat - What we will do with the information
- Incentives – **after you turn in the survey**

Attachment 6. IRS Checklist

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

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

Federal Requirements Checklist	Regulation Section Number	Report Reference
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #5
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section #5 & Attachment 1
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #5 & Attachment 1
I. Medically underserved populations	(b)(5)(i)(B)	Section #5 & Attachment 1
II. Low-income populations	(b)(5)(i)(B)	Section #5 & Attachment 1
III. Minority populations	(b)(5)(i)(B)	Section #5 & Attachment 1
c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(ii)	Section #5 & Attachment 1
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #5 & Attachment 1
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #5 & Attachment 1
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section 5
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 #7

Federal Requirements Checklist	Regulation Section Number	Report Reference
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Section #7
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Section #7
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 #8 & Attachment 5
D. Finalizing the CHNA		
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Section #3
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 #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)	Date(s) on which a-f below were done:
a. May not be a copy marked "Draft".	(b)(7)(ii)	
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)	
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

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 7. FY17 – FY19 Year-over-Year Dashboard

In 2015–16, El Camino Hospital participated in a Community Health Needs Assessment similar to collaborative 2019 effort.

The 2016 CHNA report is posted on the Community Benefit Page of the El Camino Hospital website.[1] IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years.[2]

After reviewing the findings of the 2016 CHNA, El Camino Hospital's Community Benefit Advisory Council (CBAC) identified 12 health needs to address in FY17 and the subsequent two fiscal years with community benefit grant funding.

The health needs fall under three health priority areas:

- Access to Healthcare & Delivery
- Cancer
- Cardiovascular (Heart) & Cerebrovascular (Stroke)
- Hypertension
- Obesity & Diabetes
- Oral & Dental Health
- Respiratory Conditions

- Alzheimer's Disease & Dementia
- Behavioral Health

- Economic Security
- Unintentional Injuries
- Violence & Abuse

Due to the timing of the CHNA publication and the submission of year-end data from grants, annual data for FY19 (January 1, 2019–June 30, 2019) is unavailable for inclusion. Each year, the Community Benefit Program publishes an Annual Report to the Community available on the Community Benefit page of the website.[24]

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[1] https://www.elcaminohospital.org/about-us/community-benefit
[2] https://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf

The table below, which continues on subsequent pages, describes El Camino Hospital's Community Benefit Program results in fiscal years 2017 and 2018 and the first six months of fiscal year 2019.

Each is color-coded to match one of the three health priority areas identified on page 49.

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School-based nutrition and health partnership program at two school districts	Students served	6,300	8,800	100%	6,500	6,178	67%	4,000	3,870
	Students who report being active one or more hours per day after program engagement	53%	59%		56%	58%		N/A	N/A
	Students who report the knowledge to limit sweetened beverage to zero per day after program engagement	70%	71%		75%	66%		N/A	N/A
School-based physical activity and self-esteem program for girls	Youth served	120	133	100%	120	130	100%	62	65
	Average weekly attendance	80%	89%		80%	87%		85%	84%
	Youth who are observed to have improved behavior or attitudes after each season	90%	93%		90%	86%		75%	92%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School-based adaptive physical activity program for students with physical, cognitive, and hearing disabilities	Youth served	-	-	New Partner in FY18	25	12	67%	12	12
	Students who report they want to exercise more like they do during the program	-	-		90%	100%		85%	84%
	Students who are observed to have improved behaviors/attitudes including increased participation, confidence, and social behaviors	-	-		80%	100%		75%	N/A
Screenings, education and home assessment program for families of children with asthma	Parents, children, teachers, and care providers served through air quality assessment and health condition management training	650	767	100%	800	805	100%	225	103
	Trained parents, teachers, and childcare providers who gain at least a 35% increase in knowledge of asthma management, environmental triggers and remediation steps	55%	58%		60%	55%		N/A	70%
	Parents reporting their children gained at least a 30% increase in knowledge/skills after receiving multi-session education	45%	72%		50%	50%		70%	70%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School district nurse program	Students served	-	-	New Partner in FY18	2,110	1,843	50%	1,000	1,360
	Students who have failed health screenings who saw a healthcare provider	-	-		40%	28%		N/A	N/A
	School staff who received CPR/AED training during Staff Development Days and who reported increased knowledge and confidence in performing CPR and using an AED	-	-		30%	29%		10%	40%
	Students served	6,300	8,800		6,500	6,178		4,000	3,870
	Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	-	-		30%	31%		10%	31%
School district nurse program	Students served	3,924	3,942	80%	4,560	3,910	80%	2,100	1,994
	Uninsured students who have applied for healthcare insurance	70%	64%		70%	72%		40%	48%
	Students with a failed health screening who saw a healthcare provider	72%	75%		72%	70%		40%	41%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Students identified as needing urgent dental care through on-site screenings who saw a dentist	80%	68%		60%	63%		N/A	N/A
	Students at two elementary schools who receive fluoride varnish during onsite screenings	-	-		20%	30%		N/A	N/A
Pre-diabetes screening and education program for community service agencies	Clients served in the program	375	542	100%	420	520	100%	450	396
	Clients post-screened for HbA1c	250	405		360	411		2,000	1,969
	Participants who experience at least a 0.10 percentage point decrease in HbA1c	-	-		25%	50%		N/A	N/A
	Participants scoring at least a 70% on knowledge of diabetes risks and prevention	-	-		68%	69%		N/A	N/A
	Participants who report at least 15–30 minutes of physical activity at least 4–5 times a week	-	-		75%	73%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Participants who score at least 70% on survey about diabetes risk and prevention	-	-		68%	69%		N/A	N/A
Safety-net clinic capacity building and training	Clinic staff who attend learning collaborative training sessions on patient attribution and patient engagement	-	-	New partner in FY19	-	-	New partner in FY19	20	22
	Safety -net clinics where workflow is implemented to improve processing of member attribution lists, data and patient engagement	-	-		-	-		6	6
	Increase in number of documented Initial Health Assessments (annual wellness exams or office visits) for previously unseen patients from baseline	-	-		-	-		1% (844 patients)	6% (~6,000 patients)

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School health and wellness program	Students served	82	82	100%	25	24	66%	29	29
	Physical activity student sessions provided	1,610	1,635		3146	2565		40	38
	Students who show improved Body Mass Index (BMI) per scoring in the healthy range of 14-23	70%	73%		35%	68%		30%	38%
School district nurse program	Students served	1,482	1,411	100%	1,211	1,195	100%	560	548
	Students who failed a mandated health screening who saw a healthcare provider	75%	84%		82%	91%		62%	57%
	Kindergarteners identified as needing early intervention or urgent dental care through on-site screenings who saw a dentist	75%	86%		80%	87%		N/A	N/A
	Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	75%	87%		80%	99%		80%	97%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Clinical and healthy behavior change program for pre-diabetic and diabetic patients	Patients served	600	1,341	100%	1,000	1,363	100%	800	773
	Services provided, including patient visits with a Registered Dietitian and/or Wellness Coordinator	1,800	2,762		2,100	2,747		1,280	1,163
	Patients demonstrating a reduction in body weight	30%	60%		50%	46%		49%	44%
	Patients demonstrating a reduction in HbA1c levels	30%	47%		45%	63%		65%	50%
Brain breaks, activities designed to help students focus at 183 schools in 17 districts	Schools served	183	183	100%	183	231	100%	220	246
	Physical activity breaks played	200,000	299,311		275,000	260,117		150,000	134,146
	Teachers who believe the program benefits their students' focus and attention in the classroom	90%	96%		90%	92%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Teachers who agree that the program's physical activity breaks are a valuable resource in helping their students succeed in core subjects	90%	90%		90%	86%		N/A	N/A
School-based dental and hearing screening program for children	Active users as a percentage of school staff	-	-	New Partner in FY18	N/A	N/A	100%	45%	64%
	Children screened (ages 6 months to 18 years old)	-	-		450	495		175	187
	Of those who received a referral, the percent that received dental treatment	-	-		55%	66%		N/A	N/A
	Of children hearing screened who received a referral, the percent that received and completed appropriate hearing services	-	-		N/A	N/A		35%	37%
	Of children dental screened who received a referral, the percent that received and completed appropriate hearing services	-	-		N/A	N/A		75%	73%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Clinical and healthy behavior change program for overweight and diabetic youth	Individuals served	-	-	New Partner in FY18	160	291	100%	100	145
	Students served	6,300	8,800		6,500	6,178		4,000	3,870
	Services provided	-	-		1,510	1,360		515	479
	Participants who decrease their BMI percentile	-	-		20%	48%		15%	39%
	Participants who are diagnosed with pre-diabetes or diabetes that decrease their HbA1c by at least 0.1 percentage points	-	-		70%	64%		35%	N/A
Medical care and social services for homeless patients	Patients served	145	221	100%	200	248	100%	110	105
	Program patients linked to Primary Care home	92%	90%		92%	95%		92%	91%
	Hospital days avoided for total program	550	884		800	992		420	420

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School nurse program	Individuals served	-	-	New Partner in FY19	-	-	New Partner in FY19	800	1,158
	School staff receiving CPR/AED, Epi-Pen, and seizure training who reported increased knowledge/confidence in their ability to respond as measured by a four-point rubric	-	-		-	-		80%	88%
	Students who saw a provider after a failed health screening	-	-		-	-		N/A	N/A
	Uninsured students whose families have applied for healthcare coverage	-	-		-	-		N/A	N/A
Physical activity and school climate program	Students served	2,710	2,690	100%	2,326	2,365	100%	2,328	2,332
	School staff that report the program helps teach students cooperation and respect	-	-		90%	97%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Teachers reporting that overall student engagement increased use of positive language, attentiveness and participation in class	-	-		75%	95%		N/A	N/A
	Teachers/administrators reporting that the program positively impacts school climate	-	-		90%	99%		N/A	N/A
Pre-diabetes awareness, screening and management resources program	Community members reached through the community health worker outreach program	3,000	5,754	100%	2,500	3,189	100%	1,350	1,415
	Pre-diabetes outreach events	185	211		136	205		75	96
	CDC Risk-Assessments administered	3,000	4,535		2,000	2,548		1,080	1,149
	Text messages delivered	-	-		3,500	5,974		15,700	15,987
	Impressions through culturally relevant radio ads	391,200	460,000		872,000	995,866		426,000	450,003

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
No-cost medication program for low-income population	Individuals served	-	-	New Partner in FY19	-	-	New Partner in FY19	1,250	1,919
	Prescriptions filled	-	-		-	-		10,000	12,780
	Patients who report that the services they received help or helped a great deal	-	-		-	-		95%	99%
	Patients who report that the services were provided in their preferred language	-	-		-	-		95%	97%
	Patients who report overall satisfaction as good or excellent	-	-		-	-		95%	99%
Rehabilitation, awareness, and community education for stroke	Individuals served through Community Education and Outreach Beneficiaries through community events (not including clinical patients)	-	-		-	-		186	160

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Clinical patients served through rehabilitation intervention services	-	-	New Partner in FY19	-	-	New Partner in FY19	14	14
	Rehabilitation component intervention services (hours)	-	-		-	-		520	625
	Participants who show a 10-point improvement in scores on the Western Aphasia Battery-Part 1 (quantifies severity of post-stroke communication impairment)	-	-		-	-		25%	N/A
	Participants who show a five-point improvement in scores on the Quality of Communication Life Scale (QCLS) (quantifies quality of communication as assessed by stroke/BI survivors)	-	-		-	-		25%	N/A
Program supporting	Individuals served	38	38	100%	38	38	100%	-	-
	Services provided	564	564		564	564		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
growth and development of children from low-income families	Children meeting the Child Health and Disabilities Prevention periodicity schedule on time as required by age	95%	95%		95%	95%		-	-
	Children who are not up to date on recommended procedures who come under medical care	90%	100%		90%	90%		-	-
No-cost orthodontic program for foster youth	Youth receiving braces and those in process of completing treatment plan	44	80	%	-	-	-	-	-
	Youth undergoing treatment who report being satisfied or highly satisfied with orthodontic care services	75%	80%		-	-		-	-
	Social workers who indicate that orthodontic care has had a positive impact on well-being and self-esteem of youth served in the program	75%	80%		-	-		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
School-based no-cost eye exam and glasses program	Free eye exams provided	441	195	0%	616	280	0%	-	-
	Free eyeglasses provided	353	180		490	242		-	-
	Students served	6,300	8,800		6,500	6,178		4,000	3,870
Vision Rehabilitation Program	Services provided (information and referral, intake, counseling, support group, adapted daily living skills, orientation and mobility, assistive technology, low vision evaluation)	-	-	New Partner in FY19	-	-	New Partner in FY19	200	203
	Clients who rate at least a 4 on a scale of 1 (unsatisfactory) to 5 (satisfactory) that they were informed about resources, community agencies and programs available to help live with vision loss	-	-		-	-		90%	100%
	Clients who report being somewhat confident to confident in ability to move safely within their residence	-	-		-	-		80%	100%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Clients who indicate that they are able to read printed material after program participation	-	-		-	-		70%	71%
Senior isolation and depression program	Seniors screened for depression	150	158	100%	150	152	100%	-	-
	Participants who enroll in the program	40	53		40	40		-	-
	Services provided	390	465		390	397		-	-
	Participants who demonstrate at least a one-point decrease in score on Geriatric Depression Scale	85%	90%		85%	100%		-	-
Culturally based services for patients of Alzheimer's and related disorders and their caregivers	Individuals served	-	-		-	-		238	316
	Services provided	-	-		-	-		476	316
	Participants in Educational Sessions and Forums/Conference who indicated they agree or strongly agree that they learned material to	-	-		-	-		98%	100%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	help them better care for their loved one with ADRD								
	Participants in care consultations, support groups or informational and referrals who agree or strongly agree that they know about how family, friends, and others can assist them with care and support or who indicated they know how to find resources to help them	-	-		-	-		N/A	N/A
School-based social emotional skill building program at 16 schools	Students served	290	187	75%	270	245	100%	30	169
	Counseling sessions provided	2,030	2,711		2,100	2,063		400	374
	Students who show an increase in at least 50% of the 7 relevant External Developmental Assets for their age group	70%	90%		80%	90%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Teachers of the elementary school youth who state that the child shows an improved attitude in school	70%	90%		80%	95%		N/A	N/A
Mentoring program for at-risk youth	Youth served	-	-	New Partner in FY18	10	10	100%	10	13
	Services provided	-	-		628	664		250	384
	Students who will report not drinking alcohol, smoking cigarettes, or using drugs in the previous 30 days	-	-		90%	100%		75%	92%
Therapy program for abused children	Youth served	-	-	New Partner in FY18	12	12	100%	6	6
	Services provided	-	-		140	153		70	61
	Clients who report demonstrating improvement in their coping skills	-	-		90%	100%		80%	100%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Mental health counseling at a school district	Students served	-	-	New Partner in FY18	110	95	50%	40	48
	Services provided	-	-		323	254		105	308
	Students who improved by at least 3 points from pre-test (at start of counseling) to post-test (prior to end of counseling) on the Strength and Difficulties Questionnaire and Impact Assessment based on teacher report (for students ages 10 and under)	-	-		50%	65%		N/A	N/A
	Students who improved by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report (for students ages 11–17)	-	-		50%	50%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Advocacy and support services for foster teens	Foster children served	-	-	New Partner in FY18	137	253	100%	35	70
	New volunteer Court Appointed Special Advocates (CASAs)	-	-		76	95		35	70
	CASA high school seniors who earn their diploma or equivalent	-	-		80%	75%		N/A	N/A
Mental health counseling at Campbell Union School District	Students served	-	-	New Partner in FY19	-	-	New Partner in FY19	100	102
	Total services hours provided	-	-		-	-		200	209
	Students who work directly with therapists will meet one or more treatment goals by the end of the 12 sessions	-	-		-	-		N/A	N/A
	Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 11–17)	-	-		-	-		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Students who improved by at least 3 points from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 10 and under)	-	-		-	-		N/A	N/A
Mental health counseling at a school district	Students served	170	143	50%	186	169	80%	195	258
	Services provided	2,300	2,176		-	-		N/A	N/A
	Service hours provided	-	-		2,000	3,485		1,470	2,001
	Students who improved by at least 3 points from (at start of counseling) to post-test (prior to end of counseling) on the Strength and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 10 and under)	-	-		50%	60%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Students who improved by at least 3 points from pre-test to post-test on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11–17)	-	-		50%	61%		N/A	N/A
	Students who improve on treatment plan goals by 20% in 6 months and 50% by the end of the school year as measured by counselor report	90%	73%		90%	75%		60%	61%
Behavioral health services at homeless shelters	Individuals served	-	-	New Partner in FY19	-	-	New Partner in FY19	25	29
	Hours of individual, group and milieu therapy	-	-		-	-		80	90
	Clients who attend at least three individual therapy sessions who report improved functioning and well-being	-	-		-	-		85%	90%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Peer-to-Peer counseling/ advocacy for adults with developmental disabilities	Clients who participate in at least three individual or group therapy sessions report improved understanding of behavioral health issues associated with homelessness for themselves and their children, if any	-	-		-	-		75%	80%
	Individuals served	-	-	New Partner in FY18	22	20	100%	-	-
	Services provided	-	-		175	388		-	-
	Counselees who report a 15% improvement in quantity and quality of sleep after at least 6 sessions	-	-		40%	80%		-	-
Community resource platform for	Participants enrolled	1,600	1,373		-	-	-	-	-
	Services provided	2,000	2,349		-	-		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
isolated and homebound seniors and caretakers	Participants expressing satisfaction and usefulness of the experience, intention to use the program again, and intent to refer others	75%	82%		-	-	-	-	-
Social isolation and physical activity program for caretakers	Individuals served	100	85	%	-	-	-	-	-
	Participants who increase number of steps per week from baseline to end of program period	60%	67%		-	-		-	-
Psychiatric services and medication management for underinsured and uninsured	Patients served	22	22	100%	22	22	100%	13	22
	Services provided	180	331		180	443		165	168
	Patients who avoid psychiatric hospitalization for 12 months after admission after beginning services	95%	100%		97%	100%		97%	100%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Psychiatric services and medication management for homeless and at-risk	Patients served	170	325	100%	200	179	100%	100	98
	Visits including psychiatry, therapy, and case management	550	532		645	606		322	268
	Actively managed patients who obtain permanent housing	12	11		N/A	N/A		N/A	N/A
	Psychiatric patients not hospitalized in a 12-month period	85%	91%		85%	90%		85%	85%
	Street outreach encounters	-	-		-	-		75	245
	Psychiatry patients that attend scheduled follow-up appointments	-	-		-	-		50%	%0%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Older adult isolation and caregiver respite program	Individuals served	-	-	New Partner in FY19	-	-	New Partner in FY19	30	35
	Nutritional, social activity, and personal care services provided	-	-		-	-		10,500	15,341
	Clients served who will experience a decrease in isolation of at least 1 point on a 5-item Likert scale (based on annual survey)	-	-		-	-		N/A	N/A
	Clients who maintain and/or stabilize at least one activity of daily living (ADL) with a functioning score of 0–1 as measured by the dependency profile	-	-		-	-		64%	70%
	Clients who experience improved socialization as measured by attending at least four activities daily with a functioning score of 0–2 as measured by the dependency profile	-	-		-	-		64%	70%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Mental health counseling at a school district	Students served through classroom presentations	560	422	%	-	-	-	-	-
	Case management interactions	90	69		-	-		-	-
	Counseling services group or individual	40	147		-	-		-	-
	Students receiving counseling services who increase their days of attendance compared to previous year	20%	25%		-	-		-	-
	Reduction in referrals for high risk behaviors that could result in suspension or discipline for students receiving counseling services	15%	33%		-	-		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Mental health counseling and addiction prevention services for students at a school district	Students served with individual and/or group counseling and classroom presentations	3,000	2,745	100%	2,900	2,927	88%	1,125	2,252
	Service hours provided	-	-		2,290	2,160		1,040	724
	Services provided	3,500	3,211		-	-		N/A	N/A
	Youth participating in classroom presentations who show an increase in knowledge which may improve behaviors related to high-risk activities	85%	86%		85%	89%		N/A	N/A
	Parents/caregivers who show an increase in knowledge of the topics presented and greater understanding of how to access services for youth	95%	96%		95%	98%		N/A	N/A
	Students who reduce high risk behaviors by at least 25%	-	-		65%	90%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Students who decrease exposure to violence by at least 25%	-	-		65%	100%		N/A	N/A
	Students who increase their use of coping skills for trauma, depression, anxiety and/or anger by at least 25%	-	-		75%	96%		N/A	N/A
	Students who decrease their suicidal thoughts and feelings by at least 25%	-	-		75%	95%		N/A	N/A
Cancer nutrition education and support program	Individuals served	130	419	100%	400	358	100%	150	171
	Nutrition class services provided	900	1,380		1,296	1,299		490	514
	Participants who report at least a moderate increase in understanding how nutrition may affect cancer treatments and medications	50%	91%		90%	95%		90%	96%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Promoting housing security for families through assistance and case management	Individuals served	-	-	New partner in FY19	-	-	New partner in FY19	30	28
	Services provided	-	-		-	-		57	52
	Participants who maintain or increase income capacity via stable employment within 12 months of contact	-	-		-	-		30%	29%
	Participants who are able to pay and maintain their housing or exit into other permanent housing	-	-		-	-		60%	57%
	Participants who connect with a primary care physician or access on-site nursing services	-	-		-	-		50%	47%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Screenings and culturally based education program	Individuals served	125	145	100%	150	152	100%	75	76
	Services provided	250	315		300	301		150	172
	Participants who strongly agree or agree that the program's health education or screening helps them better manage their health	85%	86%		90%	95%		N/A	N/A
Falls awareness and prevention program	Individuals served	800	1,282	-	-	-	-	-	-
	Class participants who report that they are "sure" or "very sure" of their ability to find a way to get up if they fall, find ways to reduce falls, protect themselves if they fall, increase physical strength, and be steadier on their feet	85%	85%		-	-		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Text-based hypertension awareness program	Participants who will demonstrate an improvement in their upper extremity strength, lower extremity strength, and dynamic balance	85%	85%	-	-	-	-	-	-
	Participants who receive text-message interventions	80	78		-	-		-	-
	Percent of participants in experiment group who report drinking at least one more unit of water per day	20%	43%		-	-		-	-
Eldercare support, health information and medical searches	Individuals served	1,404	1,270	100%	1,416	1,656	100%	700	599
	Community members who strongly agree or agree that information is appropriate for my needs	-	-		80%	77%		80%	75%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Individuals who strongly agree or agree that library information was appropriate to their needs	-	-		80%	77%		N/A	N/A
Culturally focused breast cancer awareness and resources	Community members educated about breast cancer, screening and prevention	-	-	New Partner in FY18	150	158	100%	-	-
	Participants who receive a Clinical Breast Exam	-	-		80%	89%		-	-
	Participants who receive a mammogram	-	-		80%	78%		-	-
	Adults served through the comprehensive services for victims of domestic violence program	-	-		154	159		66	78

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Crisis Counseling, Shelter Services and Other Support for Victims of Domestic Violence	Adults served through the FY16 support group and crisis support program	340	344	100%	-	-	100%	-	-
	Services provided	1,665	1,623		1,133	1,293		566	621
	Surveyed participants who report that they have gained at least one strategy to increase their safety or their children's safety	65%	92%		80%	94%		80%	92%
	Clients newly engaged in Self-Sufficiency Case Management who will complete a risk assessment, safety planning, and a self-sufficiency action plan	50%	56%		50%	48%		50%	66%
Screening and access to free or reduced cost hearing aids for children and adults	Individuals served	-	-	New Partner in FY19	-	-	New Partner in FY19	50	51
	Hearing aids fit	-	-		-	-		9	6

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
AED program, placing and managing devices throughout the county, including all public schools	School districts served	10	13	100%	31	31	100%	-	-
	Automated External Defibrillators (AEDs) placed	200	373		200	293		750	732
	Teachers and/or staff who attend an Automated External Defibrillator orientation will report knowing 3+ steps to do when an AED is needed.	80%	94%		85%	90%		90%	95%
Program to ensure seniors and disabled community members have access to medical care by providing safe, timely, and compassionate transport	Older adults served	100	27	-	-	-	-	-	-
	Older adults who strongly agree or agree that services helped in maintaining their independence	92%	92%		-	-		-	-
	Older adults who strongly agree or agree with that having program services made it possible to get to their medical appointments	95%	93%		-	-		-	-

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Food bank nutrition education program	Nutrition education services provided to individuals	-	-	New Partner in FY18	7,200	18,584	100%	-	-
	Clients who report that half of each meal should include fresh fruits and vegetables	-	-		30%	55%		-	-
	Clients who report that their family eats more fruits and vegetables through participation in the program	-	-		70%	84%		-	-
Program promoting safe physical activity in affordable housing communities	Individuals served	-	-	New Partner in FY18	300	342	33%	60	58
	Services provided	-	-		500	342		-	-
	Participants who report riding 6–10 times per year	-	-		20%	11%		5%	3%
	Safety workshops and community bike rides provided	N/A	N/A		N/A	N/A		125	114

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Bike Ambassadors trained in affordable housing communities and lead additional bike rides outside of and after program ends	N/A	N/A		N/A	N/A		4	4
Screenings and culturally focused education program for heart disease and diabetes	Individuals served	1,250	1,356	83%	383	389	100%	92	102
	Services provided	7,500	6,468		2,044	2,050		499	510
	Improvement in average level of weekly physical activity from baseline	16%	17%		20%	21%		20%	22%
	Improvement in average levels of daily servings of vegetables from baseline	13%	14%		20%	20%		19%	19%
	Improvement in levels of HDL-C as measured by follow-up lab test	4%	4%		5%	5%		5%	5%
	Improvement in cholesterol ratio as measured by follow-up lab test	6%	6%		7%	7%		6%	6%

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Program promoting self-sufficiency and health education for teen mothers	Individuals served	-	-	New Partner in FY18	10	10	100%	10	10
	Services provided to teen mothers	-	-		160	146		115	101
	Individuals who are enrolled in school and working towards graduation or receive their high school diploma or GED	-	-		95%	93%		85%	86%
Home gardens and nutrition education program for low-income households	Individuals/households served	-	-	New Partner in FY18	216/48	73/37	75%	92	90
	Services provided	-	-		132	411		152	150
	Participants reporting increased food security for themselves and their children by at least on level on the USDA range, as measured by pre- and post-participation surveys	-	-		80%	84%		80%	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
	Participants reporting an increase in their knowledge of nutrition and healthy cooking, as measured by pre- and post-participation surveys and final focus group	-	-		80%	80%		80%	90%
Social work case management, benefits assistance and nutrition workshops for at-risk families	Households served	120	128	100%	122	122	100%	65	65
	Households that receive intensive case management services	60	63		60	60		10	10
	Case managed clients who increased in three of the 18 domains measured by Self-Sufficiency Index	80%	80%		80%	80%		N/A	N/A
	Program participants who will improve one point in the health domain through supportive services	60%	80%		80%	80%		N/A	N/A

Partner	Metrics Metrics are considered met when the performance is within 10% of target	FY17 Annual Target	FY17 Annual Actual	FY17 % Annual metrics met	FY18 Annual Target	FY18 Annual Actual	FY18 % Annual metrics met	FY19 6-month Target	FY19 6-month Actual
Social work case management, benefits assistance and nutrition workshops for seniors	Individuals served	22	22	100%	22	43	100%	15	20
	Encounters provided	240	278		245	260		125	130
	Case managed clients who increased in three of the 18 domains measured by Self-Sufficiency Index	-	-		90%	90%		N/A	N/A
Support for at-risk women	Individuals served	-	-	New Partner in FY18	10	11	100%	4	3
	Services provided	-	-		100	83		20	14
	Individuals completing the program	-	-		60%	97%		75%	85%

8. Conclusion

El Camino Hospital worked with its Community Benefit Hospital Coalition partners, pooling expertise and resources, to conduct the 2019 Community Health Needs Assessment in Santa Clara County.

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

The 2019 CHNA, which builds upon prior assessments, meets federal (IRS) and California state requirements.

Next steps for El Camino Hospital:

- After the CHNA is adopted by the hospital's board, make the CHNA report publicly available on the website (by June 30, 2019).[3]
- Monitor community comments on the CHNA report (ongoing) Select priority health needs to address.
- Develop strategies to address priority health needs (independently or with Coalition partner hospitals).
- Ensure Community Benefit Plan and Implementation Strategy is approved by the hospital board (by June 2019).

[3] https://www.elcaminohospital.org/about-us/community-benefit