El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Fiscal Year 2019

Community Benefit Plan & Implementation Strategy

June 2018



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Introduction

El Camino Hospital 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 from Mountain View, Sunnyvale, Los Altos, Los Altos Hills, Santa Clara, Los Gatos, Cupertino, Campbell, Saratoga, and San Jose.

Per state and federal law, a Community Health Needs Assessment must be conducted every three years by nonprofit hospitals. In 2016, El Camino Hospital Community Benefit staff conducted a Community Health Needs Assessment (CHNA) in collaboration with the Santa Clara County Community Benefit Coalition. This assessment resulted in the identification of 18 significant community health needs. The 2016 CHNA serves as a tool for guiding policy and program planning efforts and is available to the public. For a copy of the full CHNA, see www.elcaminohospital.org/CommunityBenefit.

The documented needs in the 2016 CHNA served El Camino Hospital in developing this Community Benefit Plan for establishing Implementation Strategies pursuant to the Affordable Care Act of 2010 and California State Senate Bill 697. This plan outlines El Camino Hospital's funding for fiscal year 2017.

The main steps of this planning process are:

1. Conduct a countywide Community Health Needs Assessment (CHNA)
2. **Engage stakeholders to review the CHNA findings and prioritize health needs**
3. Engage stakeholders to select the health needs for El Camino Hospital
4. Establish community benefit health need priority areas
5. Grants process. Development of Annual Plan and Implementation Strategy.

These steps are further described below.

Step 1 — Conduct a Countywide Community Health Needs Assessment.

El Camino Hospital is a member of the Santa Clara County Community Benefit Coalition ("the Coalition"), 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. 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 community health needs prioritization and selection. Since its formation in 1995, the Coalition has worked together to conduct

regular, extensive Community Health Needs Assessments (CHNA) to identify and address critical health needs of the community. This 2016 CHNA builds upon those earlier assessments.

The Coalition obtained community input during the first nine months 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 CHNA for details.) Applied Survey Research (ASR) conducted this data collection on behalf of the Coalition. Prior to data collection, the Coalition identified criteria that would be used to define the list of health needs, using the 2013 CHNA criteria list as a basis.

In September 2015, ASR synthesized primary qualitative research and secondary data and then applied those criteria to the list of all possible health needs. The criteria were applied in the order found below.

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. Social determinants of health are also considered health needs. They are described as conditions in which people are born, grow, live, work, and age. The distribution of money, power, and resources at global, national, and local levels shaped these circumstances.
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 against the state average if there was no HP2020 benchmark.
    - The community prioritized it in three of the ten focus groups or a key informant identified it. 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 18 health needs that reflect the community's priorities.

Step 2 — Engage Stakeholders to Review the Assessment Findings and Prioritize Health Needs.

ASR facilitated a meeting with the El Camino Hospital Community Benefit Advisory Council (CBAC), which includes an El Camino Hospital Board Liaison, El Camino Healthcare District Liaison community leaders, physicians, and senior management. During the session, CBAC members were presented with the CHNA findings and were asked to prioritize the identified health needs for Santa Clara County using a set of criteria. The results of this prioritization are displayed in Table 1.

Table 1 Health needs Identified by 2016 CHNA

Health Needs Identified by 2016 CHNA Listed by Priority Ranking		
1. Economic security	2. Obesity/diabetes	3. Housing
4. Behavioral health	5. Healthcare access & delivery	6. Oral & dental health
7. Heart disease and stroke	8. Hypertension	9. Tobacco use
10. Violence & abuse	11. Cancer	12. Birth outcomes
13. Dementia & Alzheimer's	14. Infectious diseases	15. Unintentional
16. ADD/ADHD, learning	17. Respiratory conditions	18. Sexual health

Step 3 — Engage Stakeholders to Select the Health Needs for El Camino Hospital.

ASR distributed an electronic survey to CBAC members and asked them to recommend the health needs El Camino Hospital should address based on the previous prioritization results and the criteria displayed below. The results of the survey informed the selection of 12 of the 18 identified health needs to address.

Criteria for Recommending Health Needs for Selection

1. A needs assessment process has 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. El Camino Hospital has the required knowledge, expertise, and/or human and financial resources to make an impact.

Step 4 — Establish Community Benefit Health Need Priority Areas.

The El Camino Hospital Community Benefit staff mapped the selected health needs identified by the CBAC to three health priority areas: Healthy Body, Healthy Mind, and Healthy Community. The health needs that El Camino Hospital will address are listed below in these three areas:

Cancer
Healthcare Access & Delivery
Heart Disease & Stroke
Hypertension
Obesity & Diabetes
Oral & Dental health
Respiratory Conditions

Behavioral Health
Alzheimer's Disease & Dementia

Economic Security
Unintentional Injuries/Falls
Violence & Abuse

Step 5 — Grants process. Development of Annual Plan and Implementation Strategy.

Based on the top health needs identified by the community that were prioritized and recommended for selection by the CBAC, El Camino Hospital released the 2016 – 2017 grant application. These proposals addressed needs in the three health priority areas. The CBAC met twice in April 2016 to assess and discuss all grant proposals. Staff provided additional information requested by the Council. The Council provided funding recommendations, which are described for each proposal in the Plan's health priority areas. The Plan also contains the following:

- The health needs identified through the CHNA process that El Camino Hospital ***will*** address (below) and how it plans to meet the health needs.
- The health needs identified through the CHNA process that El Camino Hospital does ***not*** intend to address and why (page 5).

The next sections of the Plan further explain the three health priority areas, and describe the strategies and programs that will be funded to impact these areas. Findings from the CHNA are provided to illustrate the status of health needs and related disparities in Santa Clara County. El Camino Hospital used comparisons to Healthy People 2020 objectives (HP2020) where available, and state data where they were not.

Health Needs Not Addressed

The El Camino Hospital Community Benefit program addresses 12 of the 18 identified health needs through its health priority areas, strategies, and partners. The six health conditions that will not be addressed by the community benefit program either did not meet the selection criteria described above, or met them to a lesser degree than the chosen conditions. They are: ADD/ADHD and learning disabilities, birth outcomes, housing, infectious diseases, sexual health, and tobacco use.

FY19 Plan & Implementation Strategy Overview

Overview

Grant Proposals Approved by Board for Funding: 49

Total Board Approval Grant Funding: $5,990,828

Approved Plan Total (including Placeholder and Sponsorships): $3,865,000

Acknowledgement

Acknowledgement

El Camino Hospital especially recognizes the critical contribution of the Community Benefit Advisory Council (CBAC) for its guidance with the FY18 Plan. The CBAC is comprised of Board members, physicians, and representatives from the community who have knowledge about local disparate health needs.

To improve health and prevent the onset of disease in the community through enhanced access to primary care, chronic disease management, and oral health

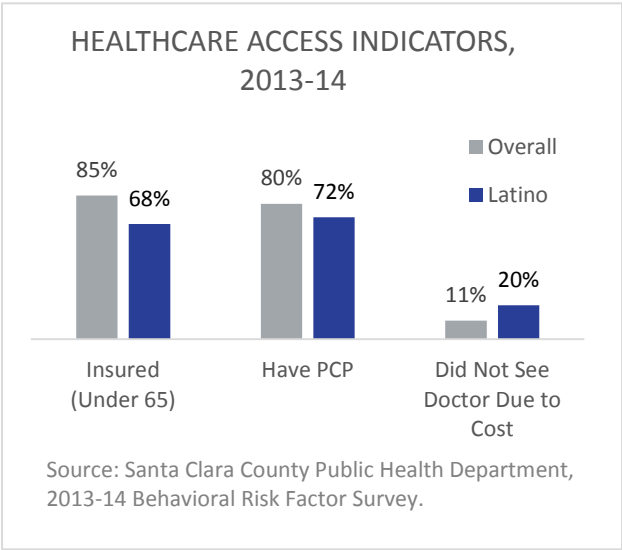
The maintenance of healthy bodies is affected by a variety of factors including the environment in which we live, social and economic factors, and personal choices and health behaviors. Poor health can be experienced as diseases and conditions such as stroke or diabetes, and their related drivers such as hypertension or lack of adequate nutrition. Access to comprehensive, quality healthcare services is important for the achievement of health equity, to improve health, and to enhance quality of life for all. Healthcare access requires gaining entry into the healthcare system, accessing a healthcare location where needed services are provided, and finding a medical provider with whom the patient can communicate and trust.

DATA FINDINGS

Services to address the needs in the Healthy Body priority area are demonstrated by the following statistics:

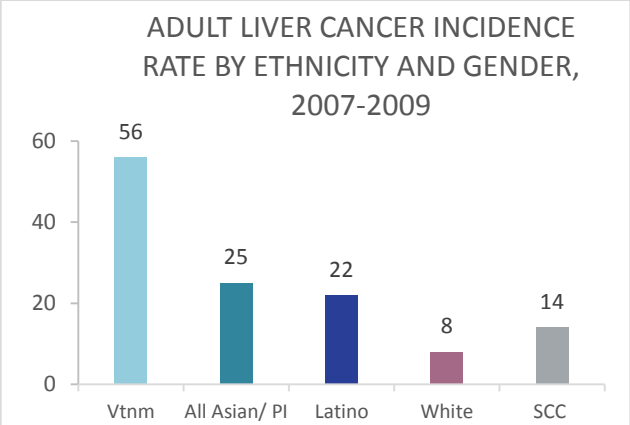
- **Access to Healthcare & Healthcare Delivery** is a need in Santa Clara County as demonstrated by the proportion of Latinos who are insured, who see a primary care physician, and who go without healthcare due to cost. For example, only 68% of Latinos in Santa Clara County are insured compared to 85%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

Figure 1 Healthcare access indicators



- **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 displayed in Figure 2.

Figure 2 Adult liver cancer incidence rate



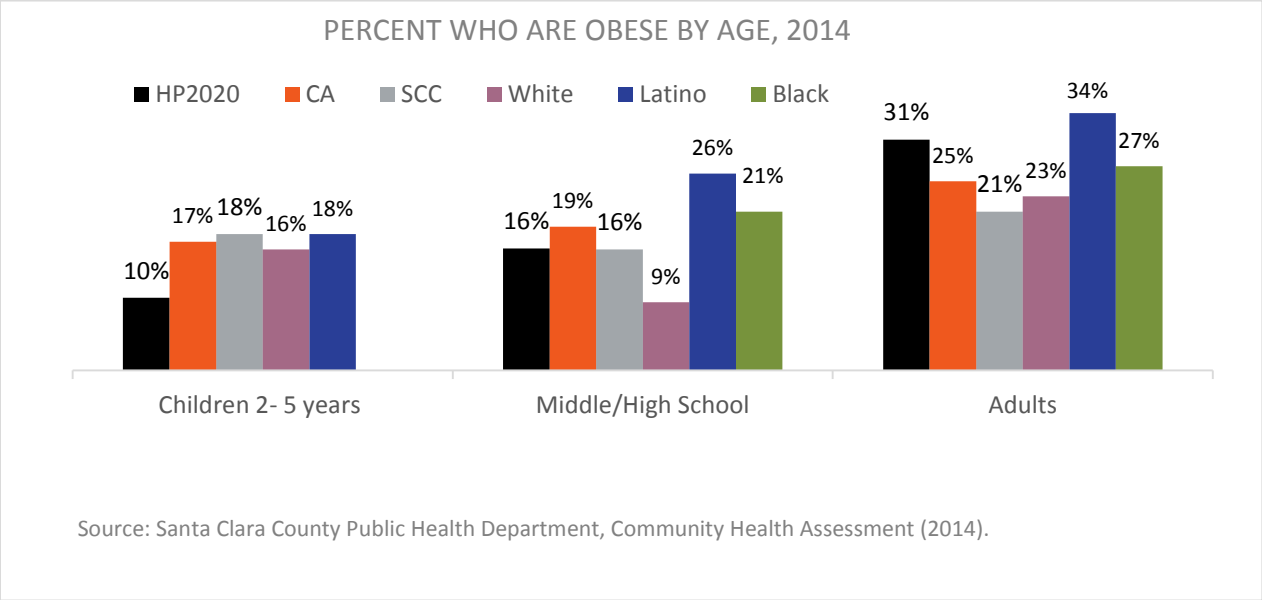
Source: Santa Clara County Public Health Department Vietnamese Report. (2011). Rates are per 100,000 of the population. "Vtnm" = Vietnamese, "PI" = Pacific Islander.

- **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.
- **Hypertension** (abnormally high blood pressure) can lead to heart disease and stroke, which are among the leading causes of death in the county. More than a quarter (27%) of county residents have been diagnosed with high blood pressure. Blacks, men, and older adults are most likely to be diagnosed.
- **Oral & Dental Health** is a need in Santa Clara County illustrated by nearly two thirds (64%) of adults lacking dental insurance. One in three adults have had tooth loss, and the statistics are worse for Black adults (49%). Additionally, youth dental care utilization rates in the county (15%) are worse than the state (19%). The community expressed concern about the proportion of adults who lack dental insurance, the lack of providers who accept Denti-Cal, and the costs of dental care for those who do not have coverage for it.
- **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%)

all have a higher prevalence of asthma than the county overall (14%). The health need is likely impacted by the physical environment (such as air quality levels), and by health behaviors such as smoking.

- **Obesity & Diabetes** are health needs because of the proportions of Santa Clara County children and adolescents who are overweight and/or obese. Moreover, one in five adult residents are obese and the proportion is higher in the LGBTQ, Latino, and Black populations. Racial and ethnic disparities exist across all age groups in overweight and obesity rates. Rates of overweight and obesity for Latinos and Blacks fail HP2020 targets. (See Figure 3.)

Figure 3 Obesity prevalence



Source: Santa Clara County Public Health Department, Community Health Assessment (2014).

STRATEGIES TO IMPROVE HEALTHY BODIES

1. Increasing access to health services, screenings and health related social service navigation for youth and their families including dental and vision screenings through staffing of school nurses and health liaisons
2. Increase youth health through physical activity programs, nutrition education and healthy living initiatives
3. Increase access to medical services and related resources such as a medical home, affordable or free medications and health related social services for vulnerable community members (homeless, at-risk, low-income, uninsured)
4. Address growing epidemic of diabetes through prevention and intervention for adults and youth
5. Provide systemic support for safety net clinics

HEALTHY BODY PROPOSALS

HEALTHY BODY RECOMMENDED FUNDING: $1,821,468

Detailed descriptions of recommended partner programs in the Healthy Body priority area follow. The Community Benefit Advisory Council (CBAC) consensus guided the funding recommendations found in the Plan.

5210 Program - Palo Alto Medical Foundation

Program Title	5210 Program- Numbers to Live By!
Grant Goal	The Palo Alto Medical Foundation 5210 Program is requesting support to offer nutrition lessons and wellness education provided by a Health Educator who will support the Program Specialist. Elementary school-aged children, parents, school staff, and administrators will benefit from the services provided to promote ongoing health and wellness messages. Services nutrition lessons, physical activity contests during school and after-school, lunch tastings of fruits and vegetables for the entire student population, and parenting classes. In addition, we partner with community organizations to provide additional education during the summer and educational presentations to staff and administrators throughout the school year. Services help encourage an environment of health for the school communities and education to prevent chronic diseases such as diabetes and obesity.
Community Need	California created an Obesity Prevention Plan in order to meet the national goal of reducing adolescent obesity to 14.5% or below. However, in Santa Clara County as of 2015, 34.5% of 5th graders were overweight or obese. (1) Only 26.6% of the same cohort meets all fitness standards. (1) In addition, according to health data in 2013, only 36% of adolescents ate 5 or more servings of fruits and vegetables daily. (2) Although Santa Clara County strives to reduce overweight and obesity in our children, changes in health are still unseen. The 5210 Program aims to reduce childhood obesity through community-based intervention as well as create environmental change. These evidence-based methods were adopted from the original Let's Go! 5-2-1-0 which began in Portland, Maine in 2008. (3) Not only do we educate students and their parents in nutrition and health, but we also provide support to their school administration and staff to promote health messages throughout the school year. By reaching multiple avenues within and around the school communities, we can promote a healthy environment. In doing so, students will have an easier time making healthy choices and reduce their risk of obesity. Sources: (1): http://www.kidsdata.org/topic/310/fitnessstandards/ (2): https://www.sccgov.org/sites/phd/hi/hd/Documents/obesity-reports/obesity-facts.pdf (3): Journal of Pediatric Psychology, Vol 38, Issue 9, 1 October 2013, Pages 1010-1020. Impact of Let's Go! 5-2-1-0: A Community-Based, Multisetting Childhood Obesity Prevention Program
Agency Description & Address	701 E. El Camino Real, Mountain View The Palo Alto Medical Foundation for Health Care, Research and Education (PAMF) is a not-for-profit health care organization dedicated to enhancing the health of people in our communities. PAMF serves more than 100 communities in Northern California. The purpose of the 5210 program is to increase nutritional awareness and competency among youth within our service area and to create environments that make healthy choices easier for families to make.
Program Delivery Site(s)	The following schools in the Campbell Union and Cupertino Union School Districts: • Blackford Elementary • Capri Elementary • Castlemont Elementary • De Vargas Elementary • Eisenhower Elementary • Forest Hill Elementary • Lynhaven Elementary • Marshall Lane Elementary

	• Monroe Middle School • Rolling Hills Middle School • Rosemary Elementary • Sedgwick Elementary • Sherman Oaks Elementary
Services Funded By Grant/How Funds Will Be Spent	Services include: • Students will be engaged through introductory assemblies, social marketing, poster and activity contests, and goal setting behaviors for each of the 5210 messages • Fifth graders will receive three 50-minute nutrition lessons • At least 10 lunchroom tastings introducing new fruits or vegetables will be held each month. This will get students excited to try new healthy foods, taste them, and have an opportunity on the lunch line to explore more options. Information on the tastings will be sent home to encourage healthy eating behaviors • 5210 staff will partner with community groups, like Safe Routes to School and UC extension, to provide education and outreach to the broader community audience Full requested funding would support partial instructor salary and program supplies.

Bay Area Women's Sports Initiative (BAWSI)

Program Title	BAWSI Girls Program in Campbell
Grant Goal	To generate positive attitudes towards rigorous exercise and active play and improve social-emotional behavior and attitudes in elementary aged girls in under-served communities. During weekly after-school sessions in the fall and spring semesters, coaches will engage young girls in fun games that build fitness and motor coordination. Using pedometers to track their steps, girls will race, jump, and hula-hoop through stations of high-energy activities focused on goal setting, body awareness, teamwork, and healthy competition. Coaches will also create opportunities for leadership conversations featuring a word of the week and interweave the program's overarching themes of respect and responsibility throughout sessions. Staff will teach basic mindfulness techniques to help pave the way for a lifetime of wellness. All BAWSI Girls will be invited to a BAWSI Game Day where they attend a local college women's sporting event, thus planting the seeds for a future that includes college. The intent is to expose the girls to healthy, active role models competing in rigorous activity, and to receive exposure to a college campus.
Community Need	While it is widely recognized that increased physical activity lowers obesity rates and positively impacts social-emotional wellbeing, studies show that girls are physically less active than boys. The Santa Clara County 2010 Health Profile lists obesity and associated chronic health conditions such as heart disease and diabetes as a major concern, citing a 25% obesity rate among middle school and high school children. Moreover the report finds the highest rates of obesity in low-income adult populations and Hispanic adult populations. The factors contributing to obesity include (among young girls) a sedentary lifestyle that correlates with low incomes, race/ethnicity, and lack of access to recreational opportunities. In a 2015 report, the Aspen Institute's Project Play cited girls as having the greatest need for physical literacy interventions. The report shared that across genders, girls are less physically active than boys and that the gender gap emerges by age 9. "Girls of color are more sedentary than their white peers, where African Americans and Asian Americans are most sedentary, with 49.5 percent and 44.1 percent of them, respectively, engaging in physical activity no more than two times a week (followed by Hispanic girls at 41.6 percent and white girls at 37.2 percent)." Research from the Women's Sports Foundation (WSF) shows that girls who are physically active and/or involved in sports have lower risks of heart disease, type 2 diabetes, higher self-esteem, lower rates of depression, more positive body image, are more likely to graduate from high school, and are less likely to engage in sexually risky behaviors and substance abuse. Further research from WSF indicates that early exposure to sports and physical activity increases the likelihood of continued participation. Sources: https://static1.squarespace.com/static/595ea7d6e58c62dce01d1625/t/5a58ff530d9297816e8e6ff8/1515781978376/PhysicalLiteracy_AspenInstitute+%28Full+report%29.pdf https://www.sccgov.org/sites/phd/hi/hd/Documents/Health%20Profile%20Report%202010/scc_health_profile_ex_summary_final_092410.pdf https://www.womenssportsfoundation.org/research/article-and-report/recent-research/her-life-depends-on-it-iii/
Agency Description & Address	1922 The Alameda, Suite 420, San Jose BAWSI mobilizes the women's sports community to engage, inspire and empower the children who need us most. We work with two populations who have the least access to physical activity and organized sports. BAWSI Girls provides free after-school programs in which female athletes inspire low-income girls to get moving, set high expectations for themselves and improve their beliefs, attitudes and behaviors related to physical activity. With a proven track record in Santa Clara County and San Mateo counties, we operate in under-served schools because this is where

	the socio-economic barriers to girls discovering their full potential are most daunting. Through the connected coaching of female athletes, BAWSI builds physical literacy, defined as the ability, confidence and desire to be physically active for life.
Program Delivery Site(s)	Rosemary Elementary, Campbell Union School District
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting weekly after school sessions where female collegiate and high school student athletes serve as positive female role models • Providing program staff to oversee volunteer student athletes • Providing supplies, including equipment and participant materials such as t-shirts, journals and pedometers Full requested funding would support staffing and program supplies.

Bay Area Women's Sports Initiative (BAWSI)

Program Title	BAWSI Rollers Program in Campbell
Grant Goal	This program provides adaptive physical activities for girls and boys with physical, cognitive, and hearing disabilities. Weekly sessions include activities focused on goal setting, teamwork and healthy competition, as well as self-respect, responsibility and leadership.
Community Need	In the state of California, 34% of children with special needs are overweight or obese, 5% higher than the general population of California children. Lower physical activity levels are a major reason for the higher incidence of obesity. The barriers to participation in sports and physical activity for children with disabilities in Santa Clara County include access, cost, and transportation. Furthermore, the Santa Clara County Office of Education's 2015-2016 SARC (School Accountability Report) shows one in four special education students come from low-income families. Reasons for lack of physical activity among disabled children include a lack of access to programs, low motor function that hinders the ability and confidence to participate, and the heavy burden of special needs child-rearing that adds to parents' time and resource constraints. A 2017 report from the Aspen Institute's Project Play cites children with disabilities as one of the most under-served groups in the United States for physical literacy interventions. Sources: http://www.kidsdata.org/topic/489/overweight-obese-special-needs-status/table#fmt=643&loc=1,2&tf=77&ch=172,173 https://www.cdc.gov/ncbddd/disabilityandhealth/pdf/aboutdhprogram508.pdf https://static1.squarespace.com/static/595ea7d6e58c62dce01d1625/t/5a58ff530d9297816e8e6ff8/1515781978376/PhysicalLiteracy_AspenInstitute+%28Full+report%29.pdf
Agency Description & Address	1922 The Alameda, Suite 420, San Jose BAWSI mobilizes the women's sports community to engage, inspire and empower the children who need us most. We work with two populations who have the least access to physical activity and organized sports. BAWSI Girls provides free after-school programs in which female athletes inspire low-income girls to get moving, set high expectations for themselves and improve their beliefs, attitudes and behaviors related to physical activity. With a proven track record in Santa Clara County and San Mateo counties, we operate in under-served schools because this is where the socio-economic barriers to girls discovering their full potential are most daunting. Through the connected coaching of female athletes, BAWSI builds physical literacy, defined as the ability, confidence and desire to be physically active for life.
Program Delivery Site(s)	Blackford Elementary School, Campbell Union School District
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting weekly after school sessions where collegiate and high school student athletes serve as positive role models • Providing program staff to deliver services and oversee student athletes • Providing supplies, including participant materials such as t-shirts Full requested funding would support staffing and program supplies.

Breathe California of the Bay Area

Program Title	Children's Asthma Services
Grant Goal	To work with schools, child care centers, and clinic partners to provide culturally competent, best practice asthma management education and support services for under-served, low-income children and their parents/families and care providers thereby increasing access to appropriate care or treatment and management of the chronic condition of asthma. The goal of this program is to increase access to appropriate care or treatment and to increase better management of their chronic condition of asthma. The agency will also work to increase asthma-friendly environments by facilitating environmental changes that will reduce the respiratory hazards where children live, work, and play.
Community Need	Asthma is a chronic condition affecting 14.5% of Santa Clara County residents (California Breathing current county profile). This rate is higher than the last statewide prevalence report of 12%. Up to 20% of local children in low socioeconomic status areas may have asthma (agency double-blind three-school research in 2,000 when overall rates were lower). Asthma is the most common chronic disease of childhood and is the number one reason for school absences due to chronic conditions, which both handicaps children's learning and costs schools thousands of dollars in ADA funds. In Santa Clara County, there are about 64,000 children and youth with asthma, and it is estimated that only 20 percent of children with persistent asthma have a level of control that is optimal (Halterman, Jill, M.D., M.P.H., Ambulatory Pediatrics, 3/15/2007). Latest data (2014) from California Breathing shows 424 hospitalizations at an average rate of $26,973, and 1,898 emergency room visits take place for children under 18 years old annually in Santa Clara County due to asthma. A large percentage of these ER and hospital interventions could be prevented with proper asthma management, and Breathe CA has the experience, expertise, and community partners to help reduce this burden.
Agency Description & Address	1469 Park Ave, San Jose Breathe California of the Bay Area (Breathe CA) is a 107-year-old grassroots, community-based, voluntary 501(c)3 non-profit that is committed to achieving clean air and healthy lungs. As the local Clean Air and Healthy Lungs Leader, Breathe CA fights lung disease in all of its forms and works with its communities to promote lung health. The organization works to establish tobacco-free communities, achieve healthy air quality, and fight lung disease such as TB, asthma, influenza, and COPD. The agency serves over 100,000 individuals per year with programs in education, public policy, research, and patient services. Breathe CA provides prevention and intervention services to a wide range of population- from children to seniors in the community, focusing on those vulnerable populations and those with health disparities and inequities.
Program Delivery Site(s)	Program delivered at schools, childcare centers, community organizations with after school programs and even their homes. Specifically the program has partnerships to deliver services at: • San Jose Unified School District sites • Indian Health Center • Health Trust • Santa Clara Family Health Plan • 4C's Community Child Care Council in Santa Clara County • First 5 Santa Clara County
Services Funded By Grant/How Funds	Services include: • Multi-session (2-8 sessions) asthma management education for elementary/middle school-

Will Be Spent	aged children on-site at their schools of 40-60 minutes average) classes, after-school programs, summer camps, and community programs • Training and technical assistance for nurses, health workers, school personnel, child care providers, and parents of 30 minutes -2 hours) • Environmental assessments of homes, child care facilities, and schools. • Assisting clients to approach landlords regarding respiratory hazards and infestations, including secondhand smoke (and operation of Secondhand Smoke Helpline); community advocacy efforts for creating asthma-friendly environments. • Provision of lung screenings, respiratory therapy equipment and supplies for uncovered clients • Information/referral to additional resources, including Covered California • All trainings meet National Asthma Education and Prevention Program (NAEPP) Guidelines and cover the basics: the respiratory system; identifying asthma symptoms and triggers; precautions to take; how to use medication/respiratory therapy and a peak flow meter Full requested amount funds partial staff salaries, such as for senior health educator, outreach specialist, program coordinator and other administrative costs.

FY19 Healthy Body Proposal Summary

Cambrian School District

Program Title	School Nursing Services as part of Multi-Tiered System of Supports School Health Services
Grant Goal	Cambrian School District is requesting funding support for our district has the strong desire to continue to build the infrastructure for a Student Services Multi-Tiered System of Supports to support the whole child in a school health services model in our school district. The school nursing services support would be to maintain the first full time credentialed school nurse Cambrian has had which was established in May 2017 with the support of the El Camino Hospital Grant and seek an additional half-time nurse and/or support efforts to move our health clerk positions from a partial day (approx. 3 hours) to a full school day. Students in grades Preschool-8th grade will benefit from the direct services of the school health services team. The teacher, itinerant, clerical, and administrative staff will also benefit from the consultative/indirect services of the school health services team. The services will be delivered to all 6 schools (Bagby Elementary, Fammatre Elementary, Farnham Elementary, Price Middle, Sartorette Elementary, and Steindorf K-8 STEAM School) during the on school days during school instructional hours as well as before and after school. The school health services are needed to support required health screenings, crisis intervention and long-term intervention for student health needs, and staff professional development for district nurse, health clerks, secretaries, and administrative school office staff to keep up to date with compliance and preventative measures.
Community Need	The program will help address universal (Tier I) level needs for students in Cambrian schools by creating identification of basic health needs (hearing and vision) required for adequate learning accessibility for our students. To address our intervention (Tier II) and intensive (Tier III) student population our school nurse supports students with health care plans and in special education. The numbers of students with health care plan needs are increasing. More students have been identified with diabetes which requires immediate intervention on a school campus to train staff, students, and parents/guardians on the appropriate calculations and usage of equipment and medicinal needs. Additionally with the increasing success of medical technology there are more and more students with unique medical conditions that are able to survive, thrive, and attend our schools, but due to their medical complexities require medical interventions at school. Prior to receiving the grant funding for this year's current cycle Cambrian never had a full time credentialed school nurse on campus and relied on very part time contractors for support and basic needs. Without having the full time school nurse to assist our growing health care population needs our students would not be able to safely attend school on an immediate and consistent basis which impacts their attendance and long term learning outcomes. It is best practice for districts to have a full time school nurse on staff and given the size of Cambrian two school nurses would be appropriate.
Agency Description & Address	4115 Jacksol Drive, San Jose Cambrian School District is located in the Cambrian Park area and serves approximately 3,500 students in Preschool through 8th grade. All five of the district's traditional schools have been recognized as California Distinguished Schools. Cambrian opened a sixth school in Fall 2016: Steindorf K-8 STEAM Magnet school.
Program Delivery Site(s)	All six schools in the Cambrian School District
Services Funded By Grant/How Funds Will Be Spent	Services include: • Health screenings including vision and hearing • Crisis intervention (individual sessions when needed) and long-term intervention for

	health needs such as diabetic, seizure, and cardiac care • Professional development for district nursing and health clerk staff to keep up to date with compliance and preventative measures. • Follow up with failed health screenings to confirm if a healthcare provider was seen, assisting with scheduling and/or physically attending the medical appointment. • Follow up with uninsured students to confirm if healthcare insurance has been obtained and/or assisting with the application to receive health care insurance Full requested funding would support 1.5 FTE School Nurses, a part time Health Clerk, equipment and professional development expenses.

FY19 Healthy Body Proposal Summary

Campbell Union School District

Program Title	Supporting and Promoting Healthy Families and Communities – School Nurse Program
Grant Goal	This program will fund two full-time School Nurses and 300 hours of Community Liaison time to provide families with direct links to healthcare services including medical, dental, and vision services. Schools are hubs of the community where resources such as healthcare insurance enrollments centers, CalFresh services, and First Five services can be shared with families in school offices or at community events such as Fall Festivals, Parent University, and Multicultural celebrations. School-based dental screenings/fluoride varnish treatments will be scheduled at two Title One schools every Fall and Spring. A twelve-week series of brief classroom interventions, aimed at reducing stress and anxiety in students, will be piloted at one of our Title One schools. Campbell schools are known by the community to be "safe places" for families to seek assistance and guidance for a variety of services and resources.
Community Need	The following health needs will be addressed in the school community: *Lack of healthcare insurance for students and families:* Data from the 2013-2014 Santa Clara County Public Health Department Behavioral Risk Factor Survey (SCCPHD BRFS) states that over 90% of children from ethnicities including Latinos, African American Asian/Pacific Islander, and Whites have healthcare insurance. While parents have self-reported 1-3% of students do not have healthcare insurance, it is clear that every child needs access to healthcare. Optimal health is necessary for optimal learning. People with a usual source of care have better health outcomes and fewer disparities and costs (Healthy People 2020). A healthcare provider can assess school readiness as well as identify children at risk for conditions such as developmental and behavioral disorders, asthma and other chronic conditions, obesity, unintentional injuries and dental caries. (Healthy People 2020) The health program will continue to reach out to local healthcare insurance enrollment services in the community to provide opportunities for families to enroll in healthcare insurance services *Hearing Needs:* Students who fail a hearing screening may have a hearing loss. Without a resolution, a hearing loss can impact school performance. Packer (2015) states, "research shows anywhere from 25% to 35% of children with unilateral hearing loss are at risk of failing at least one grade". Development of speech, behavior problems, and school disengagement may be attributed to a student's hearing loss. *Vision Needs:* Students who fail a vision screening may have a vision deficit and need optometric services. Vision deficits can commonly be caused by myopia or other refractive errors, but visual deficits may also be due to a more serious condition that, without correction, could lead to a permanent loss of vision. S.A. Lyons et al (2015) have discovered that "forty to sixty-five percent of referred children do not access follow-up comprehensive vision care after school vision screening referral". Basch (2011) noted that low-income and minority youth may have "unmet need for vision care services" (p. 13) and suggested outreach of resources to parents, communication of vision results to teachers, and on-site vision services including eye exams to meet these unmet vision needs. *Dental Needs*: Untreated dental caries can cause pain, infection, and lead to a student not being attentive in the classroom as well as increased absenteeism. In 2008 across the U.S., 15,000 children were seen in the emergency rooms due to toothaches (Lewis, 2015). It remains difficult for publicly-insured children to access dental services; fewer dentists are accepting Medicaid (Medi-Cal) (Lewis, 2015). Low-income children experience more dental caries and more complications of caries, such as dental abscesses (Lewis, 2015). Hispanic children have a caries

	rate two to three times greater than their non-Hispanic White peers (Bright Futures Promoting Oral Health, 2015).The school health program participates in the Dentists With A Heart Give Kids A Smile program, supported by the Santa Clara County Dental Society (SCCDS) and volunteer dentists. In addition, the SCCDS and volunteer dentists will continue to provide applications of fluoride varnish for students at two Title One Schools, Lynhaven and Rosemary. Fluoride varnish may be used as a primary preventive measure and is recommended for children who are deemed to be at high risk of caries. *Stress reducing interventions for three classrooms, grades 3 - 5, using "Go Noodle" exercises (vignettes)*. Pre interventions and Post interventions to be recorded using SCARED survey to measure change. Rosemary school is a Title One school with 83.8% of students receiving free or reduced fees for meals in our district. With a majority of students' ethnicity designated as Latino, 76% of students are classified as English Learners (EL). Many members of the Rosemary School family are immigrants. With the current administration in Washington, DC's political agenda, these families experience the stressors of possible deportation. Research suggests that "stressors of poverty lead to impaired learning ability in children. "(NIH.gov news release dated 8/28/12). This theory also states that "finding ways to reduce stress in the home and school environment could improve children's well-being and allow them to be more successful academically." Sources: Healthy People 2020, https://www.healthypeople.gov; Santa Clara County Health Status and Quick Facts (SCCPHD BRFS). Link: http://www.sccgov.org/sites/phd/hi/hd/Pages/brfs-quick-facts-2013.aspx Packer, L. (2015). How hearing loss affect school performance. Link: www.HealthyHearing.com Basch, C. E. (2011). Healthier students are better learners: A missing link in school reforms to close the achievement gap. Journal of School Health. Link:http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2011.00632.x/full; Lyons, S. A., Johnson, C, & Majzoub, K. (2009). School based vision centers: Striving to optimize learning. Work 39(1). (Milgrom, P. et al, 2011). Bright Futures: Promoting Oral Health (2015). Link: www.pediatriccaresolutions.aap.org Lewis, C. W. (2014). Fluoride and dental caries: Prevention in children. Pediatrics in Review, 35(1), p3-15. Milgrom, P., Weinstein, P., Hueber, C., Granes, J., Tut, O. (2011). Empowering Head Start to improve access to good oral health for children from low income families. Maternal & Child Health J., 15, p 876-882. Birmaher, B, MD, Khetarpa, S. MD, Cully, M, Brent, D. MD, and McKenzie, S. (1995). Screen for Child Anxiety Related Disorders (SCARED). Western Psychiatric Institute and Clinic, University of Pittsburgh
Agency Description & Address	155 North Third Street, Campbell Established in 1921, Campbell Union School District (CUSD) is a PreK-8 school district that includes parts of 6 cities in Santa Clara County. Our teachers educate more than 7,500 students at 9 elementary schools, 3 middle schools, a Home School Program, and district-operated preschools.
Program Delivery Site(s)	District schools, especially Title I schools.

Services Funded By Grant/How Funds Will Be Spent	Services include: • Organize school health fairs • Participate in and provide healthcare resources and activities during Parent Resource Fairs and Cultural Awareness event. • Districtwide vision screenings • Connect students who have failed a health screening to a local healthcare provider • Dental Screening/Fluoride Varnish Program • Assist students and families who have been identified as not having healthcare insurance to obtain coverage • Districtwide Healthcare Insurance enrollment event • Organize and provide Bike Safety events at two schools • Student Attendance Review Board (SARB) team member • Train staff about student health needs and emergency procedures • Medication administration training and competency testing • Develop Emergency Health Care Plans for students with severe health concerns • Train and oversee unlicensed assistive personnel and school clerks who provide care for students with health needs. • Student Study Team (SST) member collaborating with educators and parents to remove or reduce students' health-related barriers to learning. • Liaison between CUSD and Santa Clara County Health Dept. Fully requested funding would support 2FTE credentialed School Nurses and 300 hours of the Community Liaison.

FY19 Healthy Body Proposal Summary

Cancer CAREpoint

Program Title	Nutrition Program for Cancer Patients
Grant Goal	This program will improve healing and quality of life following a cancer diagnosis by developing healthier eating habits among cancer patients.
Community Need	According to the National Cancer Institute, nutrition is a major issue facing cancer patients. Cancer and treatments can affect one's sense of taste, smell and appetite and can cause health problems such as anorexia, mouth sores, nausea, vomiting, diarrhea, constipation as well as depression and anxiety.
Agency Description & Address	2505 Samaritan Drive, Suite 402, San Jose Cancer CAREpoint is the only local organization in the South Bay that provides free, non-medical support services to cancer patients and their families regardless of their cancer type, where they receive medical care, or their insurance status. This support includes counseling, classes in nutrition and movement, educational workshops, support groups for patients and caregivers, a wig bank, survivorship workshops, and access to a variety of integrative healing modalities.
Program Delivery Site(s)	The program will be delivered at the agency site in San Jose.
Services Funded By Grant/How Funds Will Be Spent	Services will include: • Providing cancer patients with private, individualized consults from a nutritionist • Conducting nutrition workshops on managing fatigue, immune boosting, eating for better sleep and benefits of balancing sugar Full requested funding will support nutritionists to provide nutrition classes and consultations, and program supplies.

Challenge Diabetes Program

Collaborative organizations: Community Services Agency Mountain View, Sunnyvale Community Services, West Valley Community Services, and Second Harvest Food Bank

Program Title	Challenge Diabetes Program
Grant Goal	This program will identify community members with pre-diabetes and prevent type 2 diabetes and to help people with type II diabetes manage their diabetes more effectively.
Community Need	Thirty-seven percent of U.S. adults aged 20 years or older have pre-diabetes. In Santa Clara County, 8% of adults have ever been diagnosed with diabetes. Percentages are highest for Latinos (11%) and African Americans (10%), those ages 65 and older (18%), those with less than a high school education (16%), and adults with household incomes lower than $50,000. Food insecurity, which affects lower-income populations more, further increases the risk for chronic diseases like hypertension and Type 2 diabetes. Lower-income people may also face choices about paying for food or medication.
Agency Description & Address	Community Service Agency Mountain View: 204 Stierlin Road, Mountain View Sunnyvale Community Services: 725 Kifer Rd, Sunnyvale West Valley Community Services: 10104 Vista Drive, Cupertino Second Harvest Food Bank**:** 4001 North First Street, San Jose Community Service Agency Mountain View (fiscal agent) is a nonprofit organization that provides important social services for residents of Mountain View, Los Altos, and Los Altos Hills. Partner agencies include Sunnyvale Community Services, Second Harvest Food Bank, and West Valley Community Services.
Program Delivery Site(s)	Services will be provided in San Jose, Mountain View, Cupertino and Sunnyvale.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing staffing for a coordinator to implement program offerings • Identify clients with diabetes or pre-diabetes through on-site screenings (CDC risk-assessment and HbA1c screening) • Preventing and/or managing clients' diabetes through education, and provision of gym memberships and healthier foods • Providing monthly food bags to families including nutritious foods and educational materials • Delivering lifestyle modification classes based on CDC's evidence-based on National Diabetes Prevention Program (DPP) • Conducting clinical screenings pre-screening and post-screenings to measure impact Full requested funding will support program staffing, clinical screenings, lifestyle modification classes, health education materials, gym memberships, outreach and program supplies.

FY19 Healthy Body Proposal Summary

Community Health Partnership, Inc. NEW

Program Title	Learning Collaborative: Patient Attribution and Engagement Project
Grant Goal	To provide training and workflow development support through a regional learning collaborative for clinical staff (including nurses, QI staff, and care coordinators) at community clinics who are working to expand their care coordination processes. This project will assist care teams with managing their patient empanelment and patient engagement processes through the implementation of patient attribution and assignment workflows. These workflows will allow previously unseen patients to be actively engaged in a health home where their needs can be identified and addressed through an initial health assessment and annual wellness visit. In addition, the learning collaborative and project activities will incorporate existing clinic outreach and enrollment staff as part of the team to support the development and implementation of patient outreach and in-reach strategies to engage the patients who have not been seen for their risk assessments and annual wellness visit. Overall, the long-term goals of these strategies are to reduce hospitalizations and better manage the care of chronically ill patients.
Community Need	There is a great need for this project. In 2016, CHP member clinics were collectively assigned 84,480 MediCal patients, however only 25,434 of these patients (or 30% of the total) assigned to a primary care physician (PCP) visited their assigned PCP. Similarly, CHP member clinics are serving approximately 6,000 patients enrolled in the Santa Clara County's Primary Care Access Program (PCAP), a program that provides health coverage for uninsured patients. CHP estimates that there are similar rates of engagement among the PCAP patient population, resulting in a significant amount of missed opportunity to actively engage patients and better meet their health care needs. Currently, about 30% of these patients are actively seen by a PCP in the clinics, as reported to CHP clinics through quarterly and annual reports from Santa Clara County and Valley Health Plan. This lack of patient engagement results in poorer health outcomes for chronically ill patients and an increased use of emergency departments (ED). The proposed project will focus on closing clinical care gaps among MediCal and PCAP (Primary Care Access Program), patients in several clinical areas by expanding capacity to identify and engage patients that have been "attributed but not seen." Effective attribution and engagement practices are critical first steps in successful care coordination models. The clinical outcomes identified for this project align with the clinical outcomes prioritized by the County through both PCAP and the MediCal managed care contract with Valley Health Plan. Without engaging in these kinds of clinical activities with their PCPs, patient needs and care gaps go unaddressed leading to poorer health outcomes and higher costs. As noted, in 2016, CHP member clinics served 84,480 MediCal patients through 76,024 PCP visits, which represents an average of 0.9 visits/patient. This rate falls short of the expectations by MediCal and PCAP payers, who have set targets for community clinics with a minimum threshold of 1.8 visits/patients annually. Increased use of primary care leads to better management of chronic illness reduces ED use, and generally, lowers overall health care spend. In addition to these clinical utilization metrics, CHP and its member clinics anticipate self-reported increases in process improvements related to: 1) improved data exchange between payers and providers; 2) improved knowledge of patient attribution models; and 3) improved use of common workflows for patient identification and engagement based on principals of Patient Centered Medical Home.

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Agency Description & Address	1401 Parkmoor Avenue, Suite 200, San Jose Community Health Partnership (CHP) represents ten community health centers serving 40 sites in Santa Clara and San Mateo Counties, providing them with resources and expertise to deliver high quality, affordable care to our diverse community. CHP gives its members a collective voice to reach and educate policy makers, funders and community leaders – supporting local health centers' efforts to shape health policy, secure funds, and strengthen the health care safety net. CHP also collaborates with members to drive best practices for quality care, maximize resources, improve technology tools, and navigate the changing health care environment.
Program Delivery Site(s)	• Learning Collaborative trainings will take place at the Sobrato Center for Nonprofits at 1400 Parkmoor Avenue in San Jose or at CHP office in San Jose • Technical assistance sessions will occur on-site at community health clinics • Coaching sessions will take place by teleconference
Services Funded By Grant/How Funds Will Be Spent	Services include: • Convening three quarterly half-day in-person Learning Collaborative sessions and two individual "action period" conference calls with each participating Community Health Clinic (CHC) to provide one-on-one technical assistance to clinical teams • Developing common clinic workflows for utilizing patient attribution list to increase the number of patients seen for initial health risk assessment (IHA) and annual wellness exams • Providing technical assistance to clinic teams to document the completion of the IHA in the Electronic Medical Record and correctly code the initial well patient visit • Developing common clinic workflows to leverage existing outreach and enrollment staff to expand patient in-reach and outreach strategies • Establishing monthly data sharing processes between CHP, the clinics, and the health plans • Providing onsite technical assistance to clinic staff to assist them with accessing health plan attribution lists for empanelment and care planning • Creating a consortium-level dashboard to track and manage utilization and clinical quality measures across the eight participating clinics Full requested amount funds partial salaries for the Medical Director and Project Manager and a small amount of administrative costs.

FY19 Healthy Body Proposal Summary

Cristo Rey Network

Program Title	Cristo Rey San Jose Jesuit High School Health and Wellness Program
Grant Goal	This program will engage students in developing healthy habits. Students will improve heart rate and blood pressure, engage in new forms of exercise, and eat more healthfully.
Community Need	Many students struggle throughout the school day because of the lack of adequate nutrition, exercise, and mental health. Especially in low-income communities, the pull factors of unhealthy food and sedentary entertainment options are very strong. In the Mayfair neighborhood, where Cristo Rey San Jose (CRSJ) is located, a majority (69%) of the neighborhood's 11,427 residents are Latino/Hispanic and almost a third (31%) are under 18 years of age. CRSJ's student population is 95% Latino. In Mayfair, there are fewer healthy food retailers than the countywide average.
Agency Description & Address	1389 East Santa Clara Street, San Jose CRSJ is a Jesuit, Catholic high school whose mission is to empower students from underserved communities in San Jose to be men and women for others who are prepared spiritually, academically, and professionally to complete college and who will become accomplished leaders committed to a lifelong pursuit of learning, faith, and justice.
Program Delivery Site(s)	The program will be delivered in San Jose.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting daily physical fitness sessions during school hours • Providing health statistics monitoring Full requested funding will support partial staffing and program materials such as equipment.

FY19 Healthy Body Proposal Summary

Cupertino Union School District

Program Title	School Nurse Program
Grant Goal	The Cupertino Union School District is requesting support to provide extra nursing and clerical support to schools serving the more underserved populations within the Cupertino Union School District. These schools include DeVargas and Eisenhower Elementary. The additional nursing and clerical support allows for extensive follow-up for health screening failures, additional staff trainings for epi-pen administration in response to allergic reactions, and assistance with access to healthcare services through community resources. School nurses also promote and market health literacy through programs provided by El Camino Hospital, provide health education to families, and provide attention to the health needs of students and staff in the school communities.
Community Need	There are significant barriers in accessing healthcare for students in our target schools. Data from Lucile Packard Foundation for Children's Health 2016 indicates that 23.3% of students in public schools within Santa Clara County are English Learners compared to 22.1% statewide. These students are more likely to have difficulty accessing quality health care which may result in health disparities for these students as adults compared to children whose households speak English primarily. Additionally, the target school sites have a greater percentage of minority students in comparison with other district school sites. Santa Clara County Measures of Economic Security Report (2014) indicates ethnic disparities in Santa Clara with minorities having greater rates of unemployment and poverty which ultimately contribute to poor health outcomes. Furthermore, the school nurse serves a population of students who have a greater truancy rate, in comparison to other school sites in the district. Analysis of absenteeism in students who took the National Assessment of Educational Progress (NAEP) in 2011 and 2013 showed that high absenteeism is associated with lower test scores in every state and city that was tested. Attendance concerns are often attributed to unmanaged chronic health conditions or students receiving medical treatment outside of school. Case management by the School Nurse can help lower rates of truancy which will ultimately increase the child's class time and improve their access to education. The Grant staff will offer additional follow-ups for health screening failures, case management services, and offer resources to families who may have difficulty navigating the healthcare system.
Agency Description & Address	10301 Vista Drive, Cupertino The Cupertino Union School District is a TK-8 school district serving over 18,000 students across 25 schools within Santa Clara County. The Cupertino Union School District has been known for its academic excellence and commitment to the organization's mission since its inception. The mission of the district is to provide a child-centered environment that cultivates character, fosters academic excellence, and embraces diversity. District families, community, and staff join as partners to develop creative, exemplary learners with the skills and enthusiasm to contribute to a constantly changing global society.
Program Delivery Site(s)	DeVargas and Eisenhower Elementary Schools

Services Funded By Grant/How Funds Will Be Spent	Services include: • Extensive follow-up and case management at target schools following health screenings. Follow-up will include additional written referrals and phone calls, referrals to health care resources, and detailed data tracking • Promotion of dental health through on-site dental screenings at target school sites. School nurses will organize screenings at target schools and follow-up with students who were identified with having dental health concerns • Promotion of health literacy and physical activity through marketing and presentation of Go Noodle health curricula. Promotion will include email blasts to educators, Go Noodle flyers, and presentation of Go Noodle health resources during staff meetings • Intensive training for staff at target schools to understand severe food allergies, anaphylaxis response, and EpiPen usage Full requested funding would support the partial salaries of a credentialed school nurse, LVN and health clerk.

FY19 Healthy Body Proposal Summary

Gardner Family Health Network, Inc.

Program Title	Down with Diabetes
Grant Goal	This diabetes prevention program targets adults who are pre-diabetic as defined by HbA1c blood levels.
Community Need	Thirty-seven percent of U.S. adults aged 20 years or older have pre-diabetes. Low-income populations are at higher risk than the general population for developing type II diabetes, and food insecurity further increases risks for chronic diseases like hypertension and type II diabetes. In Santa Clara County, 8% of adults have ever been diagnosed with diabetes. Percentages are highest for Latinos (11%) and African Americans (10%), those ages 65 and older (18%), those with less than a high school education (16%), and adults with household incomes lower than $50,000. Food insecurity, which affects lower-income populations more, further increases the risk for chronic diseases like hypertension and Type 2 diabetes. Lower-income people may also face choices about paying for food or medication. In 2013, the Gardner Family Health Network treated over 2,500 patients (11 percent) who were pre-diabetic according to their HbA1c levels. It is essential that patients who have been identified as pre-diabetic be educated about proper nutrition and physical activity.
Agency Description & Address	160 E. Virginia Street, Suite 100, San Jose Gardner is dedicated to improving the health status of the disenfranchised, disadvantaged, and most vulnerable members of our community. Gardner provides medical, dental, vision, counseling, and substance abuse services to more than 60,000 Santa Clara and San Mateo County residents.
Program Delivery Site(s)	The program will be delivered in San Jose.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing staffing for clinical staff and Wellness Coordinator who will facilitate visits with primary care providers and consults with Registered Dieticians • Providing HbA1c testing and one-on-one chronic disease management and counseling • Providing patients with access to gym memberships and fresh produce vouchers for fruits, vegetables, and healthier foods Full requested funds will support partial clinical staffing including bilingual Registered Dietitians and Health Coach, and program supplies such as gym memberships and fruit and vegetable vouchers.

FY19 Healthy Body Proposal Summary

GoNoodle, Inc.

Program Title	GoNoodle Movement Videos and Games – Brain Breaks
Grant Goal	GoNoodle, Inc. is requesting support to continue providing GoNoodle movement videos and games to school districts in El Camino Hospital's service area. In addition, we have added GoNoodle mindfulness videos that help children deal with anxiety and stress. GoNoodle will serve 183 schools. GoNoodle's internal and external teams of product and content experts, user engagement specialist, regional community managers, and contracted event squad members will provide the on-going engagement, professional development, and outreach to all covered schools and elementary teachers.
Community Need	According to a CDC and USDA study of WIC participants (2014), California ranked 6th highest in the nation for obese, low-income two to four-year-olds (16.6%). In 2016, 31.2% of California children aged 10-17 were either overweight or obese. California currently has no laws requiring schools to provide physical activity or recess during the school day. These alarming facts exemplify the need for early intervention to promote health and provide opportunities for physical activity for California's children. Sources: https://stateofobesity.org/states/ca/#policies https://stateofobesity.org/high-school-obesity/
Agency Description & Address	209 10th Ave. South, Suite 350, Nashville, TN GoNoodle gets kids moving to be their smartest, strongest, bravest, silliest, best selves. Short, interactive movement and social-emotional videos make it awesomely simple and fun to incorporate movement into every part of the day with dancing, stretching, running and mindfulness activities. At school, teachers use GoNoodle to keep students energized, engaged, and active inside the classroom. At home, GoNoodle turns screen time into active time, so families can have fun and get moving together. Currently, 14 million kids use GoNoodle each month, in all 50 states and 185 countries.
Program Delivery Site(s)	Schools in El Camino Hospital service area
Services Funded By Grant/How Funds Will Be Spent	Services include: • Unlimited GoNoodle licenses for all elementary (K-5) school teachers, administrators, staff and parents/students in ECH sponsored schools • Access to GoNoodle Plus additional movement videos and games, core subject content, and customization features • Placement of ECHD name and logo on the GoNoodle site and on materials sent to teachers, administrators, and parents • ECH name and logo extended to GoNoodle home usage, on-going platform enhancements and new games or videos added regularly • Direct mail and email campaigns designed to promote new and ongoing usage to principals and teacher champions • Social media activity (Twitter, Facebook, and Instagram posts to engage with users) • On-site GoNoodle demonstrations or webinars as requested • GoNoodle monthly reporting to the partner, and to schools Full requested funding will support for program license and the partial salary of the school engagement coordinator.

FY19 Healthy Body Proposal Summary

Healthier Kids Foundation

Program Title	DentalFirst and HearingFirst Programs
Grant Goal	Through the DentalFirst and HearingFirst programs, Healthier Kids Foundation program staff will provide dental and hearing screenings and appropriate follow up to children in preschool, charter school, public school and community organization settings.
Community Need	Not all families can afford to put health first. Parents need a resource that not only helps them learn how to raise healthy kids, but makes sure they can understand health challenges so that their children get the care they need to thrive socially and academically. Dental caries, or cavities, is the single most common chronic childhood disease in the United States (CDC, 2016). Childhood caries cause intense pain, difficulty eating, speaking and sleeping. Children who have pain in their mouth because of dental caries have more frequent school absences, trouble concentrating, and poorer academic performance (Jackson et al.,2011). Dental caries affect a child's nutrition, sleep and development (Acharya & Tandon, 2011); ultimately limiting long term productivity and success. The DentalFirst program screens children for undetected dental issues and makes sure they get the follow up care they need, because when kids have healthy teeth and gums they avoid developing caries or other dental issues that may hinder their performance in the classroom and in life. Additionally, hearing loss affects two in every 100 children under the age of 18 in varying degrees (Healthier Kids Foundation, 2018). Hearing loss can be devastating when it goes undetected. If a child has a hearing issue that goes undetected and untreated, they will miss learning from the speech and language that is happening around them and may result in delayed language and speech development, trouble concentrating, and behavioral and academic challenges. The most effective treatment for varying hearing problems is early intervention. Early diagnosis, hearing aid fittings, and an early start with special education programs maximizes a child's hearing potential and gives the child a strong pathway to successful speech and language development (CDC, 2017). The HearingFirst program screens children for undetected hearing issues and assists them in any follow up care they need, because when kids can hear clearly, they are able to pay attention and flourish in the classroom and in life. Sources: Acharya, S., & Tandon, S. (2011). The effect of early childhood caries on the quality of life of children and their parents. Contemporary Clinical Dentistry, 2(2), 98–101. http://doi.org/10.4103/0976-237X.83069. Center for Disease Control and Prevention. (2017). Hearing Loss in Children. https://www.cdc.gov/ncbddd/hearingloss/index.html. Center for Disease Control and Prevention. (2016). Hygiene-related Diseases: Dental Caries (Tooth Decay). Water, Sanitation & Environmentally Related Hygiene. https://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html. Jackson, S. L., Vann, W. F., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of Poor Oral Health on Children's School Attendance and Performance. American Journal of Public Health, 101(10), 1900–1906. http://doi.org/10.2105/AJPH.2010.200915.
Agency Description & Address	4010 Moorpark Avenue, Suite 118, San Jose Healthier Kids Foundation is a family forward health agency that gives children and those who love them the education and cutting edge tools they rightfully deserve to live a healthy life. At Healthier Kids Foundation, we believe preventative care at an early age makes things fair. Every day, we work side-by-side with families to identify and eliminate kids' health issues before they even begin. Because without us, barriers that could be corrected may stand in the way of kids joyfully climbing the ladder of life.

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Program Delivery Site(s)	Healthier Kids Foundation will be delivering services to preschool, charter school, public school and community organization settings, such as Franklin McKinley School District and Alum Rock School District.
Services Funded By Grant/How Funds Will Be Spent	DentalFirst program will provide: • Dentists screen children for dental-related issues and recommend follow up care • Dentists provide oral hygiene education to the children and literature for parents • Parents receive a copy of the child's screening result • Case management for families with child whose screening result has indicated a dental issue(s) and for those without insurance HearingFirst program will provide: • Hearing screening to children and appropriate follow up, as needed • Parents of children screened with their child's screening results • Case management as needed, including bilingual case managers Full requested amount funds partial salaries of 23 staff positions and administrative costs.

Indian Health Center of Santa Clara Valley

Program Title	Healthy Futures Program
Grant Goal	The Indian Health Centers (IHC) is requesting support to fund the Healthy Futures Program. The Healthy Futures Program will be entering into its second year. The Healthy Futures Program aims to decrease the number of Indian Health Center pediatric patients (ages 0-17) who are overweight, obese, or pre-diabetic by decreasing their BMI percentile. For the pre-diabetic and diabetic pediatric patients, the program will also aim to decrease A1c levels. Our multi-layered, patient-centered approach will include the efforts of primary care physicians, Registered Dietitians, Registered nurses, fitness instructors, health educators and diabetes prevention/management peer educators. Included in the Healthy Futures Program is a 5-day, 2 hours per day program during school break called Healthy Adventures. For pediatric patients who are pre-diabetic or diabetic, we will offer the Diabetes Education and Empowerment Program, which is a 6 week curriculum that meets one time per week for two hours. It is facilitated by trained peer educators and a registered nurse. Participants will receive nutrition services at all IHC medical clinic locations and the Wellness Center. Patients will also receive fitness services at the Wellness Center where the IHC fitness center is located. It is imperative that younger generations learn about essential health practices in ways that they can understand and relate to in order to prevent health complications. Because parents, siblings, and other family members play a significant role in the success and effectiveness of the program, they are included at every step of Healthy Futures. All of the services will be completely free of charge to the pediatric patients and families and will be available in both English and Spanish.
Community Need	According to the 2014 Santa Clara County Community Health Assessment, 16 percent of adolescents (ages 10-19) are obese. (https://www.sccgov.org/sites/phd/collab/chip/Documents/cha-chip/SCC_Community_Health_Assessment-2014.pdf) For adolescents who identify as Latino/Hispanic, 26 percent are reported to be obese. The data for the Latino/Hispanic adolescents living in Santa Clara County is higher than the national average, which according to the Centers for Disease Control and Prevention (CDC) is at 21.9%. (https://www.cdc.gov/obesity/data/childhood.html) Pre-diabetes and diabetes serve as a severe potential health consequence of prolonged overweight and obesity. The Indian Health Center of Santa Clara Valley is in constant communication with the County of Santa Clara's Public Health Department in promoting the Diabetes Prevention Initiative, where several hospitals, non-profits, and community organizations focus on preventing type 2 diabetes and raising general awareness levels among community members. Having a program that focuses on pediatric patients specifically would greatly benefit and be unique to our community. A healthy diet and staying physically active are essential in combating the conditions discussed above. According to the YMCA's Family Health Snapshots in 2015 (http://www.ymca.net/news-releases/national-survey-kids-healthy-habits-decline-during-summer) , about three-quarter of kids drink sugar-sweetened beverages at least weekly during the summer, and about a quarter of kids average one or more sweetened beverages daily or almost daily. The report also states that while food consumption rises in the summer months, many kids still do not consume the recommended amount of vegetables. As many working adults have limited time to prepare food for a family, the alternative of fast and inexpensive food may become an attractive idea. Parents may need more support and guidance to help facilitate feeding the family more healthy foods. It is important to have services that can work with the diverse and complex situations that families are facing and help find cost effective food alternatives and techniques that benefit the family

	unit. Furthermore, there is access to athletic programs and organized sports at local schools, but depending on the sport, there are oftentimes fees to purchase team merchandise or specific equipment. Athletic programs that are not affiliated with the schools can easily charge $75 and up for programs that last as little as one month. This is often is an economic barrier that families cannot take on, thus children are unable to participate in the activities. There are clear health consequences if the needs are not urgently addressed. According to the CDC, those who are obese are at an increased risk of developing high blood pressure, type 2 diabetes, coronary heart disease, stroke, Osteoarthritis, sleep apnea and breathing problems, clinical depression and body pain. (https://www.cdc.gov/healthyweight/effects/index.html) Aside from potential physical health consequences, the psychological well-being of our children is at risk. The CDC also states that children with obesity are bullied and teased more. Also, they are more likely to suffer from social isolation, depression, and lower self-esteem. (https://www.cdc.gov/healthyschools/obesity/facts.htm) The risk of developing pre-diabetes or type 2 diabetes in children and youth goes up significantly if the individual has a family history or is overweight. The CDC states that among the increasing trend of teens being diagnosed with pre-diabetes and diabetes, being overweight has been a significant risk factor. Some serious potential health complications for diabetes include neuropathy, hypertension, retinopathy, nephropathy, foot damage, and cardiovascular disease (https://www.cdc.gov/features/preventing-diabetes-complications/index.html). Understanding the potential health consequences, the program will aim to affect pediatric patients and their parents in a prevention focused approach before any serious health complications can develop as a result of being overweight or obese.
Agency Description & Address	1211 Meridian Ave, San Jose The Indian Health Center (IHC) began operation in 1977. In 1993, IHC obtained Federally Qualified Health Center (FQHC) status to provide services to anyone in need of care. IHC offers medical, counseling, nutrition, WIC, dental and wellness services. In 2002, IHC started a wellness program to promote healthy living. The program has grown and IHC now operates a Wellness Center in downtown San Jose that houses a state-of-the-art fitness center, nutrition counseling, diabetes case management, health education, and traditional American Indian cultural activities. The Wellness Center is also home to a comprehensive, award winning diabetes management and prevention program. IHC has four medical sites, two dental sites, three WIC locations, and a wellness center that has wellness, counseling, substance abuse, and cultural services.
Program Delivery Site(s)	Services will be delivered at agency site.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual 30 - 60 minute Medical Nutrition Therapy appointments with a Registered Dietitian • 60 minute Personal Training sessions with the Fitness Coordinator. Children ages 6 and up are able to receive free personal training at the Wellness Center with their parent present. Exercises include body-weight exercises and cardio. 1 Hour Youth Exercise Group facilitated by the Fitness Coordinator. • Access to the fitness center equipment and classes • Healthy Adventures Summer Program: 3 cohorts of this 5-day/2 hour program are offered during school breaks. The program is for pediatric patients and their parents. • Services for pediatric patients diagnosed with pre-diabetes (HbA1c of 5.7% - 6.4%) or diabetes with the goal of decreasing the patient's HbA1c.

	• Diabetes Education and Empowerment Program - a 6 week curriculum program for both patient and the parents/guardian to help families become motivated and empowered together to make lifestyle changes. The Indian Health Center will host two cohorts of the Diabetes Education and Empowerment Program that will serve unduplicated patients for each cohort. • Case management services for high need pediatric patients includes health education, weekly follow up and coordination of care with specialists, Indian Health Center providers and services, and community resources. The case managers are health educators that are managed by a registered nurse and work in partnership with the patient's primary care provider. Full requested funding would support staffing for an RD, RN, Diabetes Prevention Manager, Health Educator, Fitness Coordinator, Outreach Coordinator and program supplies.

Medical Respite - Healthcare Foundation of Northern & Central California

Program Title	Medical Respite Program
Grant Goal	The Medical Respite Program (MRP) is designed as a community resource that provides a clean, safe place for homeless patients to live when they are discharged from the hospital. The MRP supports homeless patients as they recuperate and receive on-going medical and psychosocial services. The objective of the program is to link the homeless patient to a primary care home, to help them access entitled benefits, and to provide psycho-social support and services. The program is located at the Boccardo Reception Center (a local shelter) in San Jose. The staff includes a medical director, 2 RNs, 2 social workers, a psychologist, a post-doc psychologist, and a community health worker. The program also provides access to an adjacent clinic, psychiatric care, and drug and alcohol services.
Community Need	According to the Santa Clara County 2014 Health Assessment "a total of 7,631 homeless individuals were counted during the Santa Clara County Homeless Census and Survey. Of these, two-thirds (5,674, 74%) were unsheltered (living on the street, in abandoned buildings, cars/vans/RVs or encampment areas). The Homeless Census and Survey estimated that 19,063 individuals in Santa Clara County experienced homelessness over the course of a year. Additional findings include: • Of homeless individuals who needed medical care in the past year, 4 in 10 (39%) reported they were unable to access needed care. • Two-thirds (64%) of homeless individuals reported one or more chronic and/or disabling conditions (including chronic physical illness, physical or mental disabilities, chronic substance abuse and severe mental health conditions). - Sixty-eight percent reported currently experiencing mental health conditions. " When homeless individuals are hospitalized and discharged to the streets they are usually unable to consistently follow physician's orders, take their medications, do wound care, etc. This often results in re-admissions to the hospital and/or frequent emergency room visits. The Medical Respite Program provides a clean, safe place for recuperation where support is provided to follow through on physician orders and treatments. Additional psycho-social support is provided to begin stabilizing the lives of the homeless.
Agency Description & Address	1215 K Street Suite 800, Sacramento The Healthcare Foundation of Northern and Central California's purpose is to help hospitals provide high quality health care and to improve the health status of the communities they serve. The Foundation was formed in 2006 and has funded many projects for the hospitals it serves.
Program Delivery Site(s)	Boccardo Reception Center, a local shelter, in San Jose
Services Funded By Grant/How Funds Will Be Spent	Services include: • A semi-private room and 3 meals are provided for each patient while they are in Medical Respite • A primary care home is established with the on-site clinic where they are seen for all outpatient medical needs • Patients are thoroughly assessed for medical and psychosocial needs • Referrals and coordination with specialty care is provided as needed

	• Supervision and education regarding medications is provided by the RN manager • Mental health services are provided at the on-site clinic • Counseling and group sessions are held on site by the County Drug & Alcohol Services • Support groups are led by the staff psychologist for patients during and after their MRP stay to help them establish their goals and to make progress toward them • Social workers and case managers assist the patient in obtaining identification, birth certificates, and documents needed to apply for benefits • Social work and case management assist the patient in applying for entitled benefits, such as MediCal, food stamps, and SSI (income) • Assistance with job searches and training is provided for those who are able to work • Applications for housing and housing subsidies are made for eligible patients Full requested funding would support the partial salaries of staff and program supplies.

FY19 Healthy Body Proposal Summary

Mount Pleasant School District NEW

Program Title	Mount Pleasant Healthy Students, Healthy Community Systems of Support- School Nurse
Grant Goal	Mount Pleasant School District is requesting support to provide direct services to students, professional development to staff on prevention and intervention, parent training on asthma, preventing obesity and diabetes and community outreach linking families to health resources and insurance programs. A credentialed nurse with the support of Health Assistants will provide the services. The entire Mt. Pleasant community will benefit from the services, especially students with current health conditions, students and staff with high absenteeism and at-risk families impacted by poverty and lacking resources. The services will entail further developing the infrastructure for a Student Services Multi-Tiered System of Support for social -emotional and behavioral health needs. The District has a high absenteeism rate, an increasing number of students with health conditions and serves a very at-risk population. Many of our parents have difficulty accessing services outside of the immediate area, are uninsured or under-insured and do not know how to navigate the system to help their children get the care they need.
Community Need	Mt. Pleasant is requesting funding support to hire 1 FTE district nurse. Mt. Pleasant has been unable to recruit a part-time nurse. The grant will allow us to hire a full time nurse to address the growing health concerns of our student population (75 student failed vision screenings, 5 students with Diabetes, 97 students with Asthma, six students with seizure disorders). Mt. Pleasant would like to hire a full time nurse to support our growing health services needs and to provide district wide solutions for outreach on nutrition, exercise, and health education. Mt. Pleasant continues to see gaps in service existing in three distinct areas: 1) data collection and compliance, 2) staff training on topics such as immunizations, epi-pens, AEDs and CPR, asthma, and seizure disorders, and 3) health education for our families, especially in the area of obesity and prevention. We wish to focus our efforts in these areas to help us remain compliant with our Local Wellness Policy, California education code 49431.5 nutritional standards and guidelines, and EC 51890 comprehensive health education. With a consistent, highly trained health professional we can increase our data collection and further fine tune our efforts to educate healthy children and support healthy families.
Agency Description & Address	3434 Marten Avenue, San Jose Mt. Pleasant Elementary School District serves a very diverse population in a high poverty area in the east side of San Jose. The District serves students in Preschool through 8th grade.
Program Delivery Site(s)	Mt. Pleasant School District schools: Mt. Pleasant Elementary, Valle Vista Elementary, Robert Sanders Elementary, August Boeger Middle School, and Ida Jew Intermediate School.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Health screenings including: vision, hearing, scoliosis • Crisis intervention and long-term intervention for students with identified health conditions • Professional development for staff in the areas of illness prevention, social emotional learning, mindfulness, trauma informed practices and health support for allergies, diabetes and seizure disorders • Professional development for district nursing and health clerk staff to keep up to date with compliance and preventative measures • Parent education on obesity prevention, asthma management, enrolling for insurance programs, and illness prevention

	• Link families to medical appointments and insurance enrollment with follow up • Collaboration with School Linked Services Committee Full requested funding would support one school credentialed nurse and partial cost for professional development.

FY19 Healthy Body Proposal Summary

Playworks, Education Energized

Program Title	Playworks - Campbell Union School District
Grant Goal	Playworks will facilitate and inspire safe, healthy play to over 2,300 children by delivering Playworks Coach program to two low-income elementary schools and Playworks Team Up program to two elementary schools in Campbell Union School District. Along with providing services to the Coach schools every school day and to the TeamUp schools at least one out of every four weeks, we propose to provide professional development available to all adults on campus. Key to that change is providing expert training to school personnel so they can model and teach the social/emotional skills students need. School climate improves as a result because the interactions between adults and children have changed. At a Playworks school, students feel physically and emotionally safe, are focused on learning, and apply simple conflict resolution techniques to disagreements. The skills students learn on our playgrounds -- to establish positive relationships, demonstrate empathy and respect, and make responsible decisions -- are highly valued in the community and in the workplace.
Community Need	Elementary students with strong social competencies are 54% likely to earn a high school diploma, twice as likely to attain a college degree, and 46% more likely to have a full-time job by age 25, a longitudinal study published in the American Journal of Public Health (2015) reports.(http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2015.302630). Social and emotional skills include demonstrating empathy and a sense of fairness, cooperating, and treating others with respect. These competencies are significant to Whole Child development/21st Century Skills/character and are essential for helping children succeed. Unfortunately, numerous Silicon Valley schoolchildren are not gaining these skills. In Santa Clara County, only one quarter (27%) of children ages 5 to 11 in Santa Clara County were physically active at least 60 minutes per day on 7 days in the past week. The percentage is slightly lower for females than males (26% vs. 29%). The percentage for Asian/Pacific Islanders (20%) and Latinos (27%) is lower than for Whites (40%) (https://www.sccgov.org/sites/phd/hi/hd/Pages/physical-activity.aspx). A 2014 study published by kidsdata.org reported that in Campbell Union School District, 39.9% of 5th graders are overweight or obese 2014. This is compared to the (already high) 34.5% in Santa Clara County. According to the same study, 5th graders in Campbell Union School District meeting fitness standards numbered only 21.4%, compared to 26.6% in Santa Clara County overall. At Playworks, we aim to move towards a solution to this problem by introducing and nurturing the love of play and physical activity, in a safe, healthy, inclusive environment. Playworks randomized control study data reports that at Playworks' schools, children are getting significantly increased vigorous physical activity. We want to keep children healthy, while also building positive connections and leadership at school.
Agency Description & Address	2155 South Bascom Avenue, Suite 201, Campbell Playworks is a national nonprofit. Our vision is that one day every child in the U.S. will have access to safe, healthy play at school every day. Our goal is to establish play and recess as a core strategy for improving children's health and social emotional skills. Playworks' theory of change embraces the notion that a high functioning recess climate and caring adults on campus lead to a positive recess climate, which therefore positively affects the entire school climate. We develop student leaders and create a caring environment on the playground, in the classroom and in the community.

FY19 Healthy Body Proposal Summary

Program Delivery Site(s)	Campbell Union District Schools: • Rosemary Elementary • Castlemont Elementary • Sherman Oaks Elementary • Lynhaven Elementary
Services Funded By Grant/How Funds Will Be Spent	Services include: • TeamUp Program to Rosemary, and Lynhaven Elementary Schools • The Coach program to Castlemont and Sherman Oaks Elementary Schools • Training in Playworks techniques and strategies to yard duty, administrative staff and teachers in each of the schools served. • Collect data on the efficacy of the team up (as well as our coach) program and work in consultation with the schools • TheTeamUp Program will offer the Junior Coach Leadership programs, class game time, and recess leadership. Leagues will be offered at all schools. Full requested funding would support staff and equipment

Pre-diabetes Initiative (Hill & Company)

Program Title	Preventing Diabetes in the Latino Community
Grant Goal	Promote awareness about diabetes and pre-diabetes in the Latino community.
Community Need	As of 2013-14, 11% of Latino adults had been diagnosed with diabetes, compared with 8% of adults in the county; 72% of Latinos were overweight or obese, a higher percentage than adults in the county as a whole (54%); only two-thirds (68%) of Latino adults ages 18 to 64 had healthcare coverage compared to 85% of adults countywide. A lower percentage of Latino adults (57%) had seen a doctor for a routine health checkup during the past year than adults in the county overall (68%), and a higher percentage of Latino adults (20%) reported that cost was a barrier to seeing a doctor when needed in the past year. In 2013-14, a higher percentage of Latino adults (8%) reported that they were usually or always worried or stressed about having enough money to buy nutritious meals in the past 12 months, compared to adults countywide (5%). 18.4% of Santa County Clara residents speak Spanish at home. Among the 324,236 Spanish-speakers, 40.6% report not being able to speak English well. According to the Public Policy Institute of California, in 2008, 180,000 undocumented immigrants lived in Santa Clara County, making up 10.2% of the county's total population. This share of unauthorized immigrants per capita was among the largest in the state. The Latino population is linguistically isolated, unhealthier than the rest of the population, financially challenged, and with higher rates of obesity and diabetes. In addition, being undocumented increases the stress of everyday life. The country's current political climate increases the levels of stress, as day-to-day survival becomes the priority. These factors make it more difficult to reach the Latino population. Sources: https://www.sccgov.org/sites/phd/hi/hd/Documents/Latino%20Health%20Fact%20Sheet_2016_Final.pdf https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF http://www.ppic.org/content/pubs/report/R_711LHR.pdf
Agency Description & Address	1290 B Street, Suite 201, Hayward Hill & Company specializes in the development and implementation of public relations initiatives and strategically focused health communication programs.
Program Delivery Site(s)	The program's services will target Latino adults in San Jose, Sunnyvale, Santa Clara, Mountain View and Campbell.
Services Funded By Grant/How Funds Will Be Spent	Services include implementing promotoras (community health workers) to use several outreach strategies to reach the target audience including: • Administering the CDC Pre-diabetes Risk Assessment in-person and online, providing follow-up phone calls to ensure clinical HbA1c testing for individuals who opt-in and recruitment for an interactive texting program • Conducting one-on-one and community-based diabetes education presentations that include Question and & Answer sessions • Providing weekly information tables at health fairs and local sites, such as the Mexican Consulate Full requested funding would support program staffing for six positions, promotoras, implementation of texting program, microsite, media plan and program supplies.

FY19 Healthy Body Proposal Summary

Santa Clara County Public Health Department

NEW

Program Title	Better Health Pharmacy
Grant Goal	This program will a) increase patient access to medication through a no-cost drug repository and redistribution pharmacy, b)increase patient awareness of hypertension, obesity, and diabetes by offering no-cost health screenings at community health fairs and c)minimize influenza infections by continuing to offer yearly, no-cost walk-in flu vaccinations. These services will be provided by public health pharmacy staff, intern pharmacists, and volunteer pharmacists. The target population is the under-insured and uninsured residents of Santa Clara County. Funding would help support Better Health Pharmacy's mission of "Medication Access for All", and allow for the provision of services to help improve medication adherence and provide access to preventative flu vaccinations.
Community Need	Santa Clara County has about 1.8 million residents. Many Santa Clara County residents, however, do not fill their prescriptions because they cannot afford the high out-of-pocket cost of medications or high copay, even when insured. The data below is from the Santa Clara County Public Health Department, 2013-2014 Behavioral Risk Factor Survey and the 2016 Community Health Needs Assessment in Santa Clara County: • 9% unemployment rate • 11% of adults could not see a doctor in past 12 months because of cost • 7% of adults could not take prescribed medication in past 12 months because of cost • 10% live below Federal Poverty Level (FPL) and 23% of live below 200% FPL • 23% living below self-sufficiency standard when adjusted for high living expenses in Santa Clara County • 15% residents still uninsured; for the Latino community 32% uninsured The resulting health complications due to under-treatment and lack of medication adherence have been shown as one of the greater challenges to the healthcare of the community. It is documented that nationally, up to 18 billion are spent annually in avoidable emergency room visits. A second health need that will be addressed is increasing access to yearly flu vaccinations. Reports from the National Institute of Health (NIH) and Centers for Disease Control (CDC) showed that 5% to 20% of the U.S. population gets the flu. This number equates to 200,000 hospitalizations and 36,000 deaths from the flu annually. In Santa Clara County, it is reported that up to 17% of adults stayed home from school or work because of the flu. Better Health Pharmacy would like to provide yearly flu vaccinations at no-cost to our patients. Lastly, agency would like to offer pharmacist-run, no-cost hypertension, BMI, and diabetes screenings at local health fairs to increase community awareness. In Santa Clara County cardiovascular diseases and diabetes continue to be health priority areas. Per SCCPHD BRFS 2013-2014 and the Santa Clara County Obesity Fact Sheet 2013 findings:

Disease Types Rates	Adults Rates in Santa Clara County	65 years or older
High Blood Pressure	27%	62%
Prediabetes	10%	16%
Diabetes	8%	18%
Overweight	38%	42%
Obese	17%	15%

Without proper screening and treatment, diabetes can lead to eye, nerve, kidney, and foot

	damage. Since many of our residents still lack health insurance, they may not be able to get screened for hypertension, obesity, and diabetes until it is too late. Sources: 1. Santa Clara County Public Health Department (SCCPHD) Behavioral Risk Factor Survey (BRFS) 2013-2014: Access to Healthcare Report. https://www.sccgov.org/sites/phd/hi/hd/Pages/access-to-healthcare.aspx Accessed 1/27/18 2. El Camino Hospital Community Health Needs Assessment 2016. http://www.elcaminohospital.org/CommunityBenefit Accessed 1/27/18. 3. Choudhry et al. Natl Assoc Comm Health Centers. 2007: 1-18 4. CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP) – United States, 2014-2015 Influenza Season. MMWR 2014; 63 (no. 32), 691-97. 5. Fast Facts: Influenza. National Institute of Health (NIH). https://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=133. Accessed 1/28/18. 6. Santa Clara County Public Health Department Epidemiology Department: Communicable Disease. https://www.sccgov.org/sites/phd/hi/hd/Pages/communicable-disease.aspx. Accessed 1/28/18. 7. Santa Clara County Public Health Department Epidemiology Department: Chronic Disease. https://www.sccgov.org/sites/phd/hi/hd/Pages/chronic-disease.aspx. Accessed 1/27/18 8. Santa Clara County Public Health Department Epidemiology Department. Obesity Fact Sheet 2013. https://www.sccgov.org/sites/phd/hi/hd/Documents/obesity-reports/obesity-facts.pdf. Accessed 1/27/18.
Agency Description & Address	976 Lenzen Avenue, 2nd floor, San Jose The Santa Clara County Public Health Department (SCCPHD) focuses on protecting and improving the health of the community through education, promotion of healthy lifestyles, disease and injury prevention, and the promotion of sound health policy. The department is comprised of a highly diverse work force that encompasses many professional disciplines and several main areas of focus. The department includes over 30 programs and services organized across seven divisions and centers.
Program Delivery Site(s)	Better Health Pharmacy is the current location for no-cost prescription medications, and the location of no-cost, walk-in flu vaccinations. Health fairs are held throughout Santa Clara County throughout the year.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Increase patient access to no-cost prescription medications: o Purchase of generic drugs to supplement our current donated medications to treat common chronic conditions such as hypertension, hyperlipidemia, diabetes, rescue breathing medication such as albuterol inhalers, and other common chronic disease states. o Pharmacist volunteer recruitment campaign ▪ Purchase liability insurance for at least 20 new volunteer pharmacists ▪ Regular volunteer appreciation activities for over 30 volunteers • Increase hypertension, diabetes, and obesity awareness o No-cost blood pressure screening at local health fairs o No-cost finger stick blood sugar testing (hemoglobin A1c & random) at local health fairs o 170 Pharmacist hours dedicate to writing new protocols, training, and staffing health fairs • Minimize spread of communicable disease o No-cost walk-in flu vaccination clinic (12.5 hours/week) o 170 Pharmacist hours dedicate to training and staffing free flu clinic Full requested funding would support Public Health Pharmacist to train, staff and support no-cost flu clinics and develop protocols, conduct trainings and staff health screenings, the purchase of generic medications and other cost for liability and promotional materials.

Silicon Valley Bicycle Coalition

Program Title	Pedal2Health
Grant Goal	To continue working with underserved communities, providing the support they need in order to choose bikes over cars for transportation, gain more physical activity and avoid bicycle injuries. These efforts will be led by League Cycling Instructors (LCI's), in partnership with affordable housing developers with whom Pedal2Health has been collaborating in order to address the specific goals and concerns of the residents. Through this partnership, certain barriers to bicycle-centered transportation have emerged and will be addressed, such as lack of access to a bike and various concerns that are primarily affecting women, including personal safety while riding on the road; how to ride with their children; and how to transition from bike seat to office chair without sacrificing her personal appearance. The second year of Pedal2Health will address these areas of concern by partnering with groups who supply bicycles at no cost to low-income families, while teaching basic maintenance and repair skills so that these bicycles don't end up in the corner simply due to an easily-repairable flat tire. Pedal2Health will continue to offer bicycling safety education, with certain workshops dedicated to women in order to create a comfortable space for them to voice their interests and concerns. Group rides will continue, with a twist - "hidden gem" rides, where the group is led on a route that visits interesting murals, landmarks, and little-known points of interest in various San Jose neighborhoods. The fun will continue even outside Pedal2Health group rides, with an app that encourages participants to rack up those miles and earn rewards. All of these activities serve an urgent need - improving health through exercise, which reduces the risks of heart disease and obesity, and has the added benefit of fighting depression.
Community Need	There are several elements of the community health needs assessment that Pedal2Health addresses. Foremost among them are obesity and unintentional falls. While there is a countywide problem with both of these elements, it is especially pronounced in low income communities. With regard to obesity, this affects 49% of Santa Clara County adults making upwards of $70,000 annually, but the rate is higher - 68 percent - for adults making less than $20,000 annually (Santa Clara County Public Health Department, July 2010). When left unchecked, obesity can cause other health problems, including hypertension, heart disease, and diabetes. (Centers for Disease Control and Prevention (CDC), June 2015). Regular exercise is a well-established method of fighting obesity; the recommended amount for adults is 2.5 hours of moderate exercise per week (CDC, June 2015). Getting this exercise through bicycle-based transportation has been found to significantly reduce obesity and its related health problems (Archives of Internal Medicine, July 2009). Through education and encouragement activities, Pedal2Health will help residents of affordable housing developments use the bicycle to help them meet the recommended amount of exercise. While bicycling is a fun, effective way to meet the weekly recommended amount of exercise, it must be done safely. Many of the 14 “Priority Safety Corridors” identified by the City of San Jose as having a high number of injury traffic collisions pass through low income communities (Vision Zero San Jose Two-Year Action Plan, 2017-2018). SVBC is already working closely with several public and nonprofit agencies to address the road conditions that contribute to the injury rate. Pedal2Health will provide additional tools to reduce the risk of injury by educating the affected communities about safe bicycling practices and leading group rides, helping residents put what they learn about safe riding to practice. Sources: Santa Clara County Health Department, July 2010: https://www.sccgov.org/sites/opa/nr/Pages/Santa-

	Clara-County-Public-Health-Department-Releases-Health-Profile-Report.aspx CDC, June 2015 (The Health Effects of Overweight and Obesity): https://www.cdc.gov/healthyweight/effects/index.html CDC, June 2015 (How Much Physical Activity do Adults Need?): https://www.cdc.gov/physicalactivity/basics/adults/index.htm Archives of Internal Medicine, July 2009 (Active Commuting and Cardiovascular Disease Risk): https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/773531 Vision Zero San Jose: http://www.sanjoseca.gov/DocumentCenter/View/56183
Agency Description & Address	96 N. 3rd Street Suite 375, San Jose Silicon Valley Bicycle Coalition (SVBC) was incorporated as a 501(c)(3) in 1993 to create a community that values, includes, and encourages bicycling for all purposes for all people in Santa Clara and San Mateo Counties. SVBC works with government partners, non-profit organizations, business partners, and community members to reach the overarching goal to have 10% of all trips taken by bike in 2025. The intention behind this is to address many of our society's most pressing problems, particularly human health.
Program Delivery Site(s)	Services will be delivered at affordable housing developments in East San Jose, in partnership with the NonProfit Housing Association.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Bike Ambassador Trainings: Pedal2Health's lasting effects rely upon residents of affordable housing developments who, upon program completion, continue to encourage a cycling culture. • Monthly Themed Bicycle Rides: Each ride will be designed in partnership with the resident Bike Ambassador and community nonprofits • Monthly Bicycling Workshops: 12 workshops that cover the basics of safe bicycle commuting • Bicycle Repair and Instruction: Basic bicycle repair or instruction will be part of each Pedal2Health event • "Earn A Bike" Bicycle Distribution: SVBC will partner with bicycle donation organizations, like Turning Wheels For Kids, to provide cost-free bicycles to low income individuals who do not own one • Ride Tracking Game: SVBC has partnered with Ride Report to develop a phone app that will allow users to track their bicycling miles and earn rewards and provide information on the success of Pedal2Health. Full requested funding would support partial salaries for staff and some supplies.

FY19 Healthy Body Proposal Summary

Tower Foundation of San Jose State University

NEW

Program Title	Rehabilitation, Awareness, and Community Education for Stroke (RACES)
Grant Goal	The Rehabilitation, Awareness, and Community Education for Stroke (RACES) program will benefit adults (ages 18 and over) who have had a stroke or traumatic brain injury (BI), as well as community members who would will benefit from outreach and education about topics such as stroke prevention, risk reduction, and stroke warning signs. The program will provide multi-week clinics, individual speech-language therapy and functional cognitive training, group conversational coaching, and therapeutic choir sessions. In addition, quarterly community-based stroke outreach and education efforts will help to raise awareness and educate diverse groups about stroke prevention, risk reduction, and critical interventions necessary following a stroke.
Community Need	Whereas several agencies in Silicon Valley actively provide information about stroke (including the Pacific Stroke Association and Stroke Awareness Foundation), few programs provide sustained rehabilitation as recommended for patient improvement: after patients are discharged from an acute hospital stay, the recommended level of treatment is several hours of therapy each week. In part, this limited service availability is likely related to the national and state-wide shortage of qualified speech-language pathologists (https://www.amnhealthcare.com/latest-healthcare-news/speech-language-pathologists/). Most patients (with either Medicare or other insurance) have limited coverage in the first few months after a stroke or during the first year following a stroke. When patients have exhausted their insurance-approved number of treatments or if they do not have insurance coverage, the standard speech therapy rates of $150 to $180 per hour make the necessary level of aphasia treatment unaffordable for most patients. In addition to financial access, research by the RACES Program Director and her co-author have identified additional barriers to accessing speech therapy and other rehabilitation services, including physical access (getting to the therapy locations) and barriers for certain minority populations (Mahendra & Spicer, 2014). Only the aphasia treatment program at California State University East Bay and the aphasia center of Oakland provide services of similar intensity, so South Bay stroke/BI survivors have no other local support options. According to a report issued by the American Heart Association (Go et al., 2013), nearly 7 million Americans live with the long-term effects of a stroke. One of the most disabling consequences of a stroke is aphasia, a language disorder that severely impairs communication, despite the person's intellect being spared. Indeed, when researchers studied the impact of 75 conditions on quality of life in more than 66,000 adults, stroke and aphasia were found to have the largest negative impact on quality of life, exceeding that of cancer and Alzheimer's disease (Lam & Wodchis, 2010). Aphasia affects over 2 million Americans (Aphasia Access, 2017), including an estimated half a million U.S. veterans. Despite the significant adverse physical, cognitive, and communicative effects of stroke, much research shows that stroke survivors receive an insufficient dosing (amount/duration/intensity) of rehabilitation, contributing to decreased ability and wellbeing for stroke survivors as well as increased burden of care for family members. The RACES program has been designed so that the stroke rehabilitation services will be delivered only on campus at SJSU's Kay Armstead Center for Communicative Disorders (KACCD), part of the Department of Communicative Disorders and Sciences (where the Program Director is a tenured faculty member). The activities planned under the community education and awareness component may be delivered on campus or at off-campus community locations. Sources: Aphasia Access (2017). White paper on the state of aphasia https://aphasiaacc.memberclicks.net/assets/ACFrOgBVgzNeh7J7nOMZG3Uuhstzd-

	C3RK7qybKrmx6kDegF0jAI9FJh2iAco_WjynfI_LxJwt5Ay_3xwdhK0yqCAo7gSvX7H_IdXUQkBjo8hUabBiV7VFXCMtvCdc=.pdf Bernstein-Ellis, E. & Elman, R. J. (2007). Aphasia group communication treatment: The Aphasia Center of California approach. In R. J. Elman (Eds). Group treatment of neurologic communication disorders. San Diego, CA: Plural Publishing. Clark, I., & Harding, K. (2012). Psychosocial outcomes of active singing interventions for therapeutic purposes: a systematic review of the literature. Nordic Journal of Music Therapy, 21(1), 80-98. Go, A. S. et al., (2013). Heart disease and stroke statistics -2013 Update. Circulation, 127(1):e6-e245. DOI: 10.1161/CIR.0b013e31828124ad. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5408511/ Hartley, M. L., Turry, A., & Raghavan, P. (2010). The Role of Music and Music Therapy in Aphasia Rehabilitation. Music and Medicine, 2(4), 235-242. Hayashi et al. (2017). The influence of speech-language-hearing therapy duration on the degree of improvement in poststroke language impairment. Rehabilitation Research and Practice. https://doi.org/10.1155/2017/7459483 Hurkmans, J., de Bruijn, M., Boonstra, A. M., Jonkers, R., Bastiaanse, R., Arendzen, H., & Reinders-Messelink, H. A. (2011). Music in the treatment of neurological language and speech disorders: A systematic review. Aphasiology, 26(1), 1-19. Lam, J.M.C. & Wodchis, W. P. (2010) The relationship of 60 disease diagnoses and 15 conditions to preference-based health-related quality of life in Ontario hospital-based long-term care residents. Medical Care, 48, 380-387. Mahendra, N., & Spicer, J. (2014). Access to speech-language pathology services for African-American clients with aphasia: A qualitative study. Perspectives on Communication Disorders in Culturally and Linguistically Diverse Populations. 21(2), 53-62. doi:10.1044/cds21.2.53.
Agency Description & Address	One Washington Square, San Jose San Jose State University is a major, comprehensive public university located in the heart of Silicon Valley and serving more than 33,000 undergraduate and graduates students each year. The mission of SJSU is to enrich the lives of its students, to transmit knowledge to its students along with the necessary skills for applying it in the service of our society, and to expand the base of knowledge through research and scholarship. SJSU offers 145 areas of study across eight colleges. The Tower Foundation of SJSU is the entity responsible for stewarding philanthropic gifts to support the university and university-led projects such as the proposed activities to be offered through the Department of Communicative Disorders and Sciences in the College of Education.
Program Delivery Site(s)	• Clinical services provided at the Kay Armstead Center for Communicative Disorders (KACCD) on the SJSU campus at One Washington Square, San Jose. • The stroke awareness and community education services provided at the Center for Healthy Aging in Multicultural Populations at SJSU campus and at various locations to engage older adults include collaboration with Silicon Valley Healthy Aging Partnership, Community Ambassadors Program for Seniors, Senior Peer Advocate Program, Hospital to Home Transition (through Yu-Ai-Kai), Academic Nurse Managed Centers, and the Timpany Center.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Two (2) 12-week clinics and one 5-week (summer) clinic • Individual 1-hour speech-language therapy and functional cognitive training sessions • Group 1-hour conversation training sessions: 2 times each week during clinics • Group 1-hour aphasia choir designed to use music and choral singing to improve speech • Four (4) community events during the grant period • Bilingual education materials provided in English, Spanish, Hindi and Mandarin Full requested funding would support partial staff salaries and administrative costs.

FY19 Healthy Body Proposal Summary

Valley Verde

Program Title	San Jose Gardens for Health
Grant Goal	Improve the long-term health outcomes of low-income residents of San Jose through a home-based gardening program which provides raised-bed gardens, supplies and workshops about urban gardening, nutrition and healthy cooking. Valley Verde helps families improve their diet, physical activity, environmental sustainability, and economic self-sufficiency by growing fresh, organic vegetables at home and learning a variety of ways to enjoy them in healthy home-cooked meals. The skills and benefits that families gain from this "seed to table" approach carry forward far beyond the grant period.
Community Need	As described in the El Camino Hospital 2016 Community Health Needs Assessment, Santa Clara County's priority health needs include addressing cardiovascular health, obesity and diabetes, all of which are strongly correlated with diet. According to the report, youth consumption of fruits and vegetables is worse in Santa Clara County than in the state overall, and our county also has more fast food restaurants, fewer grocery stores, and fewer WIC-authorized stores per capita. http://www.elcaminohospital.org/CommunityBenefit • Latinos, which comprise a high percentage of Valley Verde participants, have the highest rates of cardiovascular disease, obesity, and diabetes in our county and also some of the highest rates of poverty. These disparities have been confirmed in various reports, including the ECH 2016 Community Health Needs Assessment and the Santa Clara County Public Health Department's Latino Health Fact Sheet. (https://www.sccgov.org/sites/phd/hi/hd/Documents/Latino%20Health%20Fact%20Sheet_2016_Final.pdf) • Valley Verde's San Jose program reaches the population most in need. Our participants are residents of the highest-need areas shown in the "Santa Clara County Vulnerability Footprint" map in the El Camino Hospital 2016 Community Health Needs Assessment. According to Valley Verde's 2018 intake survey of new participants, 100% of participants are low-income (based on HUD Income Limits for San Jose). 20% have less than a high school education. • Valley Verde's intake surveys also found that 80% of participants have one or more diet-related health conditions, such as diabetes, heart disease and obesity. Sixty-four percent said they faced challenges in obtaining and preparing healthy meals, and only 17% reported having eaten the USDA recommended servings of vegetables the prior day. • Without intervention, the families served will continue along a trajectory of poor diet and poor health outcomes, ultimately resulting in lower life expectancy, as shown by the Santa Clara County Public Health Department's community profile of San Jose. (https://www.sccgov.org/sites/phd/hi/hd/Documents/City%20Profiles/San%20Jose_final.pdf)
Agency Description & Address	376 West Virginia St., San Jose Valley Verde supports the health of Santa Clara County residents by empowering them with the knowledge and skills to grow healthy organic food for themselves and their communities. Since its founding in 2012, Valley Verde has helped low-income families learn to grow healthy food in their own backyards and share that knowledge with others. Programs include teaching gardening and healthy cooking skills to meet each family's cultural needs, encouraging outdoor physical activity, fostering a sense of community as gardeners, and raising awareness of health and environmental issues. Valley Verde also brings leadership and entrepreneurship opportunities to revitalize low-income communities.

Program Delivery Site(s)	• Participants' homes in the Seven Trees neighborhood of San Jose
	• Affordable housing apartment complexes in San Jose through a partnership with The Health Trust's "Food for Everyone" project including:
	  o Cambrian Center Apartments at 2360 Samaritan Place, San Jose
	  o El Rancho Verde Apartments at 303 Checkers Drive, San Jose
	• Community workshops and volunteer days take place at the Valley Verde greenhouse at 321 Gifford Avenue, San Jose

Services Funded By Grant/How Funds Will Be Spent	Services include: • Building of organic vegetable garden beds in low-income family homes, including necessary plants, infrastructure, and supplies for a year • Monthly 90-minute workshops where participants learn about nutrition, healthy cooking, and organic urban gardening techniques. • Monthly hour-long mentorship training classes for alumni of the home gardening program who serve as mentors for new families in the program (i.e. training the trainer) • Monthly in-home visits where mentors provide families with advice, encouragement, resources, and problem-solving about home gardening and healthy cooking • Providing organic seedlings twice a year and additional gardening and nutrition advice on an ongoing basis to families participating in the program for more than a year. • Growing 4,000 organic seedlings in the community greenhouse for use in the home gardens of program participants, with a focus on culturally preferred varieties of crops • Leading monthly public workshops and volunteer days at the community greenhouse Full requested funding would support partial salaries for two staff positions and supplies.

FY19 Healthy Body Proposal Summary

Vista Center for the Blind and Visually Impaired

NEW

Program Title	Vision Rehabilitation Program
Grant Goal	Vista Center is requesting support our Vision Rehabilitation Program for blind and visually impaired adults. Program staff is credentialed in their field of specialty and the Low Vision Optometrists are Board Certified. Initial Assessments are provided by a Licensed Clinical Social Worker. A blind/visually impaired individual may have any combination of following services: Intake Assessment/Case Management, Individual Counseling/Support Group, Information and Referral, Orientation & Mobility training, Daily Living Skills training, Low Vision Exam and Assistive Technology. With the exception of the Low Vision Exam, all other services can be provided in the individual's home or community at a time that is agreed to by staff and the individual. Vista Care's program is effective in helping adults care for themselves safely and effectively in their home environment, travel confidently in the community and access community resources, and maintain a level of adjustment to disability which will prevent isolation and depression. These skills are taught in a supportive environment and are necessary to remain independent.
Community Need	According to the World Health Organization's updated Fact Sheet dated October 2017 (http://www.who.int/mediacentre/factsheets/fs282/en/), "an estimated 253 million people live with vision impairment: 36 million are blind and 217 million have moderate to severe vision impairment. 81% of people who are blind or have moderate or severe vision impairment are aged 50 years and above." The National Federation for the Blind reports that in 2015, 768,267 Californians had vision loss, 17% ages 18-64 years and 43% ages 65-74 years old. http://www.afb.org/info/blindness-statistics/state-specific-statistical-information/california/235 "Seniors who have a visual trouble or deficit are 1.5-2.0 times more likely to fall than those who do not. Visual impairment adversely affects perception of environmental elements that can cause a fall. By also interfering with perception and use of static and dynamic visual information, it compromises balance and posture and increases risk of falls. Seniors with a visual impairment are generally less active, which may cause a reduction in functional abilities and, in return, a sensory loss. This closed loop may cause degradation in efficiency of the anticipatory process and postural regulation, a reduction of dynamic balance and increased risk of falls. In addition, fear of falling, common in older persons with VI, is a significant predictor of a future fall. It can lead to a reduction in self-confidence and activities and, consequently, deterioration in physical capabilities and quality of life." http://www.inlb.qc.ca/wp-content/uploads/2015/01/Prevention-of-falls-among-seniors-with-VI-Final.pdf Without vision rehabilitation services, it becomes challenging for visually impaired/blind adults and seniors to live independently and safely in their own homes.
Agency Description & Address	2500 El Camino Real, Suite 100, Palo Alto Vista Center for the Blind and Visually Impaired's mission is to empower individuals who are blind or visually impaired to embrace life to the fullest through evaluation, counseling, education and training. We know that individuals who have significant vision loss can utilize resources and learn new ways of doing the tasks of daily living, thereby regaining their independence. We provide comprehensive vision loss rehabilitation services and resources to individuals who are blind or visually impaired in Santa Clara, San Mateo, Santa Cruz, and San Benito Counties regardless of ability to pay. In FY17, we served over 2400 families and individuals.

FY19 Healthy Body Proposal Summary

Program Delivery Site(s)	Services will be delivered at the agency or in the patient's home.
Services Funded By Grant/How Funds Will Be Spent	Services include: • One hour Initial Assessments • One hour Individual or Group Counseling • One hour Daily Living Skills • 1.5 hours Orientation & Mobility • One hour Assistive Technology • 75 minute Low Vision Exams Full requested funding would support the partial salaries of an Associate Director, Social worker, Assistant Technology Specialist, Orientation & Mobility Specialist, Daily Living Skills Specialist, Community Relations Manager, two contractors and facilities.

To improve the mental health and wellbeing of the community by providing services and increasing access to services that address serious mental illness, depression, and anxiety related to issues such as dementia, domestic violence, substance use, and bullying.

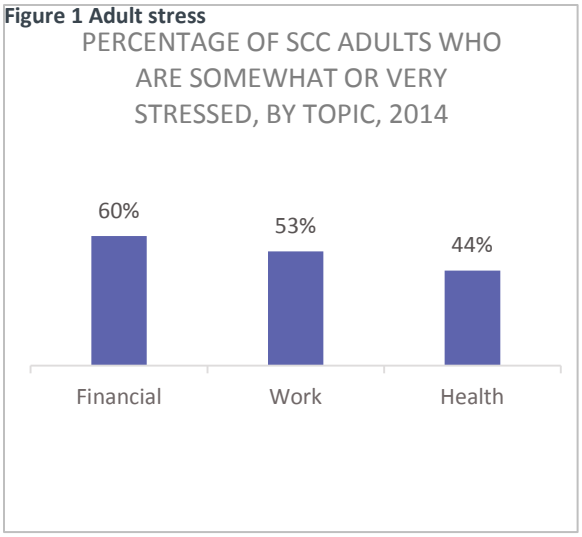
Healthy minds are essential to a person's wellbeing, family functioning, and interpersonal relationships. Good brain function and mental health directly impact the ability to live a full and productive life. People of all ages with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide. Those affected by dementia experience a decline in mental ability, which affects memory, problem-solving, and perception. The resulting confusion often also leads to depression, aggression, and other mental health issues.[1] Caregivers of those with dementia also experience depression.[2] Mental health disorders can also impact physical health and are associated with the prevalence, progression, and onset of chronic diseases, including diabetes, heart disease, and cancer.

DATA FINDINGS

Services to address the needs in the Healthy Mind priority area are demonstrated by the following statistics:

- **Behavioral Health** was prioritized as a top need of the community. This need includes mental health, wellbeing (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

Figure 1 Adult stress



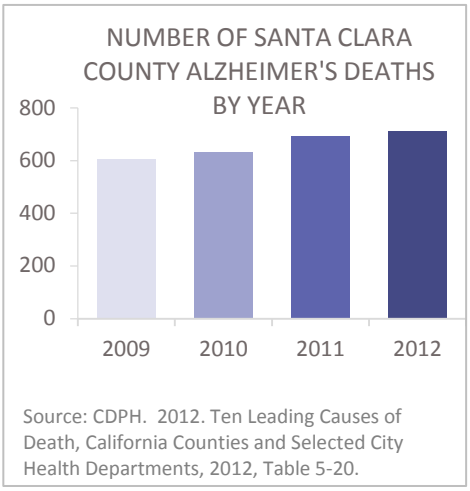
Source: Santa Clara County Public Health Department. (2014). Behavioral Risk Factor Survey.

[1] Alzheimer's Association. https://www.alz.org/care/alzheimers-dementia-depression.asp.
[2] Alzheimer's Association. https://www.alz.org/care/alzheimers-dementia-caregiver-depression.asp

months. Through focus groups and key informant interviews, the community discussed the stigma that persists for those who experience mental illness. They also expressed concern about behavioral health for older adults, LGBTQ residents, and those of particular ethnicities/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.

- **Alzheimer's Disease and Dementia:** Alzheimer's disease was the third leading cause of death in 2012, accounting for 8% of all deaths.[3] 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).[4] 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.[5] 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 dementia and Alzheimer's disease, which is a concern given the increasing proportion of older adults.

Figure 2 Alzheimer's deaths



Source: CDPH. 2012. Ten Leading Causes of Death, California Counties and Selected City Health Departments, 2012, Table 5-20.

STRATEGIES TO IMPROVE HEALTHY MINDS

1. Increase access to psychiatric services, case management and medication management for at-risk adults
2. Increase access to individual/group counseling, crisis intervention and addiction prevention education for youth through staffing of school-based services
3. Promote developmental assets and skill-building for youth
4. Increase access to programs and services for patients and families coping with Alzheimer's Disease and Dementia, such as respite care and culturally relevant efforts to mitigate stigma and encourage early diagnosis
5. Reduce isolation and depression amongst seniors

[3] CDPH, *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.
[4] 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.
[5] Silicon Valley Institute for Regional Studies, *Population Growth in Silicon Valley*, 2015.

HEALTHY MIND PROPOSALS

1. Almaden Valley Counseling Service – *page 58*
2. Alum Rock Counseling Center – *page 60*
3. Alzheimer's Disease and Related Disorders Association, Inc. (Alzheimer's Association) –*page 62*
4. Bill Wilson Center – Child Abuse Therapy Program (CHAT) – *page 63*
5. Cambrian School District – School Mental Health Counseling Program – *page 64*
6. Child Advocates of Silicon Valley – *page 65*
7. Counseling and Support Services for Youth (CASSY) – *page 67*
8. Cupertino Union School District – School Mental Health Counseling Program – *page 69*
9. Jewish Family Services of Silicon Valley – *page 71*
10. LifeMoves – *page 73*
11. Momentum for Mental Health – *page 75*
12. Peninsula HealthCare Connection – Psychiatric Services – Medication Management – *page 76*
13. Respite and Research for Alzheimer's Disease – *page 78*
14. Teen Success, Inc. – *page 80*
15. Uplift Family Services (formerly EMQ Families First) – Addiction Prevention Services –*page 82*
16. YWCA of Silicon Valley – *page 84*

HEALTHY MIND RECOMMENDED FUNDING: $1,114,860

Detailed descriptions of partner programs in the Healthy Mind area follow. The Community Benefit Advisory Council (CBAC) consensus guided the funding recommendations found in the Plan.

FY19 Healthy Mind Proposal Summary

Almaden Valley Counseling Service (AVCS)

Program Title	Counseling and Social Skills for Children
Grant Goal	To help support the Counseling and Social Skills for Children program at 20 local elementary and middle schools and address the children's emotional health needs. The goal is to address in a positive manner each child's emotional state to allow each individual child the opportunity to thrive and succeed at school, at home, and to gain an emotionally healthy future. Counselors assess children's emotional health needs which may range from very mild to very severe and require some combination of on-campus group or individual therapy and possibly off-school campus treatment. A variety of psychotherapy models will be used depending on each child's presenting diagnosis. Children with very mild emotional therapeutic needs can enroll directly into the Social Skills classes. As a child with more intense emotional health needs improves they too can enroll in the social skills classes to help cement a healthy future.
Community Need	AVCS has seen a greater need for individual therapy treatment regimens at schools and therefore has conducted fewer group therapy sessions. However, with the addition of school site individual therapy treatment regimens, students will be served more intensively. The trends impacting AVCS' ability to provide more group therapy at school sites are: (1) a constant need to provide crisis intervention and assessment at all schools as well as (2) dealing with children that are more emotionally impaired and require a large amount of monitoring and intervention on an as-needed basis. Many of these students have complicated mental health issues and it seems that some of them need a higher level of care than what school therapy/counseling can provide. AVCS is seeing a general trend toward aggressive thinking about others and they are seeing this trend at all school levels, from kindergarteners with anger issues and impulse and empathy concerns, to middle and high school students who are aggressively planning to hurt themselves or others with anger issues. The following trends and needs are seen in the local school population: • Major barriers to accessing counseling services are location and affordability • Emotional health needs of the children increasingly seem to require individual versus group therapy treatment modalities well beyond mere social skills training. • Santa Clara County's Department of Mental Health has identified a number of risk factors including socioeconomic, family structure, linguistic isolation and housing status that can influence the life chances for the child in terms of risk factors based on the analysis in the Prevention and Early Intervention (PEI) Plan. To help assess behavioral health service needs for children and youth, the County has commissioned compilations of risk factors to help predict which areas of the county might be have greater need for such services. Residential zip codes serve as the units of analysis. AVCS identifies schools where needs are greatest using this Santa Clara County Behavioral Health Services Prevention Intervention and Planning 2013 Risk Zip Code Average Map available by contacting the School Linked Services Program: http://www.schoollinkedservices.org
Agency Description & Address	6529 Crown Boulevard, Suite D, San Jose AVCS offers a range of mental health counseling services, supporting personal growth, positive family relationships and emotional well-being. The agency serves children, teens, adults, families and couples who reside in 42 of the County's 57 zip codes with 73% of clients paying at the lowest fees available ($15-$35). AVCS provides on-site school based counseling services, crisis intervention, assessments and referrals at 41 area schools in four districts. The organization focuses on prevention and intervention, helping parents work proactively towards improving their relationships with their children by providing Positive Parenting and Co-Parenting classes

	and serving victims of domestic violence, substance abuse and clients at risk for suicide. AVCS also provides programs for Victim Witness, Valley Medical, Depts. of Social Services, Family and Children Service, and County Mental Health.
Program Delivery Site(s)	Services will be provided at 20 high needs schools identified in the following school districts: • Cambrian • Orchard • San Jose Unified • Union
Services Funded By Grant/How Funds Will Be Spent	Serving children schools identify has having a range of social developmental asset needs, the program provides: • Emotional and psychotherapy services to children at high-needs local elementary and middle schools • Culturally relevant services provided in several languages (English, Spanish, and Vietnamese) • Implementation of a variety of counseling approaches tailored to children's presenting diagnosis • Referrals to off-school campus services as needed Full requested funding will support partial staff salaries, including therapists and clinical supervisor, intern stipends and other administrative costs.

FY19 Healthy Mind Proposal Summary

Alum Rock Counseling Center

Program Title	Ocala Mentoring Program
Grant Goal	Serve at-risk middle school youth before they fall into a cycle of truancy, gang-involvement and school failure. The overarching goals of the Ocala Mentoring Program are to decrease involvement in high-risk behaviors, increase involvement in safe, age-appropriate activities, improve academic outcomes and reduce middle school drop-out rates.
Community Need	Research reveals Latino youth face a greater likelihood than other demographic groups to be involved with the juvenile justice system. They are three times more likely to be arrested than their Caucasian counterparts (Lucille Packard Foundation for Children's Health (2016) Kidsdata.org http://www.kidsdata.org/topic/166/juvenilearrest-rate-race/table) and twice as likely to be committed or detained (The Sentencing Project (2017), https://www.sentencingproject.org/publications/latino-disparities-youth-incarceration). This is particularly concerning because youth who have contact with the juvenile justice system are at increased risk for a number of negative long-term outcomes—including substance use and dependency, early pregnancy, and dropping out of school (PolicyforResults.org. (n.d.). Prevent juvenile delinquency. From: http://www.policyforresults.org/youth/prevent-juvenile-delinquency) In fact, in Santa Clara County the high school dropout rate for Latino students in 2015 was 21%, the highest dropout rate of any ethnic group (Lucille Packard Foundation for Children's Health (2016) Kidsdata.org http://www.kidsdata.org/topic/755/highschoolgraduates-race/table). Latino youth have the highest rates of suspension and expulsion throughout the county (Santa Clara County, 2013, Health Status and Quick Facts https://www.sccgov.org/sites/phd/hi/hd/Pages/violence.aspx). Additionally, there is a significant academic achievement gap between Latino youth and their non-Latino counterparts. According to the 2016 CAASPP test results, only 26% of Latino youth in Santa Clara County met or exceeded grade-level standards in math and only 37% met or exceeded grade-level standard in English language arts, representing the lowest rates of all ethnic groups in the county (Lucille Packard Foundation for Children's Health (2016) Kidsdata.org http://www.kidsdata.org/topic#cat=18,25,22). Students with limited reading abilities have a harder time keeping up across multiple subjects, and those who fall behind in the early grades generally stay behind (Child Trends Databank. (2015). Reading proficiency. Retrieved from: http://www.childtrends.org/?indicators=reading-proficiency). Often contributing to these academic challenges are a variety of environmental risk factors. East San José has some of the highest rates of child abuse referrals and violent crimes of any region in Santa Clara County (Santa Clara County, City and Small Area/Neighborhood Profiles, https://www.sccgov.org/sites/phd/hi/hd/Documents/City%20Profiles/San%20Jose%20Neighborhoods/AlumRockEast.pdf). Residents predominately work low wage and low skilled jobs and East San Jose has one of the highest rates of poverty in the county, with 50% of families living below the poverty line. (United Way Bay Area (2016). A Look at Bay Area Poverty. https://uwba.org/wp-content/uploads/2017/08/Bay_Area_Poverty_Brief_June_2016.pdf). Children living in poverty are more likely to become victims of crime and violence and are at greater risk of unhealthy behaviors such as gang membership, runaway behavior, and juvenile delinquency (Children's Defense Fund (2017). The State of America's Children 2017 Report. http://www.childrensdefense.org/library/state-of-americas-children/). To succeed academically as a student in East San Jose often requires comprehensive support services, which go way beyond basic academic tutoring.
Agency Description	777 North First St. Suite 444, San Jose

FY19 Healthy Mind Proposal Summary

& Address	Since its inception in 1974, the work of ARCC has remained largely the same –to provide linguistically and culturally sensitive behavioral health and support services, which enable low-income, predominantly Latino youth and families in East Santa Clara Valley to improve their lives and reach their full potential. ARCC's Continuum of Care includes over a dozen different programs, which provide mentoring, life skills development, truancy reduction, mobile crisis response, counseling, drug and alcohol services, case management, child abuse/neglect prevention and outreach. ARCC aims to keep youth safe, attending school and living lives free from juvenile justice and dependency systems, substance abuse and violence.
Program Delivery Site(s)	Ocala STEAM Academy at 2800 Ocala Avenue, San Jose
Services Funded By Grant/How Funds Will Be Spent	Services include: • Life-skills classes using Botvin Life Skills Curriculum to improve students' Personal Self-Management Skills, e.g., social skills and Drug Resistance Skills • One-on-One Case Management • Individual Mental Health Counseling • Mentoring Group sessions for 6th graders and 1:1 mentoring for 7th and 8th graders: offer inspiration role models and includes homework time • Parent Collateral /Family Engagement: Educate families about the importance of being involved with their child's academic progress • After School Academic Tutoring • Enrichment Activities/Field Trips • School Climate Workshops Full requested funding supports partial salaries for several staff roles including bilingual counselor, volunteer coordinator, program manager and clinical program director.

FY19 Healthy Mind Proposal Summary

Alzheimer's Disease and Related Disorders Association, Inc. (Alzheimer's Association)

NEW

Program Title	Latino Family Connections--Dementia Initiative
Grant Goal	This program will provide culturally and linguistically relevant services to Latino residents dealing with Alzheimer's Disease and Related Dementias (ADRD).
Community Need	In Santa Clara County, Latinos/Hispanics living with ADRD numbers over 5,000 community members. Data analysis shows that by 2030, there will be over 275,000 Latinos/Hispanics who will be living with ADRD in California. Data suggests that the Latino population may be at greater risk of developing ADRD than any other ethnic or cultural group due to evidence that indicates that vascular disease risk factors—including diabetes—may also be risk factors for ADRD incidence. Data also suggests that Latino/Hispanics with dementia are low users of formal health care services.
Agency Description & Address	2290 North 1st Street, Suite 101, San Jose The Alzheimer's Association works on a global, national, and local level to enhance care and support for all those affected by Alzheimer's and related dementias.
Program Delivery Site(s)	Services will be delivered at clinics, housing sites and community centers.
Services Funded By Grant/How Funds Will Be Spent	Services will include: • Providing program staffing, including part-time Family Care Specialist and Community Relations Manager • Improving awareness and understanding of Alzheimer's disease within Latino communities by providing linguistically and culturally appropriate outreach • Linking families and caregivers to services available through the Alzheimer's Association and other related resources, including care consultation services and support groups Full requested funding would support partial staffing and program supplies.

FY19 Healthy Mind Proposal Summary

Bill Wilson Center

Program Title	Child Abuse Therapy Program (CHAT)
Grant Goal	Provide comprehensive treatment and psychotherapy clinical services to Santa Clara County children and youth (2-17 years) who are victims of physical abuse, sexual abuse, sexual exploitation, neglect, abandonment, parental substance abuse, domestic violence, as well as those who are witnesses of community and school violence. The CHAT program serve dependents of the court, children in the child welfare systems (under 18), those emancipating out of the system or their family, and other under-served children.
Community Need	Youth who have witnessed domestic and other violence have higher rates of behavioral and emotional problems than other children. During 2015, more than 1,785 Santa Clara County (SCC) children and youth, ages birth to 17, were victims of sexual, physical, emotional abuse; suffered from general to severe neglect; experienced exploitation; were at-risk of sibling abuse; were left alone due to caretaker absence or incapacity, and/or were put at substantial risk of safety and well-being. Of the substantiated cases of child abuse for children under 18, African American youth under 18 had the highest rate (86.2 per 1000) followed by Latinos (45.9 per 1000) (https://www.kidsdata.org/topic/9/childabuse-cases-type/table#fmt=1045&loc=59&tf=84&ch=19,18,17,16,15,13,14,12,20&sortColumnId=0&sortType=asc). The Department of Family and Children Services provides the primary intervention programs available for abused, neglected and exploited children. However, the County's mental health system continues to face budget cuts each year and relies on partner agencies, such as Bill Wilson Center, to assist in providing mental health services in a timely manner.
Agency Description & Address	3490 The Alameda, Santa Clara Since 1973 Bill Wilson Center (BWC) has been providing essential and comprehensive services that address the unmet needs of youth, families, and individuals in our community. The mission of BWC is to support and strengthen the community by serving youth and families through counseling, housing, education and advocacy. BWC's vision is to prevent poverty by building connections for youth and families. Every youth who walks through our doors is helped with building skills and resiliency, with the goal of becoming a healthy, self-sufficient adult.
Program Delivery Site(s)	Piedmont Hills High School, Eastside Union High School District in San Jose
Services Funded By Grant/How Funds Will Be Spent	Services include: • Psychotherapy Treatment services to youth • Referrals, crime victim compensation services and other information about victim/witness compensation services • Assisting child victims in understanding and preparing to participate in the criminal justice system. Full requested funding would support partial salary for staff including therapists.

FY19 Healthy Mind Proposal Summary

Cambrian School District

Program Title	Multi-Tiered System of Supports Behavioral Health Services
Grant Goal	To continue a Student Services Multi-Tiered System of Supports at Cambrian School District to support the whole child in a social-emotional-behavioral health model. The Student Services department specifically is planning for the 2018-2019 school year to advance efforts around student wellness by intentionally structuring initiatives, funding, and resources to allow for improved coordination, coherence, greater sustainability, and increased outcomes for the whole Cambrian community including students, families, and staff.
Community Need	Behavioral mental health services are needed to support crisis intervention and long-term intervention for student mental health needs, and for staff professional development and consultation for teachers and administrative staff to keep up to date with compliance, school safety, and preventative measures. The school district is seeing numbers of students with behavioral mental health needs are increasing. More students have been identified with adverse childhood experiences, trauma, unstable households/families which sometimes requires immediate intervention and ongoing intervention on a school campus to work directly with students and train staff. The program will help address our intervention (Tier II) and intensive (Tier III) level needs for students in our schools by creating a support structure needed for adequate learning accessibility for students. Without behavioral health services, some students are unable to safely attend school on an immediate and consistent basis, which impacts their attendance and long-term learning outcomes. It is best practice for school districts to have adequate staffing to intervene and have a prevention model of social/emotional/behavioral supports in place.
Agency Description & Address	4115 Jacksol Drive, San Jose Cambrian School District is elementary school district located in the Cambrian Park area and serves approximately 3,500 students in Preschool through 8th grade. All five of the district's traditional schools have been recognized as California Distinguished Schools. Cambrian opened a sixth school in Fall 2016 at Steindorf K-8 STEAM Magnet school.
Program Delivery Site(s)	The services will be delivered to all 6 schools in the district, which includes four elementary schools, one middle school and one alternative school.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual, group, parent and family counseling sessions • Crisis intervention and case management • Classroom interventions • Consultation to teachers and school administrators • School day and after-school services Full requested funding would support two full-time MFTs and partial salaries of school psychologist fieldworkers and interns, and other administrative costs.

FY19 Healthy Mind Proposal Summary

Child Advocates of Silicon Valley

Program Title	Advocacy Program for Foster Teens
Grant Goal	The Advocacy Program for Foster Teens provides support to 400 Santa Clara County foster pre-teens/teens ages 11-18 by providing them with a Court Appointed Special Advocate (CASA), who helps ensure youth do not slip through the cracks of overburdened foster care and education systems. CASAs work to ensure their teens receive appropriate educational support and develop healthy self-care habits. CASAs assist children in working toward successful emancipation from the foster care system and help them make important decisions about remaining in the dependency system, attending college, finding a home, and securing a job.
Community Need	As a result of experiencing abuse, neglect, and trauma, foster youth are susceptible to a variety of physical and emotional challenges. According to the 2016 California Children's Report Card published by Children Now (https://www.childrennow.org/files/6214/5192/8816/CN-2016CAChildrensReportCard.pdf) only 45% of California foster youth finish high school on time, compared to 79% of all California youth, and only 2-9% of California's foster youth earn a bachelor's degree. Furthermore, a 2016 study published by the American Academy of Pediatrics notes that foster children are at a "significantly higher risk of mental and physical health problems – ranging from learning disabilities, developmental delays and depression to behavioral issues, asthma and obesity – than children who haven't been in foster care." (Mental and Physical Health of Children In Foster Care," Kristin Turney, Christopher Wildeman. American Academy of Pediatrics http://pediatrics.aappublications.org/content/early/2016/10/14/peds.2016-1118.full). The study, which compared foster children to children who had never been in the dependency system, found that foster children were: • Seven times as likely to experience depression • Six times as likely to exhibit behavioral problems • Five times as likely to feel anxiety • Three times as likely to have attention deficit disorder, hearing impairments and vision issues • Twice as likely to suffer from learning disabilities, developmental delays, asthma, obesity and speech problems Providing foster youth with a CASA may help combat many of these bleak statistics. A 2015 report from the America's Promise Alliance found that supportive, adult relationships lessen the effects of adversity for youth and that youth are more likely to be successful in life when they have meaningful adult connections (http://www.americaspromise.org/sites/default/files/d8/2016-10/18006_CE_BGN_Full_vFNL_0.pdf).
Agency Description & Address	509 Valley Way, Building, Milpitas Child Advocates mission is to provide stability and hope to children who have experienced abuse and neglect by being a powerful voice in their lives. To achieve this, the agency recruits, trains and supports volunteer Court Appointed Special Advocates (CASAs) to work one-on-one with foster children. Child Advocates is the only agency in Santa Clara County providing this critical service. Statistics show that the stability and support of a CASA results in better outcomes for foster children– they receive more services while in the dependency system, are more likely to find a safe, permanent home, are less likely to experience multiple home placements, do better in school and spend, on average, 8 months less time in foster care than children without a CASA.

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Program Delivery Site(s)	Services will be provided at agency site.
Services Funded By Grant/How Funds Will Be Spent	Bilingual services to foster teens include: • Recruit, train and certify CASAs (Court Appointed Special Advocates) • Match foster youth with a CASA • Academic and emotional support to middle and high school age foster youth • Support for transitioning out of the dependency system and navigate significant milestones Full requested funding would support part of the volunteer coordinator position to manage the CASA volunteer program.

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Counseling and Support Services for Youth (CASSY) NEW

Program Title	Comprehensive Mental Health Support for Youth Attending Campbell Union School District
Grant Goal	To support a partnership with the Campbell Union School District (CUSD) to provide on-campus mental health support and resources in all twelve K-8 grade schools. CUSD will provide funding to supplement this partnership with CASSY.
Community Need	Mental health services are in great demand in Campbell and across the Greater San Jose community. More than half of all staff across Campbell Union cited the need for more support in meeting students' social-emotional needs, and 55% of staff in Campbell high schools felt that depression or other mental health issues were a moderate or severe problem at their school. Over 50 Campbell high school students annually were referred to CASSY for more intensive support due to potential self or interpersonal harm. According to a 2013 Community Health Needs Assessment conducted by Kaiser Permanente San Jose, mental health is one of the critical health needs in the San Jose Service Area, as marked by a percentage of self-reported poor mental health that is higher than the state average. The assessment showed that Latino and African-American youth disproportionately exhibit symptoms of depression, and African-American youth additionally experience suicidal ideation in rates higher than the county-wide average. Community input indicated that the health need is likely being affected by stress (driven by financial/economic and social concerns) and the lack of education about how to cope with stress; stigma about mental illness leading to fear and denial; lack of knowledge about mental health treatment; and poor access to mental health care providers and specialists. PTSD and other behavioral consequences of trauma - which have been present in CUSD students - are often related to environments where stress and mental health issues have led to violence and substance abuse. More recently and more broadly, Children Now's California Children's 2018 Report Card gave California a D+ for Mental Health & Building Resilience. According to the report, mental health is the number one reason California kids are hospitalized, and only 35% of California children who report needing help for emotional or mental health problems received counseling. Adverse Childhood Experiences (ACE's) are physical, emotional or social events that are stressful or traumatic. Of California children, 42% experience one or more ACE (examples of ACE's include: abuse, neglect, and household dysfunction). CASSY works to reverse these trends by breaking down barriers to help, offering mental health supports that are free, easily accessible, and build resilience in youth. CUSD serves a diverse community, and a large percentage of Hispanic and Latino students (47%). CASSY currently works with students from Campbell Union High School District, who mirror the mental health needs reflected in the Kaiser Permanente study. In a given year, 1 in 5 young people in Santa Clara County experience mental health issues such as depression, anxiety, substance abuse, or suicidal thoughts. Only one-third of children who are actually diagnosed will receive treatment; for teens living in poverty, only 10% will receive help. Despite the clear need for support, there are few community-based mental health providers in the San Jose area, forcing families on long car or bus rides, something they often cannot afford or logistically manage. Complicated insurance battles, the cost of private care, and the stigma associated with mental health issues also act as barriers to proper treatment. Left untreated, mental health issues have a profound impact on a student's academic achievement and future prospects. Research links unmet mental health needs with lower grades and test scores, higher rates of suspension, expulsion, and truancy, and an increased likelihood of dropping out of school altogether. Simply put, a child cannot properly focus on school when she is depressed, anxious, grieving, or scared. Teachers and parents are often at a loss as to how

	to manage the situation. Too often, the result is a child who becomes disruptive or withdrawn at school, who abuses substances, or who, in the most tragic cases, dies by suicide--the third leading cause of death for young people today. Sources: (1) https://share.kaiserpermanente.org/wp-content/uploads/2013/09/Oakland-CHNA-2013.pdf (2) 2018 California Children's Report Card, Children Now
Agency Description & Address	Sobrato Center for Nonprofits, 544 Valley Way, Milpitas Counseling and Support Services for Youth (CASSY) partners with local elementary, middle and high schools to provide free comprehensive mental health services to students on campus. Our mission is to de-stigmatize mental health services and make supporting students' social and emotional well-being the norm in our schools. In just eight years, CASSY has grown from a small summer program in the Ravenswood City School District, to a community-based organization providing a mental health safety net for 33,000 students at over 40 public schools in Palo Alto, East Palo Alto, San Jose, Milpitas, Los Gatos, Saratoga, and Campbell. Our school-based programs and services aim to provide all students with the continuity of social and emotional support they need to be successful in school and life.
Program Delivery Site(s)	All 12 elementary and middle schools Campbell Union School District: • Campbell School of Innovation • Monroe Middle School • Rolling Hills Middle School • Blackford Elementary • Capri Elementary • Castlemont Elementary • Forest Hill Elementary • Lynhaven Elementary • Marshall Lane Elementary • Rosemary Elementary • Sherman Oaks Community Charter • Village School
Services Funded By Grant/How Funds Will Be Spent	Services include: • Individual assessment and mental health treatment planning • Individual and Group Counseling • Preventative Mental Health Education • Staff Consultation and Training • Parent Consultation, Training, and Community Outreach • Crisis Intervention and Re-entry Support Full requested funding would support 7.5FTE school-based therapists and partial salary for the site supervisor.

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Cupertino Union School District

Program Title	Cupertino Union School District Counseling Intern Program
Grant Goal	To continue support of the Cupertino Union School District (CUSD) Counseling Intern Program providing individual, group, and family therapy to students and their families. Therapists also provide consultation, crisis intervention, and case management services for each school site. The services are provided to students in both elementary and middle schools who are demonstrating challenges with mental health issues that impact their ability to access their education.
Community Need	Students who are impacted by mental illness are challenged in life functioning. These challenges often impact a student's ability to fully access their education. There is a lack of access to mental health services in the community, and The CUSD Counseling Intern Program provides easily accessible counseling services to youth. The El Camino Hospital 2016 Community Health Assessment documented, "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."(http://www.elcaminohospital.org/CommunityBenefit) . Kidsdata.org documented that 22.6% of youth living in Santa Clara County reported needing help for emotional or mental health problems. Of those youth, only 67.3% received mental health services (http://www.kidsdata.org/). Additionally, according to the California Healthy Kids Survey completed in 2015, 14% of seventh grade students in the Cupertino Union School District experienced sadness and hopelessness (http://surveydata.wested.org/resources/Cupertino_Union_1516_Elem_CHKS.pdf). • The California Health Interview Survey (CHIS) reported a marked increase in teens reporting the need for emotional and mental health support. The most recently reported rate of 24.6% of teens needing emotional and mental health support in Santa Clara county was the highest it has been since 2005 with the previous highest rate of 20.8% being reported in 2011 (http://healthpolicy.ucla.edu/). • The El Camino Hospital 2016 Community Health Needs Assessment documented that "Close to four in ten (38%) Santa Clara County residents report poor mental health on at least one day in the last 30 days." The same report stated that violence and abuse is a problem in Santa Clara County which could be the reason why "a majority of youth report having been victims of physical, psychological, and/or cyber bullying". The report also indicated that the health need is affected by the following factors: "…poor family models, unaddressed mental and/or behavioral health issues among perpetrators…" (http://www.elcaminohospital.org/CommunityBenefit) • Statistics from the National Institute of Mental Health indicate that the incidence of teen mental illness was stable for 10 years through the early 2000s, the latest data available. Those surveys show that 25 percent of teens have suffered anxiety at some time in their lives, 11.2 percent major depression and 2.4 percent agoraphobia." (www.nimh.nih.gov/health/statistics/index.shtml) • The above data demonstrate that mental health services are needed to support youth in the community and at schools. The article, Children's Mental Health What Every Policymaker Should Know by Shannon Stagman and Janice L. Cooper, 2010, (http://www.nccp.org/publications/pdf/text_929.pdf) cites that "one in 10 youth has serious mental health problems that are severe enough to impair how they function at home, in school, or in the community." They go on to state, "Roughly half of all lifetime mental health disorders start by the mid-teens." The need for school-based mental

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	health services has been documented over the last 15 years. The National Association for School Psychologists (NASP) stated in their article An Overview of School-Based Mental Health Services, (https://www.nasponline.org/resources-and-publications/resources/mental-health/school-psychology-and-mental-health/school-based-mental-health-services).
Agency Description & Address	10301 Vista Drive, Cupertino The Cupertino Union School District is the largest elementary school district in northern California. The District is comprised of approximately 1,700 employees serving over 18,000 students in 19 elementary schools, one K-8 school, and five middle schools throughout the city of Cupertino and parts of the cities of Sunnyvale, San Jose, Saratoga, Los Altos, and Santa Clara.
Program Delivery Site(s)	All five middle schools in the Cupertino Union School District (Hyde, Cupertino, Miller, Lawson and Kennedy) and as-needed by referral at elementary schools in the school district.
Services Funded By Grant/How Funds Will Be Spent	Services include: • 30-60 minute, weekly Individual, group, and family counseling • Suicide and Self-harm risk assessment as needed • Crisis intervention as needed • Case Management, weekly, approximately 2-3 hours per week • Collaboration with school staff, weekly, approximately 5 hours per week Full requested funding would support 1 FTE and 4 part-time Marriage and Family Therapists and other administrative costs.

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HEALTHY MIND

Jewish Family Services of Silicon Valley

NEW

Program Title	To Life! Wellness for Seniors
Grant Goal	Jewish Family Services is requesting support to increase access to and expand our existing mental health and social services for approximately 150 lower-income, socially isolated older adults. The services will be provided onsite at Chai House Senior Living Community where the agency, JFS SV, opened a branch office in July 2017. This will result in earlier diagnosis of mental health and social issues, as well as decreased isolation and institutionalization. The services will be provided year-round by a skilled social work team, with expertise in gerontology; as well as a part-time psychiatrist. JFS will coordinate care with the San Jose State University nursing team onsite at Chai House. Services will include individual therapy, group counseling, health-related workshops, medication consultation, and linkages with relevant service providers (medical, psychiatric, social services) as needed; and be available in English and Russian. Services are needed in particular due to an increase in new Section 8 residents with significant mental health diagnoses and financial issues moving into Chai House. A few of the newest residents were recently homeless, and thus, present with PTSD and other issues. JFS is working with a much more challenging population than had resided in Chai House in the past. This trend is likely to continue to grow with the housing scarcity in Silicon Valley. The program is largely evidence-based in that it incorporates well-researched interventions based on clinical experience and ethics; along with client preferences and culture to inform how services are delivered. Earlier diagnosis of mental health and social issues will result in decreased isolation and institutionalization, and an overall healthy living environment for all Chai House residents.
Community Need	Chai House, a 144-unit senior residence, is located in North Willow Glen, in the 95126 zip code. As described in Santa Clara County City and Small Area/Neighborhood Profiles for 2016, (https://www.sccgov.org/sites/phd/hi/hd/Documents/City%20Profiles/San%20Jose%20Neighborhoods/NorthWillowGlen_neighprofilesPDF5110013.pdf) the median household income for North Willow Glen was $66,423 as compared to the rest of Santa Clara County which was $93,854. It is a high-density area, with households occupied by renters at 64% of the residences being multi-unit housing, compared to the Santa Clara County average of 33%. 100% of Chai House residents have low to very low incomes – below the median household income for North Willow Glen - with over 2/3 qualifying for Section 8 housing. Prior to opening a branch office onsite at Chai House in July 2017, the 150 residents had no access to onsite mental health services. In addition, 60% of residents do not drive – and those who do rarely venture more than a three-mile radius. Since July 2017, the social services staff has noted that at least 25% of residents have displayed elements of depression, problems with substance abuse, anxiety and other mental health issues. With each passing month, JFS's case notes reports indicate that the number and severity of residents with significant behavioral health issues – including those requiring psychiatric hospitalization and other interventions – has increased. Despite adding a full-time clinical social worker – or perhaps because of it –many previously undiagnosed conditions such as hoarding, anxiety, schizophrenia, paranoid personality disorder, depression, borderline personality disorder, psychosis, and substance abuse have been discovered. Approximately 30% of the caseload at Chai House suffers from serious behavioral health issues. This finding mirrors the El Camino Hospital 2016 Community Health Needs Assessment (CHNA) (http://www.elcaminohospital.org/CommunityBenefit) showing that behavioral health (including mental health, well-being and substance abuse) was prioritized among top community needs.

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Agency Description & Address	14855 Oka Road, Suite 202, Los Gatos Jewish Family Services of Silicon Valley (JFS SV) transforms lives and restores hope. JFS SV serves a multi-ethnic community with social, senior, behavioral health, refugee, and volunteer services. Our ethnically diverse staff speaks nine languages. JFS SV Aging with Dignity Senior Services for 2,000 elders at a variety of life stages focuses on those allowing older adults to remain at home. Project NOAH safety net services provide emergency food, financial assistance, counseling and job search support to over 1,000 low income people each year. JFS SV has provided refugee resettlement, employment and acculturation services to 5000 refugees, immigrants and asylees from all over the world.
Program Delivery Site(s)	Services will be delivered at Chai House in 814 St. Elizabeth Drive, San Jose
Services Funded By Grant/How Funds Will Be Spent	Services include: • Walk-in immunization services • Individual one-hour case management sessions • Individual one-hour therapy sessions • Thirty-minute psychiatric consultations • Ninety-minute group therapy sessions • Monthly ninety- minute health-related workshops • Weekly medical consultations with San Jose State Nurses Full requested funding would support the partial salaries a clinical social worker and a psychiatrist.

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HEALTHY MIND

LifeMoves

NEW

Program Title	BehavioralMoves
Grant Goal	Providing behavioral health services to homeless individuals, on-site and in real time, at LifeMoves homeless shelters in Santa Clara County.
Community Need	The El Camino Hospital 2016 Community Health Needs Assessment (CHNA) reports that 38% of County residents reported poor mental health at least one day in a month, and 60% report being stressed about financial concerns. Within the subset of Santa Clara County residents who are homeless, research indicates that virtually all homeless individuals suffer from trauma. Moreover, due to the fact of their having lost stable housing, we can say with certainty that all of them are under stress related to financial concerns. These financial and housing concerns also impact the overall health and well-being of homeless individuals, as indicated by "Economic Security" and "Housing" being ranked first and third, respectively, in the CHNA's prioritization of health needs. Behavioral health issues can be both a contributing factor to, and a result of, homelessness. Many families facing homelessness—especially women and their children—have experienced traumatic events, including domestic, interpersonal, and community violence and have been victims of physical, emotional/psychological, and/or sexual abuse This research coincides with LifeMoves experience, which indicates that approximately half of all women admitted to LifeMoves shelters report being survivors of domestic violence. Moreover, homelessness has a severe impact on children, and correlates strongly with development delays and academic achievement gaps, as well as later-life substance abuse, domestic violence and homelessness. Individuals and families who become homeless frequently suffer from trauma, and they may suffer from other mental health disorders as well, typically including anxiety, stress and depression. If these behavioral health issues are not addressed, homeless individuals will be less likely to regain and maintain housing stability, and less likely to become self-sufficient over the longer term. As a result, LifeMoves views its behavioral health program as an essential component of the range of supportive services that we offer to clients at all of its shelters. Sources: https://www.samhsa.gov/homelessness-housing/trauma-informed-care http://nctsn.org/sites/default/files/assets/pdfs/PFA_Families_homelessness.pdf http://nctsn.org/sites/default/files/assets/pdfs/Facts_on_Trauma_and_Homeless_Children.pdf https://pdfs.semanticscholar.org/fc6f/4fac993bdc02b097df072a13e12371d09ebe.pdf
Agency Description & Address	181 Constitution Drive, Menlo Park LifeMoves (formerly InnVision Shelter Network) is the largest and most effective non-profit committed to ending the cycle of homelessness for families and individuals in Silicon Valley. The agency operates nine shelters throughout Santa Clara and San Mateo Counties. Since 1987, our mission is to provide interim housing and supportive services for homeless families and individuals to rapidly return to stable housing and long-term self-sufficiency. Underpinning all LifeMoves programming is our innovative therapeutic service model, which breaks the cycle of homelessness by driving transformation at the source, rather than treating the symptoms.

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Program Delivery Site(s)	LifeMoves's four homeless shelters in San Jose: • Two shelters for families and single women: o Georgia Travis House at 260 Commercial Street, San Jose o Villa at 184 South 11th Street, San Jose • Two shelters for single adults: o Julian Street Inn, 546 W. Julian Street, San Jose o Montgomery Street Inn, 358 N. Montgomery Street, San Jose
Services Funded By Grant/How Funds Will Be Spent	Services include: • Screen clients for behavioral health issues • Provide individual, group and milieu therapy • Bilingual services in Spanish and English, with translation services available in other languages as- needed • Train psychologists and therapists on the behavioral health issues that accompany homelessness Full requested funding would support partial salaries for staff positions including Director of Behavioral Health, psychotherapy consultant, neuropsychology consultant and intern stipends, as well as other administrative costs.

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Momentum for Mental Health

Program Title	Mental Health Community Clinic
Grant Goal	Provide mental health services to those who do not have access to treatment because they cannot afford to pay for services and those who are uninsured. This grant will continue to help La Selva Community Clinic provide mental health services for clients who are uninsured; the majority is referred from Mayview Community Health Clinic, El Camino Hospital as well as the general community. The service address language barriers to access to care and provides an, for Medi-Cal recipients, provides quick access to treatment and essential supportive services as they often manage complex and ongoing mental health and medical conditions on a daily basis.
Community Need	Many individuals who suffer from mental health do not have access to mental health services due to lack of healthcare insurance or their inability to pay. Consequently, these individuals tend to remain untreated, utilize hospital emergency rooms when in crisis, and risk losing employment. In Primary care clinics typically lack mental health services and most mental health clinics locally have a wait list. According to the 2016 CHNA, close to four in ten (38%) Santa Clara County residents report poor mental health on at least one day in the last 30 days and six in ten county residents report being somewhat or very stressed about financial concerns. Further, some clients are not currently working and lack insurance to cover for mental health services and others cannot afford their medication fee. Momentum serves clients who are undocumented and have a difficulties in finding jobs with benefits to provide mental health services. More than half of clients are monolingual Spanish speakers and in many cases this is the first time they are seeking mental health services.
Agency Description & Address	438 North White Road, San Jose Momentum for Mental Health is an independent, non-profit corporation that provides comprehensive programs and services in Santa Clara County for youth and adults who have a severe mental illness. The staff and volunteers at Momentum believe that people with a mental illness can, and do, recover to lead productive lives and become contributing members of our community. Helping clients reach this goal informs planning and daily operations. Momentum's treatment approach focuses on building on clients' strengths to help them achieve and sustain mental health. The staff at Momentum delivers services in 37 different languages – reflecting the linguistic and cultural diversity of this region. During fiscal year 2016-17 a total of 4,124 individuals were served across Momentum's 10 locations and 11 supportive housing sites throughout Santa Clara County.
Program Delivery Site(s)	Services will be provided at agency site.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Psychiatry assessments • Treatment and medication management sessions • Case management sessions • Short-term and crisis counseling • For some clients in need of more intensive services, provide no-cost intensive outpatient program and crisis residential care Full requested funding would support partial staffing including a psychiatrist, registered nurse, a lead clinical, a program manager and other staff.

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Peninsula Healthcare Connection

Program Title	Psychiatric Services – Medication Management
Grant Goal	Provide psychiatric services to homeless and at-risk individuals of Santa Clara County to help manage and stabilize lives through assessment and diagnosis, treatment planning and medication management. The goal is to empower homeless and low-income individuals to become self-sufficient members of the community, and is a vital component to ending homelessness.
Community Need	The 2016 Community Health Needs Assessment (CHNA) identified healthcare access and delivery as a priority health need for Santa Clara County, specifically the lack of general and specialty providers, especially in community clinics. Access to healthcare for those experiencing homelessness was also cited as a top concern, particularly for behavioral health treatment and treatment for conditions that require rehabilitation and follow-up care. According to the 2017 Santa Clara County Homeless Point-In-Time Census and Survey, there was an estimated 7,394 homeless individuals residing in Santa Clara County. This represents an alarming 13% increase countywide since 2015. Individuals experiencing chronic homelessness made up 28% of the total homeless population. Among chronically homeless individuals in Santa Clara County, 50% reported an emotional or psychiatric health condition, 69% reported alcohol or substance use, 42% a physical disability, 26% with PTSD and 34% with chronic health conditions. According to a study by the National Coalition for the Homeless, people with mental illnesses are more likely to become homeless than the general population. Having a serious mental illness can disrupt a person's ability to carry out essential aspects of daily life. For homeless individuals, mental illness contributes to difficulties maintaining stable relationships, and in gaining and retaining employment and/or housing. A study of people with serious mental illnesses seen by California's public mental health system found that 15% were homeless at least once in a one-year period. Patients with schizophrenia or bipolar disorder are particularly vulnerable. For all of the reasons above: - increased homeless populations in Santa Clara County, increased demand for behavioral health treatment and increased risk for those suffering from mental illness to experience homelessness - mental health services in Santa Clara County are heavily impacted. The current system of care can prove challenging to navigate and access and initial access to mental health services can be one of the biggest barriers for individuals to address mental health issues. Sources: 1) 2017 Santa Clara County Homeless Census and Survey https://www.sccgov.org/sites/osh/ContinuumofCare/ReportsandPublications/Documents/2017%20Santa%20Clara%20County%20Homeless%20Census%20and%20Survey%20Report.pdf 2) 2016 Santa Clara County Community Health Needs Assessment http://www.elcaminohospital.org/CommunityBenefit 3) National Coalition for the Homeless, Mental Illness and Homelessness, 2009 http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf
Agency Description & Address	Agency site of service: 33 Encina Avenue, Suite 103, Palo Alto Administrative office: 1671 The Alameda, Suite 306, San Jose Since 2006, Peninsula Healthcare Connection (PHC), has been providing comprehensive health, mental health and case management services to homeless and low-income residents of Santa Clara County, free of charge, through our state licensed medical clinic located within the Opportunity Center in Palo Alto. The goal of PHC is to improve the health and well-being of our patients, and by doing so, improve the overall quality of life, livability, and safety for all local residents.

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Program Delivery Site(s)	Services will be provided at agency site in Palo Alto
Services Funded By Grant/How Funds Will Be Spent	Services include: • Comprehensive psychiatric care, including assessment, care planning and medication management to all patients requesting or requiring these services. • Connection of patients to intensive case management services and therapy as needed, utilizing PHC's comprehensive services and partnerships. • Outreach and education to homeless individuals about available services and assistance securing housing. Full requested funding would support a psychiatrist, licensed vocational nurse and case manager.

Respite and Research for Alzheimer's Disease

NEW

Program Title	Alzheimer's Activity Center
Grant Goal	This program will provide dementia specific adult social day care and caregiver respite and support for individuals diagnosed with Alzheimer's disease and related dementias and their caregivers.
Community Need	According to the US Census Bureau, nearly 12.8% of the total population of Santa Clara County are over the age of 65. According to the Alzheimer's Association report, 10% of those over age 65 has Alzheimer's related dementia. This number will grow with the aging of the Baby Boomer population and, along with it, the numbers of persons diagnosed with Alzheimer's disease and dementia will increase dramatically: by 2025 it is projected that the number of persons with Alzheimer's dementia will increase by 35%. According to the Alzheimer's Association California Alzheimer's Disease Data Report, the number of persons with Alzheimer's disease increased by 19% from 2008 to 2015. Between 2015 and 2030, this trend will increase sharply and disproportionately: in 2015 there were 32,988 persons in Santa Clara County living with Alzheimer's disease and by 2030, this number is expected to increase by 78% to 58,568. Alzheimer's disease in Santa Clara County is reaching epidemic proportions. The disease has no cure, and there is no method to stop or slow its devastating effects. The cost of caregiving can be as much as $91,000 for a skilled nursing facility, paid home health care ranges from $63,000 per year to $82,000 per year and neither of these solutions is effective for the person living with dementia or Alzheimer's disease, Sources: https://www.census.gov/quickfacts/fact/table/santaclaracountycalifornia/PST045216 https://www.alz.org/documents_custom/2017-facts-and-figures.pdf . https://www.alz.org/documents_custom/2017-facts-and-figures.pdf https://www.payingforseniorcare.com/ https://www.aplaceformom.com/blog/2013-03-22-dementia-cost-to-families-and-caregivers/
Agency Description & Address	2380 Enborg Lane, San Jose Founded in 1984, RRAD operates two collaborative programs: Alzheimer's Activity Center (AAC) and Rosa Elena Childcare Center (RECC). The AAC, a licensed social adult day program supporting persons living with Alzheimer's and dementia, provides respite services in a safe, supportive, dignified environment. The RECC licensed for children 2 years to first grade, is a play- based early childhood learning program. Co-location of these programs ensures daily intergenerational activities, providing our youth and seniors enrichment and support. The AAC is the only dementia specific adult day care program in Santa Clara County, serving up to 90 people daily, 6 days per week, 10.5 hours per day. Last year 77% of the 246 clients served were low to extremely low income.
Program Delivery Site(s)	The program services will be delivered at the agency site in San Jose.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Daily small group activities to enhance social interactions, create a personal program that individualizes the client's needs and enhances their functional abilities; activities include: arts and crafts, games, guided conversations, book club, cooking, gardening, writing, etc. • Daily group activities that capture the interest of each client visually and verbally, including; activities include exercise, singing, lectures, etc. • Weekly session of intergenerational activities with pre-school children ages 2-entry level

	first grade, including art, dance, reading, exercise, gardening cooking and educational activities. • Daily personal care per attendance to support good health and hygiene, and monitor skin conditions, including toileting, showering, podiatry and haircuts. • Providing at least one meal and two snack snacks, prepared under the guidance and direction of a Registered Nutritionist • Caregiver support for: o Individual support, referral and information sessions, as needed o Monthly small group therapeutic support sessions for up to eight caregivers o Monthly large group education and support sessions for up to 25 caregivers o Quarterly educational and networking seminars for 35 or more caregivers Full requested funding would support partial staffing of six positions.

Teen Success, Inc.

Program Title	San Jose Teen Success Program
Grant Goal	The Teen Success Program works with teen mothers to help break the cycle of poverty by supporting them in reaching their educational and life goals. Teen mothers participate in the program for 18 months. During this time, they receive: 1) weekly one-on-one coaching from a Teen Success Advocate that includes case management to mitigate barriers to school completion; educational navigation to support getting on track toward graduation; and coaching to support goal setting, problem solving, skill building and self-empowerment, and 2) a weekly peer learning and support group to build knowledge and skills in the following areas – reproductive health, child development and parenting, and social emotional learning.
Community Need	In 2015, there were 24,395 births to females under 20 years of age in California. Although teen birth rates having decreased significantly over the past 15 years, there are areas of California where significant disparities exist. Furthermore, teen pregnancy disproportionately affects low-income communities and young women of color. Two out of every three babies born to teens in California are born to Latinas. The communities that Teen Success, Inc. serves are primarily comprised of people of color and have some of the highest teen pregnancy rates in the state and nation; many of these communities have teen birth rates that are double the state average. (U.S. Department of Health & Human Services, Office of Adolescent Health. https://www.hhs.gov/ash/oah/facts-and-stats/national-and-state-data-sheets/adolescent-reproductive-health/california/index.html Teen mothers and their children face tremendous challenges. Only about 40% of teen mothers graduate high school and less than 2% graduate college by the age of 30. Children of teenage mothers face their own challenges – they are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult (The Power to Decide, the campaign to prevent unplanned pregnancy https://powertodecide.org/). Teen Success, Inc.'s model is informed by the research on Positive Youth Development and best practices identified by the Healthy Teen Network, a leading national membership organization for adolescent health professionals and organizations that support pregnant or parenting youth. The model emphasizes skill development, social emotional learning and developing trusting relationships with caring adults. The Positive Youth Development framework favors a "strength-based or asset-based" approach, such as leadership and skill-building opportunities, which tend to be more effective than "deficit-based" programs that focus narrowly on issues like drug abuse and teen pregnancy prevention. The program also emphasizes the Developmental Assets model developed by the Search Institute. Research shows that having a greater number of developmental assets reduces youths' tendency towards alcohol use, tobacco use, illicit drug use, antisocial behavior, violence, school failure, sexual activity and attempted suicide. Beyond prevention, developmental assets have also been show to help youth thrive by overcoming adversity, delaying gratification, succeeding in school, valuing diversity, helping others, demonstrating leadership and being physically healthy (Search Institute, https://www.search-institute.org/our-research/development-assets/current-research-developmental-assets/.

FY19 Healthy Mind Proposal Summary

Agency Description & Address	508 Valley Way, Milpitas Teen Success, Inc. believes that having a baby as a teen is not a permanent barrier to success in school or in life. In order to break the cycle of intergenerational poverty that is often inherent in teen parenting, we support low-income, first time teen mothers in completing high school, maintaining their family size and learning how to nurture their child's positive development. By empowering teen mothers to rise above their challenges and achieve their full potential in school and as parents, Teen Success, Inc. is creating a pathway out of poverty for two generations.
Program Delivery Site(s)	• Peer Learning Group sessions are delivered at Mayfair Community Center, San Jose • One-on-One coaching sessions are delivered at local community centers, libraries, school, coffee shops, parks or wherever convenient
Services Funded By Grant/How Funds Will Be Spent	Services include: • Teen mothers (members) will each receive 60 hours of one-on-one coaching with an advocate over the course of 18 months • Members will each attend weekly Peer Learning Group sessions that last 2.5 hours for 40 weeks which includes educational navigation with school counselors and parent and life skill development Full requested funding would support partial salaries for the program manager, advocates, child watch providers, supplies, incentives, staff development and training.

FY19 Healthy Mind Proposal Summary

Uplift Family Services

Program Title	High School Counseling - Addiction Prevention Services
Grant Goal	Continue Uplift Family Services deliver of Addiction Prevention Services (APS) at Campbell Union Unified School District. This school-based program helps supports the gaps that are often seen in school districts as it relates to mental health supports. The goal is to decrease the use of all substances, and increase youths' physical, mental, academic, and social functioning.
Community Need	Over the past two years, Uplift Family Services has observed a noticeable increase in the use of marijuana, "vaping" e-cigarettes, and abuse of Xanax prescription pills at the Campbell Union High Schools. As a result there is more need for prevention, education, and early treatment of substance use in these schools. These youth, including the unmet needs of LGBTQ students, need support and understanding in addressing their safety and overall health needs. With the legalization of recreational marijuana in 2018, our program staff is preparing for what could be an increase in use and interest in the substance. The legalization of marijuana and its more mainstream visibility in pop culture is impacting youth's perception of harm. As a 2013 University of Michigan study noted, there is a correlation between increased use of marijuana among youth as their perception of harm decreases. The growing legalization of marijuana has also sparked the American Academy of Child and Adolescent Psychiatry (AACAP) to strongly oppose the new laws because it is the Academy's belief that "marijuana's deleterious effect on adolescent brain development, cognition, and social functioning may have immediate and long-term implications, including increased risk of motor vehicle accidents, sexual victimization, academic failure, lasting decline in intelligence measures, psychopathology, addiction, and psychosocial and occupational impairment." Due to the increased bullying, violence and lack of social support that LGTBQ students may experience, these youth are at greater risk for adverse impacts. According to The Center for Disease Control and Prevention, "LGBT youth are at greater risk for depression, suicide, substance use, and sexual behaviors that can place them at increased risk for HIV and other sexually transmitted diseases (STDs). Nearly one-third (29%) of the youth had attempted suicide at least once in the prior year compared to 6% of heterosexual youth." (https://www.cdc.gov/lgbthealth/youth.htm). With the significant increase in suicide attempts, this program seeks to work more next year with the Gay Straight Alliance (GSA) groups that are on each of the CUHS campuses. A focused level of education on suicide prevention, drug and alcohol abuse, and healthy coping will be critical in supporting this vulnerable population of youth.
Agency Description & Address	251 Llewellyn Avenue, Campbell Uplift Family Services is a statewide non-profit organization. We are proud to be one of California's leading providers of social services that help children with severe emotional, social, and behavioral needs, and their family members. The agency's mission is to do whatever it takes to strengthen and advocate for children, families, adults, and communities to realize their hopes for behavioral health and well-being. Annually, the agency provides services to over 20,000 children from birth to 21 years of age, and their families throughout more than 30 counties in California. Our goal is to help children and families access healing and hope towards a brighter future.
Program Delivery Site(s)	Six high schools in the Campbell Union High School District: • Westmont High, Campbell • Prospect High, Saratoga • Leigh High, San Jose • Branham High, San Jose

	• Del Mar High, San Jose • Boynton High, San Jose
Services Funded By Grant/How Funds Will Be Spent	Services providing substance abuse prevention, intervention, and post-intervention services for at-risk youth include: • Assessments, intake and risk management: determine level of care as needed • Classroom workshops (gangs, bullying, suicide prevention, drug and alcohol education, stress/anxiety management) and school assemblies • Targeted Intervention Groups (reduce high risk behavior) • Individual counseling • Year-round access to services for local youth who are Medi-Cal eligible (as needed) • Teacher/staff trainings & workshops • Parents/caregiver meetings and education regarding access • Targeted family case management • Brief Intervention Full requested funding would support two on-site counselors at five schools and some program administrative costs.

FY19 Healthy Mind Proposal Summary

YWCA Silicon Valley

Program Title	Valor Program
Grant Goal	The Valor Program provides information, tools, and referrals to support participants who are trying to leave the life of sex work. Individuals who are charged with a first-time offense for solicitation of a sex act or loitering with the intent of prostitution, and deemed eligible by the DA's office, are referred to the YWCA Silicon Valley's Valor Program. Participants of the Valor Program typically have experienced past trauma such as childhood sexual abuse, physical abuse, as well as lack of family support and stability. Participants take part in the six week diversion Program held at YWCA and implemented by the Clinical Manager of Human Trafficking Services and graduate level Marriage and Family Therapy (MFT) associates, which is comprised of workshops designed to assist in building life skills, and individual and/or group therapeutic support.
Community Need	Due to the underground nature of the illegal commercial sex industry, summing up the exact statistics on prostitution in the United States is difficult. What is known, is that about 40% of prostitutes are former child prostitutes who were illegally forced into the profession through human trafficking or once were teenage runaways. Many of the runaways fled because their homes were abusive, poor, or did not approve of them. https://sex-crimes.laws.com/prostitution/prostitution-statistics In 2017, the Human Trafficking Hotline saw the highest number of reports of human trafficking from the State of California. https://humantraffickinghotline.org/states . Research of people involved in prostitution has found: • 65-95% were sexually assaulted as children. • 60-70% have experienced rape. • 70-95% of those in prostitution been physically assaulted in prostitution. • 80-95% want to escape, but have no other option. • The estimated age of entry into prostitution is 12. http://www.psychiatrictimes.com/sexual-offenses/content/article/10168/48311 The traditional law enforcement approach to prostitution provides little or no services to the individual addressing their needs or the forces that led them to enter lives of prostitution. That system results in extremely high recidivism rates (80 percent of prostitutes arrested are repeat offenders), ongoing sexual exploitation and violence, and enormous costs to the criminal justice and public health systems. Prostitution has much in common with other forms of violence against women.
Agency Description & Address	375 South Third Street, San Jose YWCA Silicon Valley is a multi-service organization founded in 1905 in Santa Clara County, with a mission to eliminate racism and empower women. For over 110 years YWCA has identified the unique needs of Santa Clara County women and families, delivering innovative programs to meet those needs. YWCA currently focuses on three key areas: a) empower by working to end racism and violence; b) achieve solutions for survivors of violence facing homelessness; and c) inspire by closing the education and prosperity gap. Services include: counseling; childcare; domestic violence, human trafficking and sexual support services and advocacy; housing for survivors; and youth education, including violence prevention and STEM. In 2018, YWCA will reach a projected 18,000 people in Santa Clara County at over 20 community-based locations.
Program Delivery Site(s)	Services will be provided at agency site in San Jose.

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Services Funded By Grant/How Funds Will Be Spent	Services included: • Four, six-week Valor Program cohorts • Each Valor Program cohort is divided into the following two components: o 50 minute-Individual and/or group therapeutic support group o 90 minute-education and information workshops focusing on the following topics: STD Health, Money Management, Job Skills/Resume Building, Trauma, Healthy Relationships, and Self-Care. Full requested funding would support the partial salaries of a clinical manager, 2 MFT associates and program expenses.

HEALTHY COMMUNITY

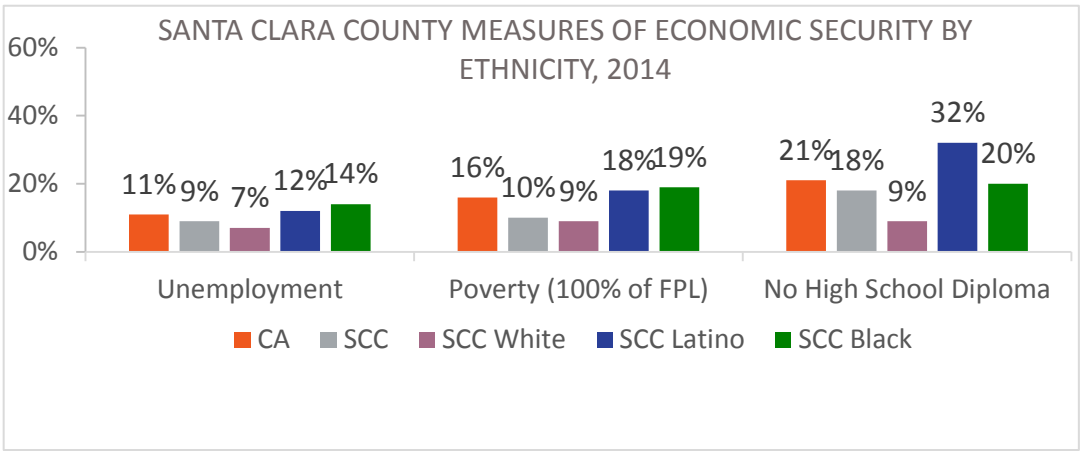
To improve the overall health of the community by providing services and increasing access to services that improve safety, provide transportation, and educate the community about health and wellbeing.

A healthy community can impact health positively by providing safe places to live, work, and be educated. When a community lacks affordable and sufficient transportation, lacks awareness of health issues and risk for chronic diseases, and is not able to access culturally competent services, its residents experience poor health.

DATA FINDINGS

Services to address the needs in the Healthy Community priority area are demonstrated by the following statistics:

- **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 in Santa Clara County 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 (FPL). 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.



- **Unintentional Injuries** are a concern in Santa Clara County because rates of deaths due to falls and adult drowning in the overall population are higher than HP2020 targets. In addition, rates for some ethnic/racial groups in the county exceed HP2020 targets in various injury categories. For example,

death rates from pedestrian accidents among Latinos (2.2 per 100,000) and Asians (1.6 per 100,000) exceed the HP2020 objective of 1.3 per 100,000.

- **Violence & Abuse** in the county is a problem that disproportionately affects people of color, including adult homicide and domestic violence deaths. Also, a majority of youth reports 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, dysfunctional 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.

STRATEGIES TO IMPROVE COMMUNITY HEALTH

1. Promote access to medical searches and improve health literacy
2. Increase self-sufficiency amongst vulnerable families and older adults through social work case management
3. Reduce incidence of chronic diseases such as heart disease, hypertension and diabetes through culturally relevant programs, screenings and expanded access to medical devices
4. Provide domestic violence survivor services
5. Promote physical activity and healthy lifestyles
6. Address social determinants of health such as homelessness

HEALTHY COMMUNITY PROPOSALS

1. Abode Services – *page 88*
2. Chinese Health Initiative (El Camino Hospital) – *page 90*
3. Health Library and Resource Center – Los Gatos – *page 91*
4. Next Door Solutions to Domestic Violence – *page 92*
5. Pacific Hearing Connection – *page 94*
6. Racing Hearts – *page 96*
7. South Asian Heart Center – *page 98*
8. West Valley Community Services - CARE Senior Services – *page 100*
9. West Valley Community Services - CARE – *page 101*

HEALTHY COMMUNITY RECOMMENDED FUNDING: $628,672

FY19 Healthy Community Proposal Summary

HEALTHY COMMUNITY

Abode Services

NEW

Program Title	Project Independence & Rapid Re-Housing Program
Grant Goal	Abode Services is requesting support for the Project Independence and Rapid Re-Housing Programs. In FY17, Abode Services successfully housed more than one-thousand households the Rapid Re-Housing model. Further, through Project Independence, services were provided to prevent and end homelessness for vulnerable youth ages eighteen to twenty-four, who are emancipated from the foster care system, by offering housing placement, rental assistance, and comprehensive supportive services (including mental health services, employment/education assistance, financial skill building, parenting/family services, and life skills support) for up to two years. The Rapid Re-housing and Project Independence programs work to help families, adults, and young adults emancipating from foster care escape homelessness, through provision of services designed to promote maximum self-sufficiency and housing stability. Project Independence (PI) utilizes Youth Service Coordinators (YSC) who provide support and connection to mental health, education and employment and parenting services. Project Independence takes into account the needs of this special population and makes services accessible for a defined period of eighteen - twenty-four months. Rapid Re-Housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Both programs share an overarching goal, to help households stabilize in housing and access the services they need in the community.
Community Need	• Silicon Valley is quickly becoming one of the most expensive places to live, with average rents above $2,100 (from a 2/26/15 article in The Contra Costa Times). According to the 2011 Eastern Alameda County Human Services Needs Assessment, more than thirty percent of renting households were paying more than 35% of their gross income for rent, putting them at risk of housing instability. These high housing costs come at a time when more families than ever are seeking public assistance with basic costs of living. According to the same assessment, the number of people receiving Medi-Cal, CalWORKs, or general assistance tripled between 2003 and 2011, while the number of people receiving food assistance (SNAP) increased by a multiple of six. Further, HUD's 2016 Homeless Assessment Report estimated that there are nearly thirty-two thousand young adults between eighteen and twenty-four who are homeless nationwide, with over ten thousand of them being in California. • In Santa Clara County, there are currently 7,394 homeless individuals. This is a staggering and growing need as it has risen steadily over a ten year period. Abode Services will address this growing need by offering sustainable, supportive housing solutions via Project Independence and Rapid Re-Housing. We aim to catch transitional age youth before they slip into chronic homelessness. • If the need is not addressed, we will experience a higher volume of homelessness in our communities. Only twenty-six percent of homeless individuals are sheltered at present. Without permanent supportive housing, these individuals will eventually leave the shelter and return to living on the street. • At present, there is not enough low-income housing available. There is a gap in service as homeless individuals experience a major challenge and waiting period in being connected with suitable, permanent housing. Abode Service is an active participant in the Homeless Management Information System (HMIS) database, and uses it to track participant information, including demographics, household composition, and disability

	status, as well income and destination at program exit. Source: 2017 Santa Clara County Homeless Census and Survey Report: https://www.sccgov.org/sites/osh/ContinuumofCare/ReportsandPublications/Documents/2017%20Santa%20Clara%20County%20Homeless%20Census%20and%20Survey%20Report.pdf
,Agency Description & Address	40849 Fremont Boulevard, Fremont Abode Services' mission is to end homelessness by assisting low-income, un-housed people, including those with special needs, to secure stable, supportive housing; and to be advocates for the removal of the causes of homelessness.
Program Delivery Site(s)	Services will be provided within the Abode Services for individuals in Santa Clara County.
Services Funded By Grant/How Funds Will Be Spent	Services include: • One-Hour Meeting with Case Manager • Ninety-Minute Support Group and Information Sessions • One-Hour, Appointment with Mental Health Service Provider • Immunizations via HOPE Mobile Clinic (Registered Nurse) • Access to Skill-Building, Employment, Debt Repair, Life Skills Full requested funding would support Housing Assistance, Move-In Cost/Rent and Utilities and some supplies. Labor would be in-kind.

FY19 Healthy Community Proposal Summary

Chinese Health Initiative

Program Title	Chinese Health Initiative
Grant Goal	This program addresses the unique health needs of the Chinese community. The four focus areas of the program include: health disparities, health literacy, community wellness and culturally competent patient care. CHI provides free health screenings, workshops, dietitian consults and resources to members of the Chinese community.
Community Need	According to the National Institute of Health, about 21% of Asians have diabetes but more than half are undiagnosed. Hypertension is also a disease of high prevalence among the Chinese population and a lot can be done to educate this group on this disease and its prevention. There are also language and cultural barriers to access care and medical resource as two third of Chinese community members in the Bay Area were born outside of the Unites States and many of them speak limited English. Sources: https://www.nih.gov/news-events/news-releases/more-half-asian-americans-diabetes-are-undiagnosed
Agency Description & Address	2500 Grant Road, Mountain View Chinese Health Initiative at El Camino Hospital addresses the unique health disparities in the growing Chinese population, and accommodates cultural preferences in education, screening, and the delivery of healthcare.
Program Delivery Site(s)	The program services will be delivered at various community sites including senior centers and community centers.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting educational workshops to raise awareness of health disparities • Providing screenings • Producing newspaper articles and print material addressing health concerns specific to the Chinese community Full requested funding would support partial staffing and program materials for screenings and outreach.

FY19 Healthy Community Proposal Summary

Health Library and Resource Center, Los Gatos

Program Title	El Camino Hospital, Los Gatos Health Library & Resource Center
Grant Goal	The Health Library and Resource Center serves to improve health literacy and knowledge of care options for patients, families and caregivers.
Community Need	Individuals want and need accurate information to make the best possible healthcare and medical decisions. Without such information, they may undergo unnecessary treatment, fail to understand the impact of diet and exercise, ignore important warning signs, and waste healthcare dollars. Studies indicate that many Americans have low health literacy which adversely impacts their ability to understand health information and make informed decisions about health issues and lifestyle choices that affect their lives. Individuals with low health literacy are likely to report poor health outcomes. The inability to understand Health Information can lead to undesirable lifestyle choices leading to poor health outcomes and an increase in National Healthcare expenditures. Individuals want and need accurate information to help them make the best possible lifestyle decisions and to effectively partner with their physician to obtain optimal healthcare outcomes. They often lack the time and skills needed to sort through the myriad of information that is available and then assess its quality and accuracy. The library can direct patrons to information sources suitable to their individual needs, interests, and abilities. The assistance received helps our patrons in making informed decisions regarding procedures, treatments, and lifestyle issues. The library provides current healthcare resources, including evidenced based materials, tailored to each patron's information needs and desires. Sources: https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006483 ; https://nces.ed.gov/pubs2006/2006483.pdf ; https://health.gov/communication/literacy/issuebrief/ ; https://health.gov/communication/literacy/quickguide/factsbasic.htm
Agency Description & Address	530 South Drive, Mountain View El Camino Hospital is a nonprofit organization with hospital campuses in Mountain View and Los Gatos.
Program Delivery Site(s)	The services will be delivered at the Health Library and Resource Center at El Camino Hospital, Los Gatos and open to all members of the local community.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing access to vetted print, electronic, and online information sources coupled with professional assistance in selecting appropriate resources • Conducting outreach to local senior centers • Providing eldercare consultations and assist community members with developing a long-range care plan based on their personal family situation Full requested funding would support partial staffing for a Librarian and supplies such as books and subscriptions.

FY19 Healthy Community Proposal Summary

Next Door Solutions to Domestic Violence

Program Title	Comprehensive Services for Survivors of Domestic Violence
Grant Goal	To support the emotional health needs of survivors of domestic violence by addressing the key needs of safety, stability and self-sufficiency through comprehensive, bilingual intervention and support services.
Community Need	Domestic violence, also known as intimate partner violence (DV/IPV), is prevalent in every community and affects all people regardless of age, socioeconomic status, sexual orientation, gender, race, culture, religion, or nationality. Victims of DV/IPV comprise an isolated and extremely underserved - almost invisible – population in need of a distinctive approach to providing safe housing and other crisis services, peer counseling and support groups, and self-sufficiency services. Those whose lives are characterized by DV/IPV face very unique and difficult obstacles to achieving safety, stability, and greater self-reliance. Per the Centers for Disease Control and Prevention (CDC), "intimate partner violence is a preventable health epidemic": 1 in 3 women, and 1 in 4 men have been physically abused by an intimate partner; 1 in 4 women and 1 in 7 men have been severely physically abused by an intimate partner in their lifetime (Link #1). Per a 2013-14 report by the Santa Clara County Public Health Department (link #2): One in ten (10) adults in Santa Clara County (SCC) have ever been threatened with physical violence by an intimate partner. The percentage is higher among females than males (12% vs. 7%) and is highest among African Americans (17%) followed by White (14%) and Latino (12%). The percentage is higher among US born than foreign born adults (14% vs. 5%). Young adults, 18-24 years, and those 65 years and older reported within single digits (3% and 8% respectively). Those ages 25-64 years (in 10 year increments) varied by 1 -3 points (10% to 13%). Twelve percent (12%) of adults have ever been hit, slapped, kicked, or hurt in any way by an intimate partner. The percentage is higher among females than males (15% vs. 9%) and is highest among those identifying as Two or More Races (27%) followed by African American (19%), White (16%), and Latino (14%). Percentage based on income levels (by increments) varied 10% to 17%, but did not reduce as income increased: below $15K 13%; $15k - $24K 17%; $25 - $35k 10%; $35K - $49K and $50K to $74K 14% each; and above $75K 11%. US born was higher compared to foreign born (17% vs. 6%). Patterns by gender, race/ethnicity, and nativity are similar to those for ever being threatened with physical violence by an intimate partner. (Link #2, Ibid) DV/IVP is a leading cause in women's homelessness. And generally, if there are children in the household, then they, also, are at greater risk of homelessness. Without supports to find viable housing options, many battered women, particularly those already living in poverty, or those without control of their financial assets, are forced to remain in abusive relationships, to accept inadequate or unsafe housing conditions, or become homeless and perhaps increase their risk of further violence. Housing instability is associated with poorer outcomes above and beyond a survivor's level of danger (Link #7). As batterers isolate their partners, victims become increasingly vulnerable to social and economic isolation. In addition to addressing issues of income, employment, and education, survivors are also addressing serious safety issues for themselves and their children as well as dealing with DV related health issues, i.e., anxiety, stress, trauma. Sources: Link #1: https://www.cdc.gov/violenceprevention/nisvs/infographic.html Link #2: https://www.sccgov.org/sites/phd/hi/hd/Pages/violence.aspx Link #3: https://www.apa.org/about/division/activities/partner-abuse.pdf

	Link #4: https://openjustice.doj.ca.gov/crime-statistics/domestic-violence Link #5: https://harderco.com/...work/working-together-promote-healthy-safe-relationships-san; Working Together to Promote Healthy and Safe Relationships in Santa Clara County Link #6: https://www.sccgov.org/sites/opa/newsroom/Pages/domesticviolenceawarenessmonth.aspx; County of Santa Clara news release, 10/02/17 Link #7: https://safehousingpartnerships.org/taxonomy/term/82?page=1; Domestic Violence Housing First: The Intersection of Domestic Violence and Homelessness
Agency Description & Address	234 E. Gish Road, Suite 200, San Jose Next Door Solutions to Domestic Violence (NDS) is dedicated to addressing the impact of domestic violence – at the individual and community level. Its mission is "to end domestic violence in the moment and for all time", empowering survivors to move from crisis to safety, stability, and greater self-reliance. Core programs are Shelter & Housing Services, Community & Systems Advocacy, Support Services, and Community Partnerships. Governed by a volunteer board of 12 community members, NDS provides a continuum of services to nearly 3,000 clients annually.
Program Delivery Site(s)	At NDS' Community Office at 234 E. Gish Road, Suite 200, San Jose 95112 and the following off-site support group locations and undisclosed HomeSafe locations sited below: • St. Mary's Church: 219 Bean Street, Los Gatos • San Miguel Family Resource Center: 777 San Miguel Avenue, Sunnyvale • Amigos de Guadalupe, Center of Justice & Employment: 1897 Alum Rock Avenue, #25, San Jose • Palo Alto Medical Foundation, Mountain View Center: 701 E. El Camino Real, Mountain View • Elmwood Women's Correctional Facility: 701 Abel Street, Milpitas Off-Site Self-Sufficiency Services also provided at two disclosed HomeSafe locations in San Jose and Santa Clara.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Community & Systems Advocacy sessions: Walk-In Crisis Counseling, Risk Assessment, Safety Planning, Legal Advocacy, completing and filing Emergency Orders of Protections and Restraining Orders, case management, referrals to pro bono attorney services, and access to a Virtual Legal Clinic; • Support Group sessions (Spanish and English) • Self-Sufficiency Intensive Case Management: assistance with personal, financial, employment, housing, health/wellness, and educational goals • Bilingual services in Spanish and English with translation services available for other languages as needed Full requested funding would support partial staff salaries, including Self Sufficiency Advocates, Crisis Support Advocates and Support Group Facilitators, and some administrative costs.

FY19 Healthy Community Proposal Summary

Pacific Hearing Connection

NEW

Program Title	Hearing Aids for lower income children and adult patients
Grant Goal	Audiologists will diagnose hearing loss of the individual and fit the hearing aids. Patients, both children and adults, will be selected based on income, using the metric of 400% of the federal poverty level or less as the criteria. Program services will include an initial diagnostic audiology screening, hearing aid fitting if appropriate and follow up appointments to adjust the aids as needed. Pacific Hearing Connection's experience suggests that individuals with income levels that would be considered comfortable in other parts of the country struggle to make ends meet here in the Bay Area. As a result, we have observed that this population tends to be under served and often cannot afford hearing healthcare.
Community Need	According to the National Institute on Deafness and Other Communication Disorders (NIDCD), 36 million Americans have a hearing loss—this includes 17% of our adult population. The incidence of hearing loss increases with age. Approximately one third of Americans between ages 65 and 74 and nearly half of those over age 75 have hearing loss. NIDCD, 2010 https://www.nidcd.nih.gov/health/age-related-hearing-loss.Hearing loss is the third most prevalent chronic health condition facing older adults (Collins, J. G. (1997). Prevalence of selected chronic conditions: United States 1990–1992. National Center for Health Statistics. Vital Health Statistics, 10, 194 https://www.cdc.gov/nchs/data/series/sr_10/sr10_194.pdf. Unfortunately, only 20% of those individuals who might benefit from treatment actually seek help. Most tend to delay treatment until they cannot communicate even in the best of listening situations. On average, hearing aid users wait over 10 years after their initial diagnosis to be fit with their first set of hearing aids (Davis, A., Smith, P., Ferguson, M., Stephens, D., & Gianopoulos, I. (2007). Acceptability, benefit, and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment, 11, 1–294 https://www.ncbi.nlm.nih.gov/pubmed/17927921. For individuals in the Bay Area, this problem is made worse by the cost of living in our area. For example, the cost of living in Santa Clara, CA is 81% higher than the national average. Hearing aids are rarely covered by insurance, and for many cases of low income adults and children, the hearing loss goes untreated. The program's intention is to, in addition to serving people who live in poverty, serve people who do not qualify for state or federal assistance yet cannot make ends meet due to the cost of living in their chosen community. Untreated hearing loss leads to negative effects in people's lives, including sadness and depression, less social activity and emotional security. It also leads to adverse effects on income http://www.betterhearing.org/hearingpedia/consequences-hearing-loss.Finally, there is a strong association between early cognitive decline and untreated hearing loss (Lin, JAMA, 2013 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1558452.
Agency Description & Address	496 1st Street, Suite 120, Los Altos It is the mission, duty and purpose of Pacific Hearing Connections to address, educate, coordinate and provide hearing healthcare to under-served and unserved populations on a local level. Our target population is low income adults and children who are under-served, unserved or under-insured and at risk for hearing loss. Our goal is to provide these services to this population with dignity and respect. Hearing healthcare is defined as diagnostic audiology leading to the appropriate medical intervention to remediate medically correctable hearing loss, and the fitting of hearing aids for hearing loss that is not correctable by medical intervention.
Program Delivery Site(s)	Los Altos agency site

Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing free/reduced/sliding scale hearing healthcare to underserved/unserved and underinsured populations • Providing free/reduced/sliding scale hearing aids to clinics/patients • Offering workshops and educational seminars on health, hearing loss awareness and enhanced positive communication programs • Providing training of and mentoring opportunities for local volunteers interested in promoting the hearing health of patients within established clinics. • Establishing programs which generally promote the mental, emotional, physical and spiritual health and wellbeing of the communities wherein the clinics operate to ultimately provide a sense of hope for a better future for the population in and around those communities. Full requested funding would support program expenses and cost of goods. Salaries are in-kind.

FY19 Healthy Community Proposal Summary

Racing Hearts

Program Title	Santa Clara County (SCC) Automated External Defibrillator (AED) program
Grant Goal	Racing Hearts is partnering with the SCC Public Health Department and the SCC Board of Supervisors to provide AED programs to at risk community locations to help increase heart safety in our community.
Community Need	According to the American Red Cross, about 300,000 American's die of sudden cardiac arrest (SCA) each year. SCA results in more deaths than from breast cancer, lung cancer, colon cancer, and HIV combined.
Agency Description & Address	The mission of Racing Hearts is to increase awareness of and improve access to automated external defibrillators. Racing Hearts empowers people to use AEDs to save lives during a sudden cardiac arrest. Established in 2012, Racing Hearts has increased the heart safety of over 350,000 people placing over 200 AEDs to date. In 2015, Racing Hearts pioneered AED legislation alongside El Camino Hospital to update CA AED law (SB658), making California one of the most progressive states relative to AEDs.
Program Delivery Site(s)	Program locations sites include: • Mountain View (city and school districts) • Campbell (city and school district) • Los Gatos (city and school district) • Eastside Unified School District • San Jose Unified School District • Cambrian School District • Berryessa School District • Santa Clara School District • Franklin McKinley School District • Moreland School District • Oak Grove School District • Evergreen School District • Alum Rock School District • Cupertino School District • Orchard School District • Loma Prieta School District • Mt. Pleasant School District • Union School District • Santa Clara County Office of Education Community organization sites include: • Avenidas • Mayview Community Health • LifeMoves • Bill Wilson Center • Santa Clara Players • Homefirst Shelters • Los Gatos-Monte Sereno Police Department

Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing staffing for AED program manager • Program manager will coordinate site assessments between AED location and the vendor which includes supplies for the first five years and service/maintenance from the vendors for the first three years Full requested funding would support the program manager position.

FY19 Healthy Community Proposal Summary

HEALTHY COMMUNITY

South Asian Heart Center

Program Title	AIM to Prevent Program
Grant Goal	The South Asian Heart Center is seeking funding support to enroll, screen, and coach participants in its AIM to Prevent program, a specialized, evidence based, three phase prevention program: 1) Assess with advanced and comprehensive screening to uncover hidden risks, 2) Intervene with culturally-appropriate Lifestyle MEDS™ counseling and 3) Manage with personalized, heart health coaching.
Community Need	South Asians have at least a two-fold increased risk for cardiovascular disease (CVD) and four- to six-fold increased risk for diabetes (1,2) compared to other ethnic groups (3) and suffer CVD and its risk factors at an earlier age (3,4). Coronary artery disease (CAD) is the leading cause of death (5) and hospitalizations among South Asians in California (6,7). Since traditional CV risk factors do not fully explain the marked disparity in the incidence of heart disease among South Asians (1), additional risk factors have been investigated, albeit inconclusively: fibrinogen, insulin resistance and metabolic syndrome, low high-density lipoprotein (HDL), HDL2b, high triglycerides, small dense low-density lipoprotein (LDL), homocysteine and lipoprotein(a) (8,9). Despite this higher risk, South Asians in the US are still understudied, and little research is available on culturally appropriate treatment strategies to treat them. Despite comprehensive guidelines on appropriate prevention and management strategies for cardiovascular disease (CVD), implementation of such risk-reducing practices remains poor among South Asians in the U.S. (10). Sources: 1. McKeigue P, Ferrie J, Pierpoint T, Marmot M. Association of early-onset coronary heart disease in South Asian men with glucose intolerance and hyperinsulinemia. Circulation. 1993;87(1):152-161. 2. Barnett AH, Dixon AN, Bellary S, et al. Type 2 diabetes and cardiovascular risk in the UK south Asian community. Diabetologia. Oct 2006;49(10):2234-2246. 3. Palaniappan L, Wang Y, Fortmann SP. Coronary heart disease mortality for six ethnic groups in California, 1990-2000. Annals of epidemiology. Aug 2004;14(7):499-506. 4. Narayan KM, Aviles-Santa L, Oza-Frank R, et al. Report of a National Heart, Lung, And Blood Institute Workshop: heterogeneity in cardiometabolic risk in Asian Americans In the U.S. Opportunities for research. Journal of the American College of Cardiology. Mar 9 2010;55(10):966-973. 5. Palaniappan L, Mukherjea A, Holland A, Ivey SL. Leading causes of mortality of Asian Indians in California. Ethnicity & disease. Winter 2010;20(1):53-57. 6. Klatsky AL, Armstrong MA. Cardiovascular risk factors among Asian Americans living in northern California. American Journal of Public Health. 1991;81(11):1423-1428. 7. Klatsky AL, Tekawa I, Armstrong M, Sidney S. The risk of hospitalization for ischemic heart disease among Asian Americans in northern California. American Journal of Public Health. 1994;84(10):1672-1675. 8. Enas EA, Kannan S. How to beat the heart disease epidemic among South Asians: a prevention and management guide for Asian Indians and their doctors: Advanced Heart Lipid Clinic; 2005. 9. Rather MA, Bhat BA, Qurishi MA. Multicomponent phytotherapeutic approach gaining momentum: Is the "one drug to fit all" model breaking down? Phytomedicine: international journal of phytotherapy and phytopharmacology. Sep 11 2013. 10. Azar KM, Jose PO, Kang JB, et al. Culturally-tailored heart health coaching (in press). Journal of Immigrant and Minority Health. 2013.
Agency Description & Address	2480 Grant Road, Mountain View The mission of the South Asian Heart Center at El Camino Hospital is to reduce the high incidence of coronary artery disease among South Asians and save lives through a comprehensive, culturally-appropriate program incorporating education, advanced screening, lifestyle changes, and case management.

FY19 Healthy Community Proposal Summary

Program Delivery Site(s)	Program services will be delivered at agency sites and online through webinars.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Conducting health assessment and development of risk reduction plan for participants • Engaging participants in the AIM to Prevent Program • Providing outreach, workshops on lifestyle topics, specialized nutrition and exercise counseling, and grocery store tours • Delivering trainings that provide Continued Medical Education (CME) units for physicians Full requested funding would support partial staffing and program supplies.

FY19 Healthy Community Proposal Summary

West Valley Community Services

Program Title	Community Access to Resources and Education (CARE) Senior Services
Grant Goal	This program will provide social work case management to low-income older adults.
Community Need	The 2016 Age-Friendly Survey extensively examines affordable housing, transportation, and social inclusion as some of the major issues to consider regarding aging in place or age-friendly cities. According to the annual report published by Santa Clara Social Services Department of Aging Services, by 2030, one in four Santa Clara County residents will be over the age 60 (27.6%). The fastest growing segment of this population is the oldest of the old (those 85 or older). The increase in the percentage of people over the age of 60 impacts the whole county. The affordable housing crisis in Santa Clara County has a disparate impact on seniors living on a fixed income. Rising housing costs place significant stress on the household budgets of seniors living on a fixed income, and undermine the diversity of our communities. Poverty affects Santa Clara County's seniors differently based on different races and ethnicities such that Asian, Hispanic and Black seniors are more likely to be living below the federal poverty line. There are also significant cultural and linguistic barriers found among seniors accessing services, and an overall lack of services available to meet specific cultural needs. Sources: https://www.sccgov.org/sites/ssa/daas/Documents/Final%20Age%20Friendly%20Survey%20Presentation%201.pdf
Agency Description & Address	10104 Vista Drive, Cupertino West Valley Community Services is a nonprofit provider of community services in Cupertino, Los Gatos, Monte Sereno, Saratoga, and West San Jose. They offer assistance with food, family support, housing assistance, financial assistance, and case management.
Program Delivery Site(s)	Services will be delivered at agency location in Cupertino and CARE mobile services through the Mobile Food Pantry.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing a comprehensive assessment that evaluates physical and emotional status, strengths and limitations, and the ability to live independently • Conducting weekly or monthly client check-ins to ensure clients are connected to services and provides necessary resources • Weekly food drop off to homebound residents and group homes • Coordinating services with other local senior programs • Delivering education on managing health conditions, healthy diet, and fall prevention Full requested funding would support partial staffing for a case manager and program materials.

FY19 Healthy Community Proposal Summary

West Valley Community Services

Program Title	Community Access to Resources and Education (CARE)
Grant Goal	This program will increase access to healthcare and social services by providing comprehensive case management for families with children, at-risk youth, older adults, individuals and disabled adults with low-income or fixed-income, and individuals who are homeless or at-risk of becoming homeless.
Community Need	Due to the high cost of living in West Valley Community Services' service area, many clients lack health insurance and are not connected to available services primarily due to a lack of knowledge, time, and accessibility. A recent Santa Clara County Quality of Life assessment indicated four major areas of need: coordinated comprehensive services, transportation, affordable housing, and home-based supportive services.
Agency Description & Address	10104 Vista Drive, Cupertino West Valley Community Services is a nonprofit provider of community services in Cupertino, Los Gatos, Monte Sereno, Saratoga, and West San Jose. They offer assistance with food, family support, housing assistance, financial assistance, and case management.
Program Delivery Site(s)	Services will be delivered at agency location in Cupertino.
Services Funded By Grant/How Funds Will Be Spent	Services include: • Providing staffing for a full-time program coordinator and a partial case manager • Providing emergency financial assistance, food pantry access, employment services and financial coaching • Case Manager assistance with application for public benefits • Conducting health education workshops Full requested funding would support partial staffing and program materials.

Financial Summary

Overview

Total Board Approved Grant Funding: $3,565,000

Sponsorship funding: $200,000

Placeholder: $100,000

Total: $3,865,000

Conclusion

The community health needs assessment revealed three significant areas of health needs in El Camino Hospital's target communities: healthy bodies, healthy minds, and healthy communities. These needs overlap with one another, in that persons having one of these health needs are likely to face challenges in another. El Camino Hospital's Community Benefit grant portfolio is targeted to address the needs in and across each of the three health priority areas through integrated and coordinated funding.

The grants proposed in this plan have been carefully screened based on their ability to impact at least one of the three priority areas. The Board of Directors' support of this Community Benefit plan will allow El Camino Hospital to continue responding to the most pressing needs faced by the most vulnerable residents in our communities.

The premise — and the promise — of community benefit investments is the chance to extend the reach of hospital resources beyond the patient community, and address the suffering of our most underserved, at-risk community members. These annual community grants provide an essential, potentially life-saving resource to people who do not have access to healthcare. Community Benefit dollars fill important gaps by funding critical, innovative services that would otherwise not be supported. The Community Benefit plan helps El Camino Hospital fulfill its mission of improving the health and wellness of the entire community, far beyond the hospital walls.