El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2016 Community Health Needs Assessment

March 2016



Acknowledgments

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

- **El Camino Hospital**, Barbara Avery, Director of Community Benefit
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- **Hospital Council of Northern & Central California**, Jo Coffaro, Regional Vice President
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Community Benefit Advisory Council Members:

- Barbara Avery (Chair), Director of Community Benefit, El Camino Hospital Mountain View and El Camino Hospital Los Gatos
- Bonnie Broderick, Director of Chronic Disease and Injury Prevention, Santa Clara County Public Health Department
- Cecile Currier, President, CONCERN-EAP; Vice President, Corporate & Community Health Services, El Camino Hospital
- Dr. Rhonda Farber, Past Superintendent, Campbell Union High School District
- Laura Macias, Past Councilmember and Mayor, City of Mountain View
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EXECUTIVE SUMMARY

Overview of the Community Health Needs Assessment (CHNA)

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

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

The 2016 CHNA should serve as a tool for guiding policy and program planning efforts and is available to the public. For Coalition member hospitals, it serves to assist in developing Community Benefit Plans pursuant to California State Senate Bill 697, as well as assist in meeting Internal Revenue Service (IRS) requirements for Community Health Needs Assessment and Implementation Strategies pursuant to the Affordable Care Act of 2010.[1]

About El Camino Hospital & Its Community

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

How Was El Camino Hospital's Assessment Conducted?

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

[1] For a copy of the full CHNA, see www.elcaminohospital.org/CommunityBenefit.

The health needs described in this report fall into one or more of the four categories described below:

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

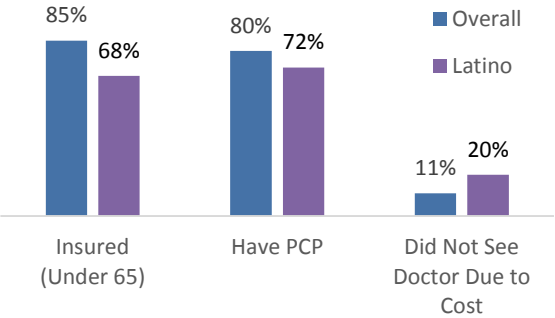
In September 2015, the Coalition identified health needs by synthesizing primary qualitative research and secondary data, and then filtering those needs against the following progressive criteria:

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

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

What Are the Priority Health Needs?

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



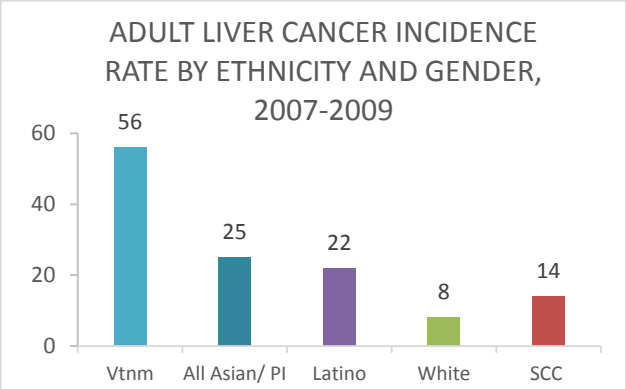
Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey.

2 **Alzheimer's Disease & Dementia** impact older adults, and the rates of these conditions are expected to rise along with the aging population. The age-adjusted death rate of Alzheimer's disease in Santa Clara County in 2011 was 35.9 per 100,000, which was higher than the state overall in 2010 (30.1 per 100,000).[2]

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

4 **Birth Outcomes** are a health need in Santa Clara County as evidenced by stark racial and ethnic disparities. For instance, the mortality rate of Black infants (7.8 per 1,000) is higher than the HP2020 target (6.0 per 1,000).[3] Moreover, over a quarter of Blacks (29%) and Latinos (26%) experience inadequate prenatal care.[4]

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



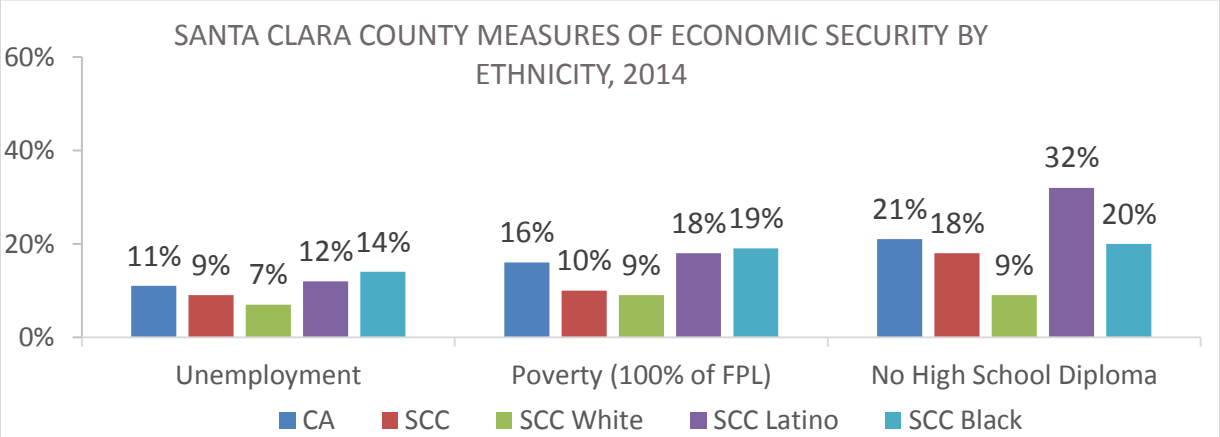
Source: Santa Clara County Public Health Department Vietnamese Report. (2011). Rates are per 100,000 of the population. "Vtnm" = Vietnamese, "PI" = Pacific Islander.

[2] Centers for Disease Control and Prevention (CDC), *Community Health Status Indicators (CHSI)/National Center for Health Statistics, County Profile*, 2011; CDC, *National Center for Health Statistics (NCHS) Data Brief*, 2010; CDC, *Health Data Interactive for National Data*, 2011.
[3] California Department of Public Health, *Birth Profiles by Zip Code*, 2011.
[4] Ibid.

6 **Cardiovascular (Heart) and Cerebrovascular (Stroke) Diseases** are responsible for 26% of all deaths in the county. In addition, ethnic disparities exist in mortality rates of heart disease and stroke. Poor nutrition is a driver of cardiovascular diseases. Youth consumption of fruits and vegetables is worse in Santa Clara County compared with California. Compared with California overall, Santa Clara County has more fast food restaurants, fewer grocery stores, and fewer WIC-authorized stores per capita.

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

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



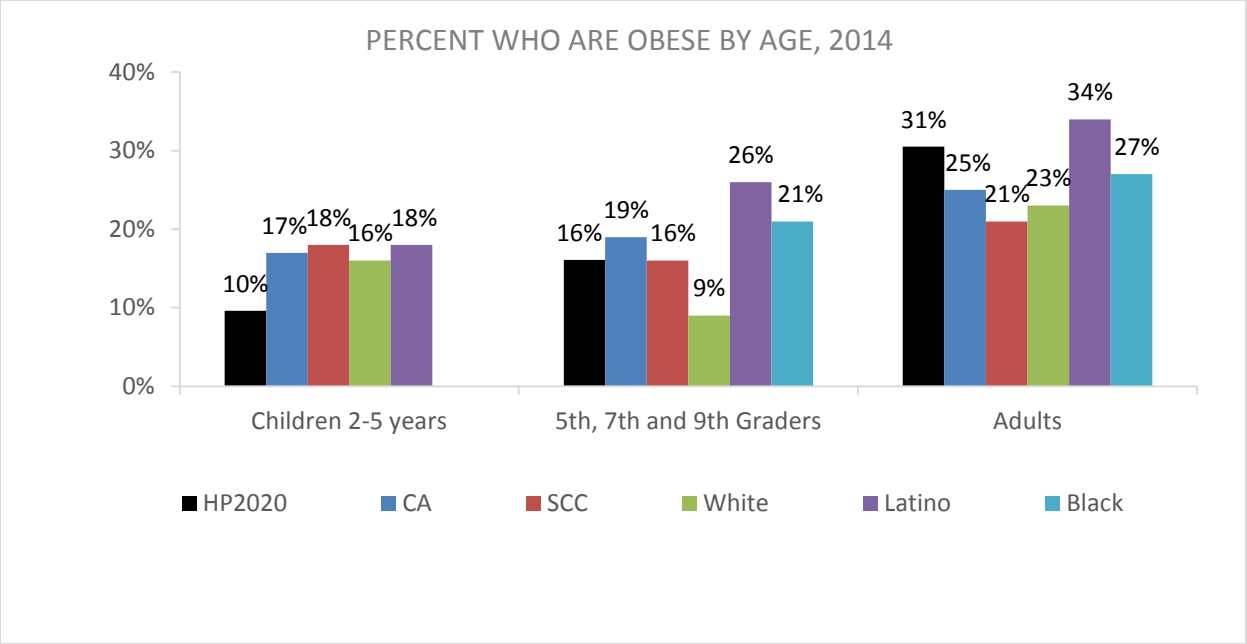
Sources: Unemployment and high school graduation: Santa Clara County Public Health Department, Community Health Assessment (2014). Poverty: Community Commons. The Federal Poverty Level for a four-person household was $23,550 in 2013 and $23,850 in 2014. (http://obamacarefacts.com/federal-poverty-level).

9 **Housing** is a health need because Santa Clara County is one of the most expensive places to live in California, and a lack of safe, stable housing contributes to poor physical and mental health outcomes. Rents increased significantly in the past five years in the San Jose-Sunnyvale-Santa Clara metropolitan area. Rents for a two-bedroom residence averaged $1,994 in 2015, a 21% increase when compared to rents from 2013. Of mortgage-holders, a higher proportion of Blacks and Latinos spend 30% or more of household income on housing (52% and 59% respectively) compared to Santa Clara County overall (45%) and California (46%). Community focus group participants expressed housing and homelessness as a top concern.

10 **Hypertension** (abnormally high blood pressure) can lead to heart disease and stroke, which are the leading causes of death in the United States. More than a quarter (27%) of Santa Clara County residents have been diagnosed with high blood pressure. Blacks, men, and older adults are more likely to be diagnosed with high blood pressure than county residents overall.

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

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



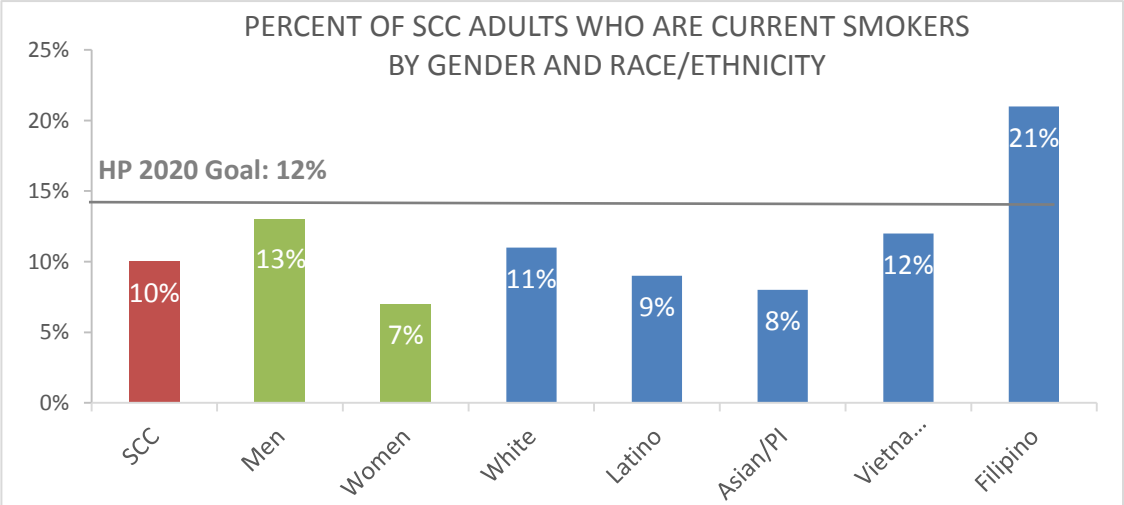
Source: CA Department of Health Care Services, Child Health and Disability Prevention Program, Pediatric Nutrition Surveillance 2010 Data (Kids); BRFS (5th, 7th, 9th graders) Santa Clara County Public Health Department, Community Health Assessment (2014; Adults) .

13 **Oral & Dental Health** is a need in Santa Clara County illustrated by nearly two thirds (64%) of adults lacking dental insurance.[5] One in three adults have had tooth loss, and the statistics are worse for Black adults (49%).[6] Additionally, youth dental care utilization rates (15%) are worse than the state (19%).[7] The community expressed concern about the proportion of adults who lack dental insurance, the lack of providers who accept Denti-Cal, and the costs of dental care for those who do not have it.

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

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

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



Source: Santa Clara County Public Health Department, Tobacco Use in Santa Clara County (2014).

[5] Santa Clara County Public Health Department. *Behavioral Risk Factor Survey, 2013-2014.*
[6] Ibid.
[7] Centers for Disease Control & Prevention. *Behavioral Risk Factor Surveillance System, 2009.*
[8] Santa Clara County Public Health Department. *Behavioral Risk Factor Survey, 2013-2014.*

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

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

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

Next Steps

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

From Assessment to Implementation

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

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

- Behavioral Health
- Alzheimer's Disease & Dementia

- Violence & Abuse
- Unintentional Injuries (including falls)
- Economic Security

The Coalition selected health needs based on the following criteria:

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

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

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

INTRODUCTION/BACKGROUND

The CHNA Effort

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

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

ABOUT EL CAMINO HOSPITAL

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

Our Mission

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

Brief History

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

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

In 2006, after the second groundbreaking event in El Camino Hospital's history, construction began on the new seismically compliant main hospital building at the Mountain View campus. Three years later, after a festive ribbon cutting and community day with more than 8,000 people taking tours of the new facilities, the new state-of-the-art hospital in Mountain View opened on November 15, 2009.

In 2008, the hospital acquired the assets of the former Community Hospital of Los Gatos. The former owners closed the hospital in April 2009, but a fully renovated and staffed El Camino Hospital Los Gatos reopened within 90 days of the closure in July 2009. The 143-bed hospital continues to offer full service, acute care to residents of Los Gatos and surrounding communities, just as it had been doing since it first opened in 1962.

Specialty Care and Innovation

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

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

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

About El Camino Hospital's Community Benefit Program

For more than 50 years, El Camino Hospital has provided healthcare services beyond its walls – crossing barriers of age, education, and income level − to serve the people of its region − because a healthier community benefits everyone.

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

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

Integral to the process is the valuable guidance the Hospital receives from the Community Benefit Advisory Council (CBAC). The CBAC is comprised of Board members, physicians, and representatives from the community who have knowledge about local disparate health needs.

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

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

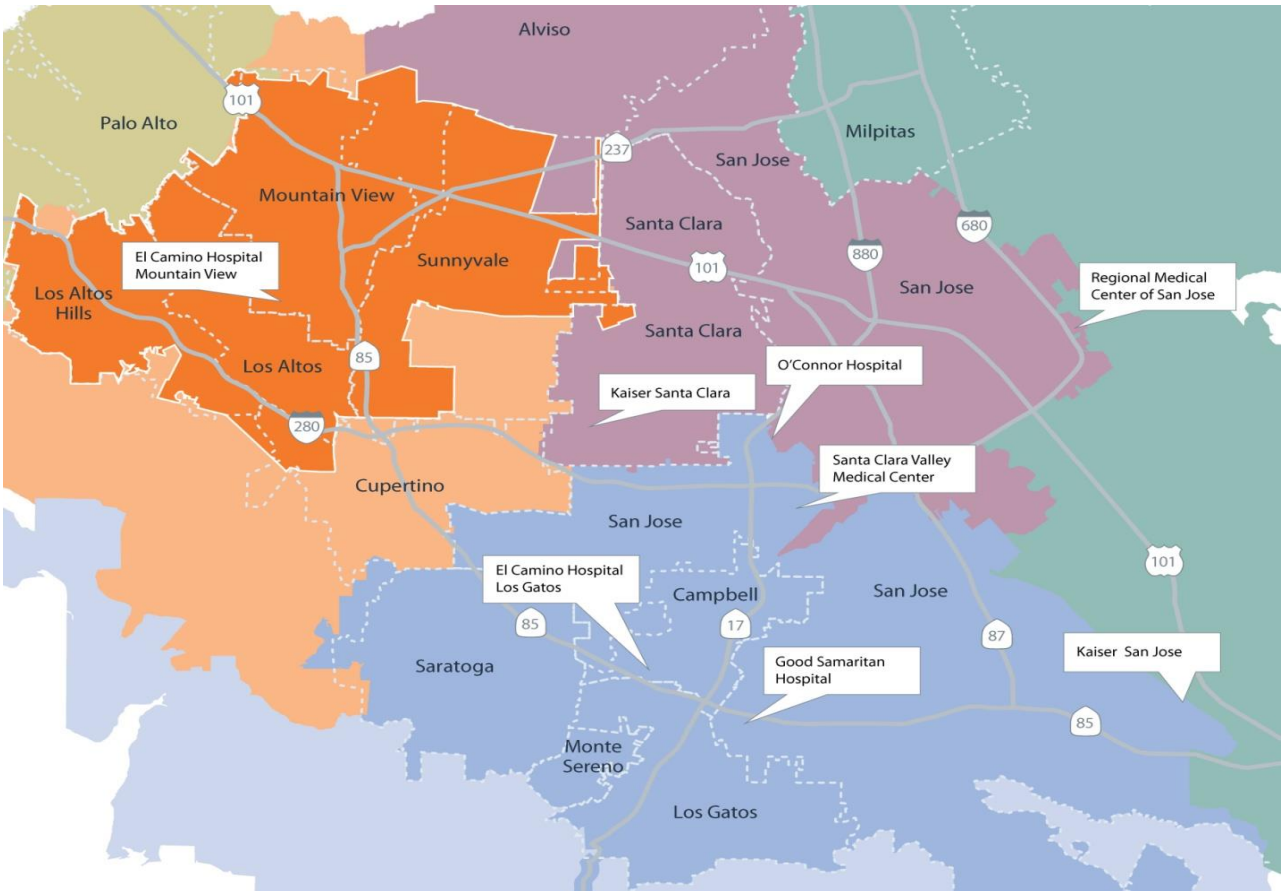
Demographic Profile of Community Served

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

Regions, Cities, and Towns Served by El Camino Hospital

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

Map of Communities Served by El Camino Hospital



El Camino Hospital Market Areas

- **El Camino Healthcare District**
- **East Primary**
- **North Secondary**
- **East Secondary**
- **Mountain View Primary**
- **Los Gatos Primary**

El Camino Hospital's primary market area is the area in which the majority of its inpatients reside. The El Camino Healthcare District sits within El Camino Hospital Mountain View's primary service area. El Camino Hospital also provides care to residents in the secondary market with primarily specialized care such as cardiovascular surgery, high-risk obstetrics, and/or cancer care.

Santa Clara County

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

Race/Ethnicity

Race/Ethnicity	Santa Clara County %	ECH Community %
White	54	48
Black	3	3
American Indian/Alaskan Native	1	<1
Asian	35	34
Pacific Islander/Native Hawaiian	<1	<1
Some Other Race	11	9
Two or More Races	5	5
Latino (of Any Race)	27	27

Source: U.S. Census Bureau, American Community Survey (2009-2013 5-Year Estimates).
*Note: Percents do not add to 100% because they overlap. ECH Community data are averages of cities served by ECH.

Foreign-Born by Race/Ethnicity

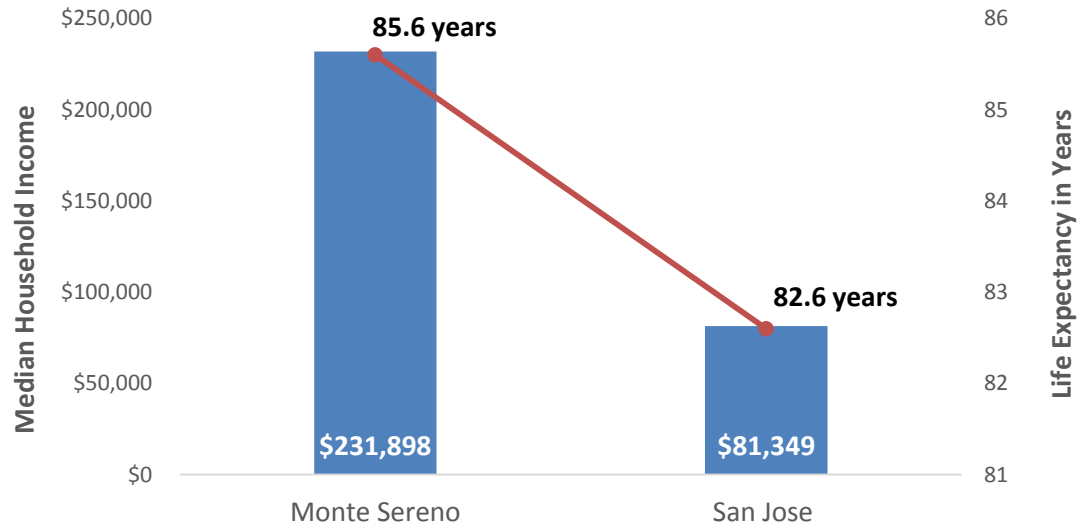
Race/Ethnicity	SCC Foreign-Born %	ECH Community Foreign-Born %
Any race	37	39

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

Social Determinants of Health

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

Income in Life Expectancy of SCC Cities with the Highest and Lowest Median Household Incomes



Source: Santa Clara County Public Health Department, Monte Sereno Profile 2015 and San Jose Profile 2015.

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

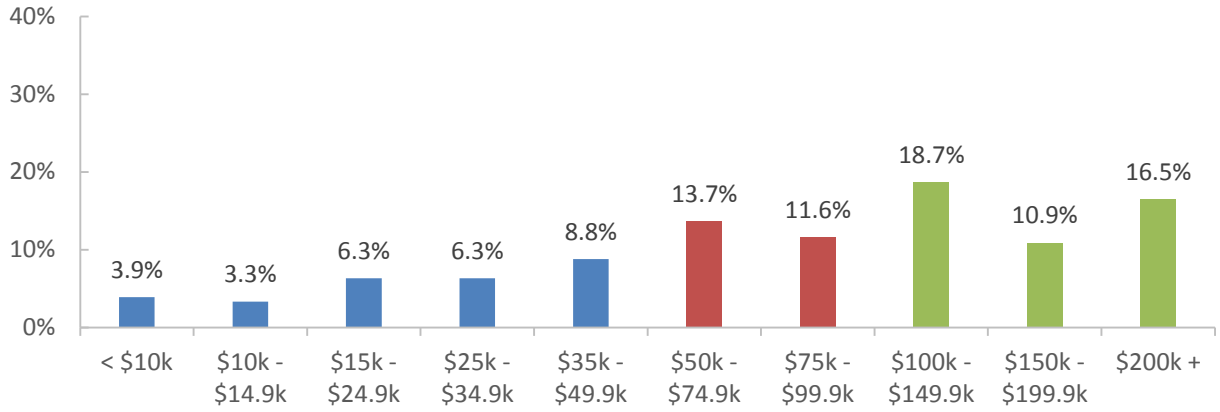
Santa Clara County has one of the highest annual median incomes in the country and one of the highest costs of living.

Comparing poverty measures for family of 4:

2014 Federal Poverty Level: $23,850
2014 Economic Self-Sufficiency Standard: $63,979

[9] U.S. Census Bureau, American Community Survey (2011-2013 3-Year Estimates).

Percent of Santa Clara County Households by Income Range



Source: U.S. Census Bureau, American Community Survey (2011-2013 3-Year Estimates). Blue bars include the $0-50k income range, red bars include the $50-100k income range, and green bars include the $100k and over income range.

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

[10] Avalos, G. "Home Prices Soar to Records in Santa Clara and Alameda Counties." San Jose Mercury News.
[11] Santa Clara County and Applied Survey Research. *Santa Clara County Homeless Census Point-in-Time Census and Survey Comprehensive Report 2015*.
[12] U.S. Census Bureau. American Community Survey (2009-13 5-Year Estimates). Retrieved from Community Commons.

Santa Clara County Vulnerability Footprint

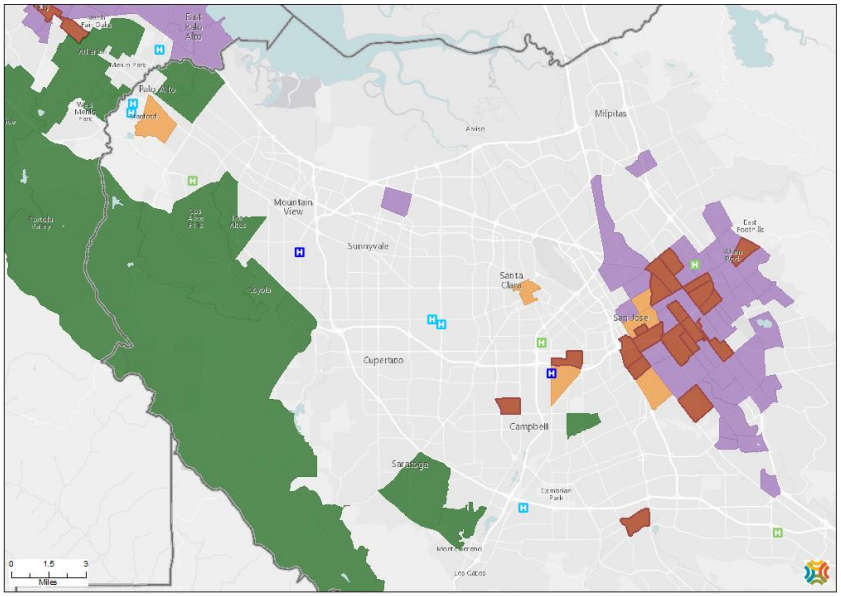
Population (25% or more) living at or below 100% of FPL

Population (25% or more) aged 25 and older and lacking high school diploma

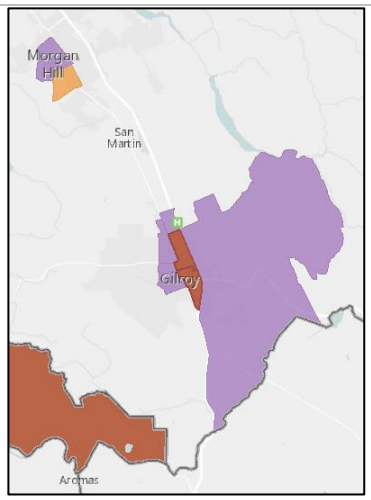
Population (25% or more) both lacking high school diploma and living at or below 100% of FPL

Population (top 20% of earners) has a mean income that is at least double the county mean income.

North/Central County



South County



Source: U.S. Census Bureau. American Community Survey (2008-12 5-Year Estimates).

The Affordable Care Act in California and Santa Clara County

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

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

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

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

[13] In addition to disabled adults, non-disabled adults who qualified before ACA included those who qualified for CalWORKS; Supplemental Security Income and State Supplemental Program (SSI/SSP); Entrant or Refugee Cash Assistance (ECA or RCA); In-Home Supportive Services (IHSS); or Foster Care or Adoption Assistance Program.
[14] Health for California Insurance Center. *Covered California.* Retrieved from http://www.healthforcalifornia.com/covered-california.
[15] California Healthcare Foundation. *Fresh Data on ACA 411 Show Impacts of Health Reform.* Retrieved Nov. 1, 2015 from http://www.chcf.org/articles/2015/08/fresh-data-aca-411.
[16] County of Santa Clara Board of Supervisors, *Medi-Cal 2020 Waiver Renewal- Support*, 2015. Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SCC_Letter.pdf
[17] California Health Interview Survey (CHIS), 2014. Retrieved Nov. 1, 2015 from http://www.chcf.org/aca-411

ASSESSMENT TEAM

Hospitals & Other Partner Organizations

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

Identity & Qualifications of Consultants

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

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

CHNA 2013 NEEDS & EVALUATION FINDINGS

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

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

Santa Clara County 2013 Countywide Prioritized Health Needs

IDENTIFIED COUNTYWIDE HEALTH NEED	HEALTH NEED CHOSEN BY THE HOSPITAL
Alzheimer's Disease	**YES**
Birth Outcomes	**NO**
Cancer	**YES**
Cardiovascular & Heart Disease, Stroke	**YES**
Diabetes	**YES**
Poor Mental Health	**YES**
Obesity	**YES**
Poor Oral/Dental Health	**YES**
Respiratory Conditions	**YES**
STDs/HIV-AIDS	**NO**
Substance Use (ATOD)	**NO**
Unintentional Injuries (Falls)	**YES**
Violence	**NO**

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

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

Evaluation Findings of 2013-2016 Implemented Strategies

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

El Camino Hospital Community Benefit Dashboard FY14

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Healthcare Access (Primary, Oral, and Chronic Conditions Care)	**School District 1** *School nurse program*	· Students served	3,903	3,963
		· Uninsured students who have applied for insurance	60%	62%
		· Students with failed health screening at schools with improved attendance	80%	82%
		· Students identified as needing urgent dental care through on-site screenings who saw a dentist	80%	74%
		· Schools with at least 25% of staff CPR certified	83%	83%
	School District 2 *School nurse program*	· Students served	1,850	1,857
		· Uninsured students who have applied for insurance	80%	88%
		· Students who failed vision or hearing screening and saw a healthcare provider	69%	76%
		· Students identified as needing urgent dental care through on-site screenings who saw a dentist	75%	76%
		· Students absent 10% or more and who improved their attendance by 2 days or more over a 2-month period	60%	60%
		· Kindergartners who received a well-care exam by the end of school year as measured by the receipt of a completed CHDP (Child Health & Disability Prevention) "Health Exam for School Entry" form	60%	50%
	School District 3 *School nurse program*	· Students served- 3 schools	2,600	3,112
		· Students who failed health screening who received healthcare provider visits	67%	70%
		· Students identified as needing urgent dental care through on-site screenings who saw a dentist	50%	63%
		· Incoming 7th-grade students compliant with Tdap	90%	92%
	Program 1 *Advocacy for low-income families and teen parents*	· Children served	72	88
		· Services provided	500	500
		· Children meeting the CHDP periodicity schedule	95%	95%
		· Children identified with developmental delays linked to mental health and/or Program 1 services within 30 days of identification	95%	100%
		· Children flagged for non-attendance (4 consecutive days for other than minor medical reasons) receiving referrals for support services	25%	26%
		· Families with an identified need (per Family Needs Assessment) receiving services within 60 days with follow up conducted every 60 days	90%	95%

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Healthcare Access (Primary, Oral, and Chronic Conditions Care)	**Program 2** *Orthodontic services*	· Number of youth receiving orthodontic services · Orthodontic services provided · Social workers who report "Yes Absolutely" to the survey question, "Orthodontic treatment had a positive impact on their client's wellbeing and self-esteem"	35 400 80%	38 421 100%
	Program 3 *Medical care and shelter for homeless patients*	· Patients served (full program) · Patients served from El Camino Hospital Los Gatos (ECH LG) · Linkage to Primary Care Home · Discharged to interim or permanent housing · Avoided hospital days (full program) · Avoided hospital days (ECH LG)	120 2 92% 87% 480 8	131 1 93% 80% 484 4
Mental Health Access	**Community Based Organization (CBO) 1** *School counseling services at and countywide crisis program for children and families*	· Individuals served by Addiction Prevention Services (APS) · Services provided by APS · Youth participating in individual and group counseling who show a 50% improvement in positive behavior and attitude, as assessed by Youth Development, Parent Development and School Staff Surveys · Youth participating in the Holistic Intervention Prevention Partnership who show a 50% or greater improvement in change as measured by the surveys identified above · Parents/caregivers who demonstrate an increase in knowledge of the topics presented and a better understanding of how to access services for their child as measured by APS Satisfaction Survey · Youth served by Child and Adolescent Mobile Crisis Program (CACP) · Non-recidivist youths served by CACP who are able to stay with their families	2,150 2,625 75% 81% 95% 40 71%	2,943 2,711 84% 88% 98% 88 76%
	CBO 2 *Psychiatric services and medication management*	· Patients served · Psychiatry, therapy, and/ or case management visits · Actively managed patients who obtain housing · Psychiatric patients not hospitalized in a 12 month period	100 500 10 85%	171 365 13 85%
	CBO 3 *Senior Wellness Program*	· Seniors served · encounters/ sessions · Seniors with 2 point improvement in PHQ-9 depression survey results	150 400 85%	135 603 81%
	CBO 4 *Daybreak Care and Home Care and Golden Gateway Programs*	· Seniors served · Services provided · Seniors with 3 point improvement in PHQ-9 depression survey results	30 270 70%	19 330 68%
	Foundation 1 *Training in the Principles of Recovery*	· Mental health professionals trained · Training hours provided · Respondents who "strongly agree/agree" that immersion training enhanced their knowledge and improved service delivery to clients	30 600 90%	30 600 91%
	CBO 5 *Counseling and medication management for uninsured*	· Patients served · Services provided · Patients avoiding hospitalization for 12 months after admission · Patients who show a 10% improvement on the Global Assessment of Functioning Scale	22 162 99% 95%	26 164 99% 96%

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Healthy Eating, Physical Activity and Obesity	**CBO 6** *School-based physical activities program for students*	· Students served- 3 schools	1,500	1,791
		· Teachers reporting moderate to significant increase in physical activity	90%	95%
		· Teachers reporting moderate to significant decrease in bullying	45%	90%
		· Teachers reporting increase in students' healthy play	85%	93%
		· Teachers reporting increases in "positive impact on reduction in disciplinary action" and "positive impact on school climate"	90%	93%
	Initiative 1 *School-based physical activities program for low-income students*	· Students served	130	130
		· Initiative 1 "Focus Girls" who are observed to have improved behavior and attitudes toward physical activity, healthy eating, and life skills taught each week	80%	100%
		· Initiative 1 "Focus Girls" who self-report two or more positive effects of program participation	90%	100%
		· Average weekly attendance	80%	78%
	Program 4 *School-based nutrition and physical activity program*	· Students served	800	850
		· Increase in students who are physically active one or more hours per day (weekdays; pre-/post survey)	20%	21%
		· Increase in students who limit sweetened beverages to 0-1 per day (pre/post survey)	50%	59%
		· Increase in students reporting that a balanced diet includes eating 5 fruits/vegetables per day	40%	39%
Community Health Education and Health Literacy	**CBO 7** *Case-management and referrals for low-income families*	· Clients served in case management	100	118
		· Clients participating in Benefit Clinics	120	122
		· Contacts made by case manager offering information and referrals	2,700	2,722
		· Clients who sign up for public benefits	80%	100%
		· Households moved out of food insecurity and out of poverty	10 households	22
		· Case managed clients who increase in 3 of the 18 domains measured by Self Sufficiency Index	75%	74%
	Library 1 *Health Information and Eldercare consultations*	· Community members served	1,400	1,399
		· Clients who strongly agree or agree with the question, eldercare referrals appropriate to my needs	95%	95%
		· Clients who strongly agree or agree with the question, increase my knowledge of care options	95%	94%
		· Clients who strongly agree or agree with the question, the library has proven valuable in helping me manage my health or health of a friend or family member	65%	85%
		· Clients who strongly agree or agree with the question library information appropriate to my needs	80%	95%
	Program 5 *On-line health education curriculum*	· Schools served	198	143
		· Teachers who report improvement in students' health knowledge	70%	94%
		· Teachers who report satisfaction with program	90%	90%
	Initiative 2 *Health education and support for Chinese community*	· Individuals served	150	220
		· Services (including education/training, screening and referrals)	375	460
		· Screened participants who are vaccinated or monitored through their physicians	50%	63%
		· Participants who strongly agree or agree with the statement, program education and screening events help me better manage my health	80%	94%
	CBO 8 *Health education and lifestyle modification for South Asian Community*	· Participants screened	100	115
		· Number of assessment, lifestyle intervention, and coaching touch-points	700	733
		· Reduction in triglycerides in retest follow-up of participants	11%	17%
		· Improvement in number of participants consuming 3+ vegetable servings per day	8%	12%
	CBO 9 *Countywide campaign for Hepatitis B prevention*	· Individuals receiving information regarding hepatitis B at community events	1,000	1,500
		· Individuals screened and tested for hepatitis B at Hep B Free events	400	348
		· Clinicians who sign the Clinicians Honor Roll to pledge that they will follow CDC testing guidelines	100	26
	CBO 10	· Individuals served	2,500	2,594
		· Emergency Medical Services (EMS)/ first responders trained in falls prevention	100	60
		· Emergency Medical Services (EMS) workers who report increased knowledge after training	90%	90%
		· Community members who report confidence they will engage in falls prevention behavior learned at presentations	85%	93%

El Camino Hospital Community Benefit Dashboard FY15

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Health Care Access (Primary, Oral, and Chronic Conditions Care)	**School District 1** *School nurse program*	· Students served	3,902	4,102
		· Uninsured students who have applied for insurance	62%	79%
		· Students with failed health screening who saw a healthcare provider	70%	77%
		· Students identified as needing urgent dental care through on-site screenings who saw a dentist	80%	77%
		· Schools with at least 25% of staff CPR certified	85%	85%
	School District 2 *School nurse program*	· Students served- 3 schools	3,100	3,075
		· Students who failed health screening and saw a healthcare provider	70%	88%
		· Teachers who accessed HealthTeacher materials	50%	49%
		· Kindergarten and second-grade students identified with urgent dental care needs screenings who saw a dentist	50%	51.9%
		· Incoming 7th-grade students compliant with Tdap	93%	94.5%
	Program 1 *Advocacy for low income families and teen parents*	· Children served	88	88
		· Services provided	500	523
		· Children meeting the CHDP periodicity schedule	95%	96%
		· Children identified as not having received all recommended procedures for an earlier age brought up to date	90%	92%
		· Children with a dental home, receiving oral health exams and treatment	95%	95%
		· Parents participating in educational opportunities	25%	27%
		· Families with an identified need (per Family Needs Assessment) receiving services within 60 days with follow up conducted every 60 days.	95%	95%
	Program 2	· Clients served	100	48
		· Services (rides)	480	567
		· Strongly agree" or "agree" with the statement, having RoadRunners (RR) services helped in maintaining my independence	90%	94%
		· Strongly agree" or "agree" with the statement, having RoadRunners (RR) made it possible to get to my medical appointments	95%	95%
	Program 3 *Orthodontic services*	· Children served	51	52
		· Services provided	1,046	1,083
		· Youth at mid-treatment and completing orthodontic services who report being satisfied with their orthodontic care	75%	97%
		· Social workers of youth at mid-treatment and completing orthodontic services who indicate that orthodontic care has had a positive impact on clients' well-being and self-esteem	75%	94%
	Program 4 *Medical care and shelter for homeless patients*	· Patients served (nine hospitals in collaborative) / ECH	140/2	183/2
		· Linked to primary care physician	92%	91%
		· Discharged to interim or permanent housing	75%	70%
		· Avoided hospital days	500	584
Mental Health Access	**Community Based Organization (CBO) 1**	· Services provided by APS	2,775	2,811
		· Youth served by Child and Adolescent Mobile Crisis Program (CACP)	40	40
		· Youth participating in individual and group counseling showing a 50% improvement in positive behavior and attitude	75%	78%
		· Youth participating in the Holistic Intervention Prevention Partnership who show a 50% or greater improvement in change	81%	86%
		· Parents/caregivers who demonstrate an increase in knowledge of the topics presented and a better understanding of how to access services for their child	95%	98%
		· Non-recidivist youths served by CACP hospital diversion rate	70%	70%
		· Non-recidivist youths served by CACP who are able to stay with their families	71%	71%

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Mental Health Access	**CBO 2** *Psychiatric services and medication management*	· Patients served · Psychiatry, therapy and/ or case management visits · Actively managed patients who obtain housing · Psychiatric patients not hospitalized in a 12 month period	125 500 12 85%	165 687 12 85%
	CBO 3	· Seniors screened for depression · Seniors enrolled in Healthy IDEAS · Healthy IDEAS encounters · Healthy IDEAS clients with decrease in score on Geriatric Depression Scale-15 · Healthy IDEAS clients reporting new knowledge and skills to maintain mental health	150 40 400 85% 85%	160 64 322 96% 84%
	Foundation 1 *Training in the Principles of Recovery*	· Mental health professionals trained · Training hours provided · Respondents who "strongly agree" or "agree" that immersion training enhanced their knowledge and improved service delivery to clients	28 504 90%	28 504 96%
	CBO 4 *Counseling and medication management for uninsured*	· Patients served · Services provided · Patients avoiding psychiatric hospitalization for 12 months after admission · Patients who demonstrate a 10% improvement on the Global Functioning Scale (GAF) · Patients who demonstrate improvement on the PHQ-9 from admission to discharge	22 180 90% 95% 95%	22 168 100% 90% 95%
	Hospital 1	· Older adults served · Encounters provided by a Geriatric Psychiatrist · Encounters provided by a Psychiatric Nurse Practitioner · Older adults who received access to care with a Geriatric Psychiatrist or Psychiatric Nurse Practitioner within 10 days of initial contact · Older adults who received care from a Geriatric Psychiatrist or Psychiatric Nurse Practitioner who saw at least a one category improvement (mild, moderate, or severe) of anxiety as measured by the GAD-7 assessment tool · Older adults who received care from a Geriatric Psychiatrist or Psychiatric Nurse Practitioner who saw a one category improvement (mild, moderate, moderately severe, or severe) of depression as measured by the PHQ-9 assessment tool	80 652 490 90% 80% 80%	115 715 94 100% 76% 82%
	School District 3 *School- based mental health services*	· Students served through classroom intervention · Students served in individual/group counseling · Counseling sessions provided · Case management interactions · Students (receiving counseling services) who increased days of attendance (at least 10% by 6 months and 25% by year end) compared to previous year · Students (receiving counseling services) earning a 2.0 GPA or higher in a 12 month period · Reduction of incidences of high risk behavior that may result in suspension or discipline referrals for students receiving counseling services compared to previous year	500 30 400 30 20% 15% 15%	877 53 241 50 15% 59% 0%
	School District 4 *School-based mental health services*	· Students served in individual/group counseling · Counseling sessions provided · Students who improved on treatment plan goals by 20% in 6 months and 50% by end of school year · Students who improved from pre-test to post-test on the Strength and Difficulties Questionnaire by 50%	110 1,800 90% 75%	134 2,000 90% 60%

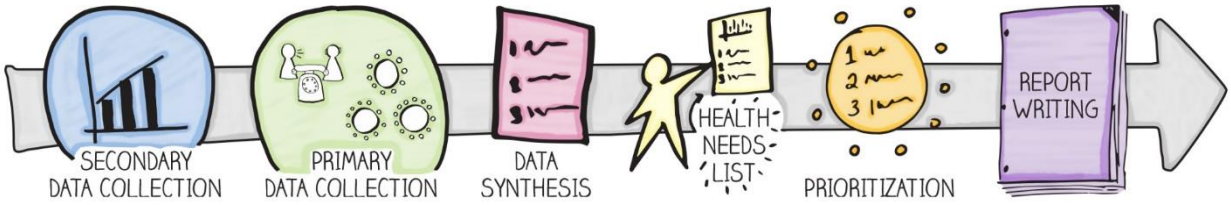
Category	Partner	Goals/Metrics	Annual Target	Annual Total
	Library 1 *Caregiver Program*	· Number of Family Caregivers enrolled in program	75	75
		· Caregivers who log on to linkAges system at least once a month	50%	90%
		· Percentage of caregivers who attend planned activities/events per program period	65%	65%
		· Percentage of participants who increase number of steps per week from baseline to end of program period (6 months)	60%	74%
Healthy Eating, Physical Activity and Obesity	**CBO 5** *School-based physical activities program for students*	· Students served- 3 schools	1,700	1,745
		· Teachers/administrators reporting increase in students who are physically active and engaged in healthy play	90%	100%
		· Teachers/administrators reporting decrease in time spent in class resolving conflicts	85%	87%
		· Teachers/administrators reporting time spent in class resolving conflicts	85%	87%
		· Teachers/administrators reporting decrease in number of bullying incidents	85%	82%
		· Teachers/administrators reporting a reduction in disciplinary incidents	85%	82%
		· Teachers/administrators reporting reduction in disciplinary action and a positive impact on school climate	85%	88%
	Initiative 1 *School-based physical activities program for low-income students*	· Students served	96	131
		· Group encounters	47	26
		· "Focus Girls" observed to have improved behavior or attitude	80%	100%
		· Average weekly attendance	80%	81%
	Program 5 *School-based nutrition and physical activity program*	· Total individuals served (unduplicated)	2,500	2,946
		· Students who report being active one or more hours per day after 5210 engagement	50%	60%
		· Students who limit sweetened beverages to 0-1 per day after 5210 engagement	70%	71%
		· Students who report the knowledge that a balanced diet includes eating 5 fruit/vegetables per day after program engagement	80%	83%
	CBO 6 *Challenge Diabetes Program*	· Clients educated about Challenge Diabetes program	400	1,490
		· Participants enrolled in program	200	282
		· Completion of Pre-screening and Post-screening	200	245
		· Participants with increased knowledge of risks and causes of diabetes	30%	18%
		· Participants who have made at least one lifestyle improvement (Increased consumption of fruits/vegetables, decreased consumption of high sugar/high fat foods, and/or increased physical activity)	30%	59.5%
Community Health Education and Health Literacy	**CBO 7** *Case-management and referrals for low-income families*	· Case management clients	120	120
		· Clients participating in Benefit Clinics	144	231
		· Clients participating in nutritional and education workshops	36	219
		· Contacts made by case manager offering information and referral	3,376	3,380
		· Clients who sign up for public benefits	85%	70%
		· Households moved out of food insecurity and out of poverty	12	18
		· Case managed clients who increase in 3 of the 18 domains measured by Self Sufficiency Index	80%	80%
	Library 2 *Health Information and Eldercare consultations*	· Community members served	1,400	1,314
		· Clients who "strongly agree" or "agree" with the question, eldercare referrals appropriate to my needs	95%	98%
		· Clients who "strongly agree" or "agree" with the question, increase my knowledge of care options	95%	95%
		Clients who "strongly agree" or "agree" with the question, the library has proven valuable in helping me manage my health or health of a friend or family member	65%	78%

Category	Partner	Goals/Metrics	Annual Target	Annual Total
Community Health Education and Health Literacy	**Program 6** *Online health education curriculum*	· Schools served	145	153
		· Physical activity breaks played (GoNoodle)	7,228	80,597
		· GoNoodle monthly active users as % of total staff	14%	57%
		· Teachers who report improvement in students' health knowledge	90%	91%
		· Teachers who report they are satisfied with GoNoodle program	95%	99%
		· Teachers who report they believe in the benefit of GoNoodle for their students' performance in the classroom	90%	90%
		· Teachers who report using HealthTeacher improved students' health behaviors	85%	83%
	Initiative 2 *Health education and support for Chinese community*	· Individuals served	75	97
		· Services (including education/training, screening, and referrals	400	475
		· Develop and distribute a resource guide to 150 Chinese seniors	150	271
		· Participants who strongly agree or agree with the statement, program education and screening events help me better manage my health	80%	99%
	CBO 8 *Health education and lifestyle modification for South Asian community*	· Individuals receiving information regarding hepatitis B at community events	1,000	860
		· Individuals screened and tested for hepatitis B at Hep B Free events	6,700	7,222
		· Clinicians who sign the Clinicians Honor Roll to pledge that they will follow CDC testing guidelines	80	89
	CBO 9	· Community members served	2,500	2,638
		· Organizations receiving technical assistance	10	14
		· Presentations and health fairs delivered	35	38
		· Community members who report they will engage in falls prevention behavior learned at presentations	85%	90%
		· Hits on Website	3,500	4,029
		· Participants who report confidence in their ability to protect themselves, reduction in concerns about falling, and intention to exercise appropriate to their needs	85%	90%
		· Organizations reached through Falls Prevention Awareness Day activities	30	30
	CBO 10 *Systems Innovation*	· Participants enrolled	600	531
		· Participants 60+ years	180	254
		· Participants reporting a reduction in feelings of loneliness and isolation	60%	88%
		· Participating seniors reporting increased connections with surrounding communities	70%	57%
		· Number of TimeBank exchanges	600	871
		· Number of hours exchanged by participants	1,200	1,701
	CBO 11 *Intensive geriatric case management and transitions assistance to older adults*	· Participants attending outreach events and educational presentations targeting Latino populations	200	1,036
		· Participants of outreach and educational who "agree" or "strongly agree" they increased their understanding of the signs and symptoms of Alzheimer's disease)	90%	100%
		· Staff and volunteers trained in best practices for working with Latino populations	40	53
		· Participants involved in the training will "agree" or "strongly agree" that they learned best practices in Latino outreach strategies and communication	90%	92%
		· Increased number of Helpline calls received from Latino families	8%	61%
	CBO 12 *Intensive geriatric case management and transitions assistance to older adults*	· Households served through case management	20	20
		· Clients participating in workshops and other socialization activities to build self-sufficiency	20	61
		· Encounters made by case manager offering information and referrals	160	180
		· Isolated households connected to community services and improving their self-sufficiency	10	10
		· Case managed clients who increased in 3 of the 18 domains measured by Self-Sufficiency Index	30%	66%

PROCESS & METHODS

The Coalition worked in collaboration on the primary and secondary data requirements of the 2016 CHNA. The CHNA data collection process took place over eight months and culminated in ASR writing a report for the Coalition in March of 2016.

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



Mar.-Oct. 2015	Jul.-Nov. 2015	Nov. 2015-Apr. 2016

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

Data Sources of CHNA Input

Secondary Quantitative & Qualitative Data Collection

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

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

- 2014 Santa Clara County Community Health Assessment
- Behavioral Risk Factors Survey (BRFS) Quick Facts 2014
- Status of African/African Ancestry Health: Santa Clara County, 2014
- Status of LGBTQ Health: Santa Clara County, 2013
- Status of Vietnamese Health: Santa Clara County, 2011
- HIV/AIDS Epidemic in Santa Clara County, 2012

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

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

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

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

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

[18] Powered by University of Missouri's Center for Applied Research and Environmental System (CARES) system, www.communitycommons.org.
[19] htttp://www.healthypeople.gov

Primary Qualitative Data (Community Input)

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

The assessment included input from various populations:[20]

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

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

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

Each focus group and interview was recorded and summarized as a stand-alone piece of data. When all data had been collected, the team used NVivo, a qualitative research software tool, to analyze the information. ASR then tabulated how many times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview. This tabulation was used in part to assess community health priorities.

Community Leader Input

In all, ASR solicited input from almost 100 community leaders and representatives of various organizations and sectors. These representatives either work in the health field or improve health conditions by serving those from the target populations. Multiple community leaders participated from each of these types of agencies:

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

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

- Nonprofit community-based organizations serving children, youth, seniors, parents, immigrants, those experiencing homelessness, and those with dementia, mental health, and substance use disorders

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

Community Leader Survey

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

Health Expert Key Informant Interviews

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

Details of Key Informant Interviews

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

Community Leader Focus Groups

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

1. What are the unmet health needs that you see in Santa Clara County? Which are the most pressing among the people you serve/represent? How are the needs changing?
2. How has the Affordable Care Act impacted access to healthcare, including insurance and adequate healthcare services, of the people you serve/represent?

3. What drivers or barriers are impacting unmet health needs?
4. What policies or resources exist or are needed to impact the health needs?

Details of Focus Groups with Professionals

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

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

Resident Input

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

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

Details of Focus Groups with Residents

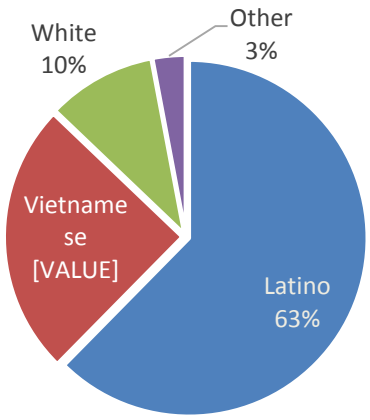
POPULATION FOCUS	FOCUS GROUP HOST/PARTNER	DATE	NUMBER OF PARTICIPANTS
Family caregivers of older adults	Family Caregiver Alliance (Avenidas, Palo Alto)	4/16/15	4
New and pregnant mothers (conducted in Spanish)	Columbia Neighborhood Center (Sunnyvale)	5/5/15	6
High school youth	Los Altos High School (Los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

2016 Resident Participant Demographics

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

- 63% of participants were **Hispanic/Latino**. 25% were Vietnamese, 10% were White, and 3% reported an "other" race.
- Vietnamese participants' ages ranged from 34 to 81 years, with the average being 59 years. 40% of other participants (12) were under 20 years old, and 13% were 65 years or older.
- 13% (5) were **uninsured**, while 82% had benefits through Medi-Cal, Medicare or Health Kids/Healthy Families public health insurance programs. 5% had private insurance.
- Residents lived in multiple areas of the county: Mountain View (12), San Jose (4), Sunnyvale (5), Palo Alto (3), and one each in Santa Clara and Menlo Park.[21]

Resident Focus Group Participants by Race/Ethnicity



- 68% of those who responded[21] reported having an annual household income of under $45,000 per year, which is below the 2014 California Self-Sufficiency Standard[22] for Santa Clara County for two adults with no children ($45,802). The majority (64%) earned under $25,000 per year, which is below Federal Poverty Level for a family of four. This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.[22]

[21] Demographic does not include Vietnamese residents due to missing data on this item.
[22] The Insight Center for Community Economic Development, *Self-Sufficiency Standard Tool for California* (2014). Retrieved July 2015 from http://www.insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california

Information Gaps & Limitations

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

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

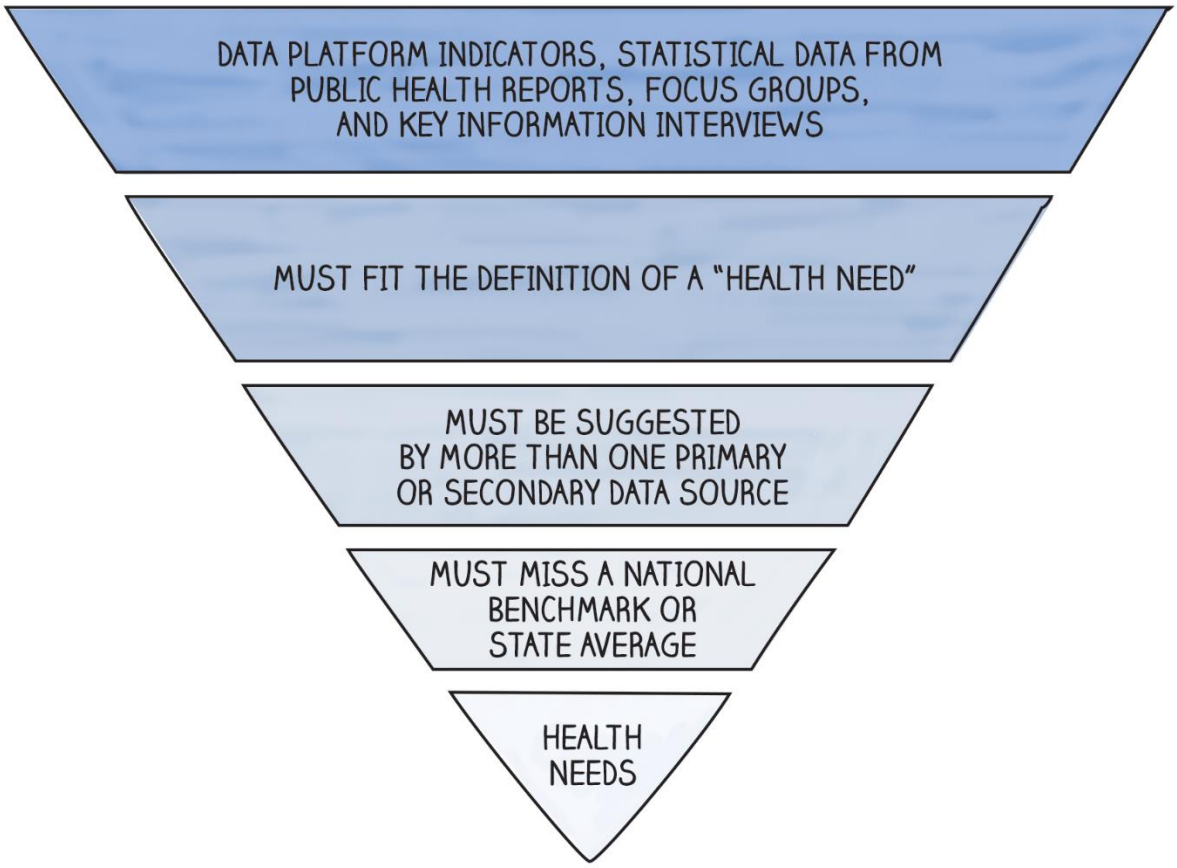
Another limitation is related to the local and national Behavioral Risk Factor Surveillance System (BRFSS). In 2011 BRFSS data collection, structure, and weighting methodology changed to allow the addition of data collection by cellular telephones. Because the CDC changed the methods for the BRFSS, trend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

[23] Center for Disease Control and Prevention, *BRFSS: Comparability of Data* (2013). Retrieved from http://www.cdc.gov/brfss/annual_data/2013/pdf/compare_2013.pdf

IDENTIFICATION & PRIORITIZATION OF COMMUNITY HEALTH NEEDS

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

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



Identification of Priority Community Health Needs

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

DEFINITIONS

- A health **condition** is a disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.
- A health **driver** is a behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health. May be social determinants of health.
- A health **need i**s a poor health *outcome* and its associated health *driver*, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
- A health **outcome** is a snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality.
- A health **indicator** is a characteristic of an individual, population, or environment which 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.

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

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

Eighteen health conditions or drivers fit all three criteria and were retained as community health needs. The list of needs, in alphabetical order, is found below.

Summarized Descriptions of Priority Santa Clara County Community Health Needs

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

2 **Alzheimer's Disease and Dementia** are health needs in Santa Clara County as evidenced by Alzheimer's disease being the third leading cause of death in 2012, accounting for 8% of all deaths.[24] In California, it was the fifth leading cause. The age-adjusted death rate of Alzheimer's disease in Santa Clara County in 2011 was 35.9 per 100,000, which was higher than the state overall in 2010 (30.1 per 100,000).[25] In the next 10 years, nearly one in five local residents will be 65 years or older, which puts the population at higher risk for dementia and Alzheimer's disease.[26] Also, the county population is slightly older than the state overall. Local professionals who serve seniors expressed concern over the lack of dementia and Alzheimer's diagnoses. There are a lack of countywide data on the prevalence of these diseases, which is a concern given the increasing proportion of older adults.

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

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

[25] Centers for Disease Control and Prevention (CDC), *Community Health Status Indicators* (*CHSI)/National Center for Health Statistics, County Profile*, 2011; CDC, *National Center for Health Statistics (NCHS) Data Brief*, 2010; CDC, *Health Data Interactive for National Data*, 2011.

[26] Silicon Valley Institute for Regional Studies, *Population Growth in Silicon Valley*, 2015.

4 **Birth Outcomes** are a health need in Santa Clara County as evidenced by stark racial and ethnic disparities. For instance, the mortality rate of Black infants (7.8 per 1,000) is higher than the HP2020 target (6.0 per 1,000).[27] Moreover, over a quarter of Blacks (29%) and Latinos (26%) experience inadequate prenatal care.[28] The health need is likely impacted by certain social determinants of health (such as food insecurity experienced by pregnant mothers) and by the percentage of women receiving early prenatal care.

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

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

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

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

[27] California Department of Public Health. *Birth Profiles by Zip Code*, 2011.
[28] Ibid.

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

10 **Hypertension**, which is abnormally high blood pressure, can lead to heart disease and stroke, which are the leading causes of death in the United States. About one of three U.S. adults have high blood pressure and only about half (52%) have their high blood pressure under control.[29] More than a quarter (27%) of Santa Clara County residents have been diagnosed with high blood pressure. Blacks, men, and older adults are more likely to be diagnosed with high blood pressure than county residents overall.

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

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

[29] Centers for Disease Control and Prevention. *Know the Facts about High Blood Pressure*, 2015. Retrieved March 8, 2015 from http://www.cdc.gov/bloodpressure/facts.htm.

13 **Oral and Dental Health** is a need in Santa Clara County illustrated by nearly two thirds (64%) of adults lacking dental insurance.[30] One in three adults has had tooth loss, and the statistics are worse for Black adults (49%).[31] Additionally, youth dental care utilization rates (15%) are worse than the state (19%).[32] The community expressed concern about the proportion of adults who lack dental insurance, the lack of providers who accept Denti-Cal, and the costs of dental care for those who do not have insurance. The community also reported that some dental insurance benefits are not sufficient for those who need services beyond cleaning and extraction.

14 **Respiratory Conditions** are a health need in Santa Clara County as marked by disproportionality among non-Whites who have been diagnosed with asthma. Specifically, those with household incomes of $50,000-$74,999 (25%), multiracial adults (22%), and Blacks (19%) have a higher prevalence of asthma than the county (14%).[33] Although there are lower asthma hospitalization rates in Santa Clara County compared with California, there are ethnic and geographical disparities. Blacks are twice as likely as Whites to be hospitalized for asthma, as are those living in East San Jose and North San Jose (95134 zip code). The health need is likely being impacted by health behaviors such as percentage of youth smoking and by issues in the physical environment such as air quality levels. Also, asthma is associated with obesity,[34] which is a problem for Santa Clara County children.

15 **Sexual Health** is a health need in Santa Clara County as demonstrated by high incidence rates of HIV among Black and Latino men, as well as male primary and secondary syphilis incidence rates, which are higher than those in California. Women are twice as likely to contract chlamydia as men, at a rate of 422.3 per 100,000 compared to 203.7. The health need is likely impacted by low screening rates for HIV (countywide, the percentage of teens and adults ever screened for HIV is lower than the state average). Community feedback suggests that the health need is perceived as primarily affecting youth, LGBTQ, and single people, which may drive low screening rates for those who think they are low risk. Data show that large proportions of LGBTQ residents have never been tested for sexually transmitted infections. In addition to the perception of low risk, the LGBTQ community also cited fear of finding out that they had HIV or AIDS and a lack of time as reasons they had not been tested. Regarding teen births, the rate (per 1,000 females aged 15-19) decreased from 24.6 in 2003 to 16.8 in 2012. However, the Latina teen birth rate (36.9 per 1,000 females aged 15-19) was more than twice as high as the Black teen birth rate (14.4) and six times higher than the White teen birth rate (6.3).[35]

[30] Santa Clara County Public Health Department. *Behavioral Risk Factor Survey, 2013-2014.*
[31] Ibid.
[32] Centers for Disease Control & Prevention. *Behavioral Risk Factor Surveillance System*, 2009.
[33] Santa Clara County Public Health Department. *Behavioral Risk Factor Survey, 2013-2014.*
[34] Delgado J, Barranco P, & Quirce S., (2008). "Obesity and Asthma," *Journal of Investigational Allergology & Clinical Immunology*, 18(6): 420-5.
[35] Santa Clara County Public Health Department. *Maternal, Infant, and Child Health Brief Santa Clara County,* 2014.

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

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

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

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

[36] Santa Clara County Public Health Department. *Tobacco Use in Santa Clara County,* 2014.
[37] California Department of Public Health. *Center for Health Statistics & Informatics, Vital Statistics Query System, Death Records,* 2013.
[38] Santa Clara County Public Health Department. *Santa Clara County: Unintentional Falls Among Older Adults,* 2015.
[39] University of Missouri, Center for Applied Research and Environmental Systems; California Department of Public Health. *Death Public Use Data*, 2010-12.

Prioritization of Health Needs

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

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

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

The score levels for the prioritization criteria were:

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

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

List of Prioritized Needs

The need scores ranged between 1.4 and 3.0, with 3 being the highest score possible and 1 being the lowest score possible. The needs are ordered by prioritization score in the following table.

Health Needs Ranked by Prioritization Score

Rank	Health Need
1	Economic Security
1	Obesity & Diabetes
3	Housing
4	Behavioral Health
5	Access & Delivery
6	Oral & Dental Health
7	Cardiovascular (Heart) & Cerebrovascular (Stroke) Diseases
7	Hypertension
9	Tobacco Use
10	Violence & Abuse
11	Cancer
12	Birth Outcomes
13	Alzheimer's Disease & Dementia
14	Communicable Diseases
14	Unintentional Injuries
16	Learning Disabilities
17	Respiratory Conditions
18	Sexual Health

CONCLUSION

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

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

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

- Behavioral Health
- Alzheimer's Disease & Dementia

- Violence & Abuse
- Unintentional Injuries
- Economic Security

The CBAC selected these health needs based on the following progressive criteria:

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

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