Implementation Strategy Report and Community Benefit Plan, FY 2026

June 2025

El Camino Health®

I. GENERAL INFORMATION

Contact Person:	Tim Daubert
Years the Plan Refers to:	Fiscal year 2026
Date Written Plan Was Adopted by Authorized Governing Body:	June 17, 2025
Authorized Governing Body that Adopted the Written Plan:	El Camino Hospital Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	El Camino Hospital EIN 94-3167314
Address of Hospital Organization:	El Camino Hospital 2500 Grant Road Mountain View, CA 94040-4302

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II. ABOUT EL CAMINO HEALTH

El Camino Health has served the communities of Silicon Valley and the South Bay for more than 60 years, with nationally recognized physicians and nurses at two not-for-profit acute care hospitals in Los Gatos and Mountain View, and 21 care locations across Santa Clara County, which includes primary care, multi-specialty care, and urgent care. Across the organization, El Camino Health has over 4,300 employees, over 1,500 physicians, and 466 patient beds. Key service lines include cancer care, cardiovascular care, maternity care, mental health and addiction services, orthopedics, pulmonology, urology, and women's health. Affiliated partners include El Camino Health Medical Network, El Camino Health Foundation and Concern.

MISSION

It is the mission of El Camino Health to heal, relieve suffering and advance wellness.

COMMUNITY BENEFIT PROGRAM

For more than 60 years, El Camino Health has provided healthcare services beyond its walls — crossing barriers of age, education and income level — to serve the people of its region, because a healthier community benefits everyone.

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

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

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

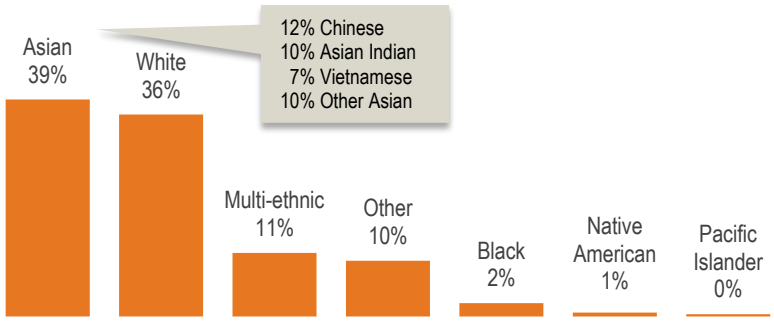
[a] https://www.elcaminohealth.org/about-us/community-benefit

III. EL CAMINO HEALTH'S SERVICE AREA

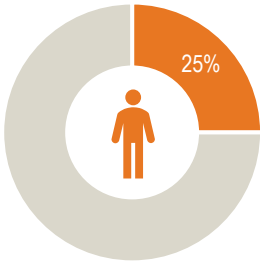
El Camino Health is located in Santa Clara County, and its community encompasses most of the cities in that county, including Cupertino, Los Altos, Los Altos Hills, Los Gatos, Mountain View, San José, Santa Clara, and Sunnyvale. Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2023, close to 1.9 million people lived here, making it the sixth largest county in California by population. San José is its largest city, with almost 970,000 residents (52% of the total).

SANTA CLARA COUNTY DEMOGRAPHICS

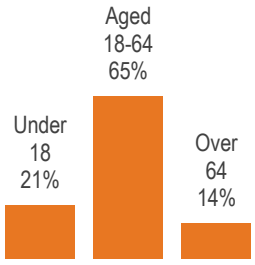
A majority of residents are non-White.



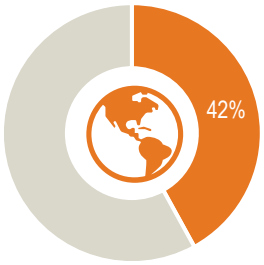
One-quarter are Hispanic.



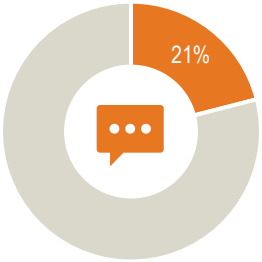
About one in five residents are children.



Over two in five residents are foreign-born.



About one in five over age 5 speak limited English.



$128,176

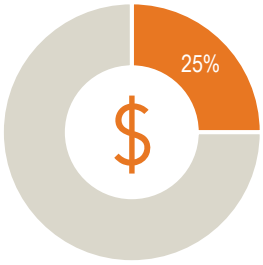
4-person household
Real Cost Measure (RCM)

$1.7M

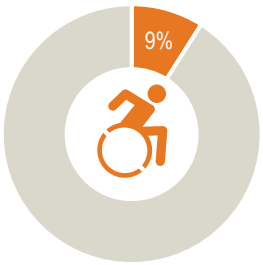
median home sale price

Sources: United Way: Real Cost Measure, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2017-2022, other demographics, 2023.

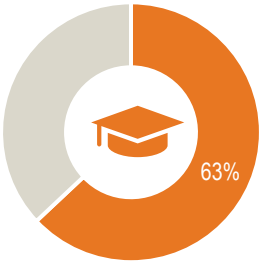
On average, one in four households lives below the Real Cost Measure.



Almost one in ten residents lives with a disability.



Over three in five residents aged 25+ have earned at least a Bachelor's degree.



Source: U.S. Census Bureau: race and age, 2017-2022, other demographics, 2023.

In our assessment of the health needs in our community, we focused particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

IV. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

Per state and federal law, a Community Health Needs Assessment (CHNA) must be conducted every three years by nonprofit hospitals. In 2025, El Camino Health Community Benefit staff conducted a Community Health Needs Assessment in collaboration with the Santa Clara County Community Benefit Coalition. This assessment resulted in the identification of community health needs. The 2025 CHNA serves as a tool for guiding policy and program planning efforts and is available to the public. For information about El Camino Health's 2025 CHNA process and for a copy of the 2025 CHNA report, please visit https://www.elcaminohospital.org/about-us/community-benefit.

IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years. Section 1.501(r)(3)(c) of the IRS regulations pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address.

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Health's planned response to the needs identified through the 2025 CHNA process. Per IRS requirements, the following descriptions of the actions (strategies) El Camino Health intends to take include the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

This 2026 IS Report and CB Plan is based on the 2025 CHNA and outlines El Camino Health's funding for fiscal year 2026. It will be updated annually based on the most recently conducted CHNA.

Financial Summary

FY26 El Camino Health Community Benefit Plan:

- 46 Grants: $3,310,000
  - Requested Grant Funding: $6,438,982
- Sponsorships: $85,000
- Placeholder: $15,000
- Plan Total: $3,410,000

V. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2025 CHNA

The 2025 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide rates and averages.

To be considered a health need for the purposes of the 2025 CHNA, the need had to fit a standard definition, be present in at least two data sources, and either prioritized by key informants or focus groups, or suggested by direct statistical indicators that fail benchmarks or exhibit documented inequities by race.[b] A total of 14 health needs were identified in the 2025 CHNA. The health need selection process is described in Section VI of this report.

2025 Community Health Needs List

1. Housing
2. Economic Stability
3. Behavioral Health
4. Diabetes & Obesity
5. Respiratory Health
6. Unintended Injuries/Accidents
7. Healthcare Access & Delivery
8. Heart Disease & Stroke
9. Maternal & Infant Health
10. Education
11. Cancer
12. Communicable Diseases
13. Community Safety
14. Sexual Health

[b] The definition of a health need is a poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need. Further definitions of terms and specific criteria for health needs identification may be found in El Camino Health's 2025 CHNA report.

VI. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) & COMMUNITY BENEFIT PLAN DEVELOPMENT

El Camino Health selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health initiative. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VII. HEALTH NEEDS THAT EL CAMINO HEALTH PLANS TO ADDRESS

PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In October 2024, the Hospital Community Benefit Committee (HCBC) met to review the information collected for the 2025 CHNA. The purpose of the meeting was to help select the needs El Camino Health would address, which would form the basis for its FY2026 community benefit plan and implementation strategies. The HCBC, by consensus, selected the following needs to address:

- Healthcare Access & Delivery (including oral health)
- Behavioral Health (including domestic violence and trauma)
- Diabetes & Obesity
- Other Chronic Conditions (other than Diabetes & Obesity)
- Economic Stability (including food insecurity, housing, and homelessness)

DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTH PLANS TO ADDRESS

Healthcare Access and Delivery (including oral health)

Healthcare Access and Delivery, which affects various other community health needs, was identified as a top health need by two-thirds (67%) of focus groups and key informants combined. CHNA participants highlighted high copays and lack of insurance coverage among community residents (e.g., high deductibles, lapsed coverage among Medi-Cal-eligible individuals) as barriers to healthcare access. Statistical data show that Santa Clara County's proportion of uninsured residents is low, yet it is slightly higher (worse) than San Mateo County's. Many key informants and focus group participants connected healthcare access with economic instability, noting that people are less likely to seek care if they cannot pay for it.

Participants felt there were significant issues with access to preventive care (e.g., colonoscopies, mammograms), including long wait times for such appointments, which could lead to worsened health outcomes. Some professionals specifically noted that the healthcare system is under such strain that some preventable issues become acute due to the consequent long waits for these appointments.

CHNA participants indicated that community-based clinics and programs providing direct healthcare services are beneficial but underfunded. In particular, participants focused on difficulties in accessing dental care, especially for low-income individuals and those on Medi-Cal. They explained that there is a significant lack of providers who actually accept Denti-Cal. Participants noted that even basic dental care can be prohibitively expensive, leading patients to delay or forego treatment altogether.

Participants said migrant and undocumented communities struggle greatly with access to healthcare due to high costs, lack of insurance, and difficulty navigating the medical system.

Many community members have challenges understanding medical terminology and knowing what questions to ask providers. Participants also mentioned access barriers for individuals with disabilities or special needs and those with poor transportation options.

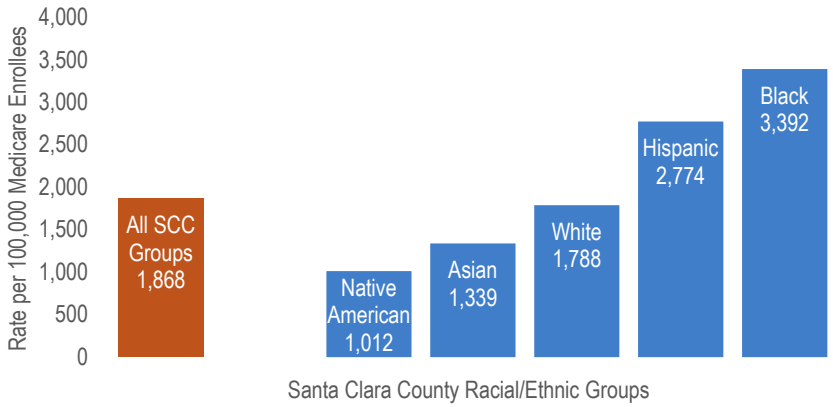
> *"Most nurses or medical practitioners do not know ASL [American Sign Language]... I do not feel good always going with the translator or having to write [things] down or wait longer periods just to be attended to."*
>
> —Participant, Community Focus Group

CHNA participants described the lack of cultural concordance, or at least cultural competence, as a significant issue in healthcare delivery, with certain populations experiencing discrimination and language barriers that hinder access to care. Close to 9% of the county's population is not proficient in English. In particular, over 9% of children in Santa Clara County live in a limited English-speaking household, a higher proportion than in neighboring San Mateo County or California overall (both around 7%). In addition to limited English-speaking households, participants also recognized the LGBTQ+ community as a group that faces significant disparities across health indicators. One local expert noted that stigmas and historical mistreatment make it difficult to gather data on the LGBTQ+ population's specific needs.

> *"I'm seeing folks who are not aware of resources, if they're aware of resources they don't know how to access, or they have apprehensive thoughts or actions about accessing those resources for a variety of reasons."*
>
> — Service Provider, Health Equity Focus Group

CHNA participants described systemic inequalities resulting in higher rates of chronic illnesses and lower quality of care for Black, Indigenous, and people of color (BIPOC) groups. For example, preventable hospital stays, which are higher among Black and Hispanic populations compared to Whites and Asians in Santa Clara County, may be a sign of inequitable access to high-quality care.

Black and Hispanic Medicare enrollees have significantly higher rates of preventable hospital stays than other groups.



Source: Center for Medicare & Medicaid Services Mapping Medicare Disparities Tool, 2020. Retrieved from County Health Rankings, June 2024.

Several CHNA participants specifically mentioned inequities in care provided to Black people, including inadequate maternal care. Access to critical maternal health services, including perinatal care, was a recurring issue among participants consulted during the CHNA as well. Certain maternal and infant health statistics are worse in East San José than in the county overall, including the proportion of premature births, low birthweight births, and infant mortality. Infant mortality and pre-term births in Santa Clara County are highest for Black and Hispanic babies. The county's low birthweight babies are disproportionately born to Black mothers. Teen births are highest among the county's Latinas (16 per 1,000 females aged 15-19) compared to their peers of other ethnicities (most fewer than 6 per 1,000).[c] Of all teen births, nearly 84% are to Santa Clara County Latinas. Maternal morbidity in Santa Clara County is highest among the Black population (193.9 per 10,000 delivery hospitalizations) compared to the overall rate (136.7 per 10,000), including issues such as preeclampsia, hypertension at delivery, and postpartum depression.[c] Young mothers and mothers of color who participated in the CHNA reported feeling judged and stereotyped by healthcare providers, which affected their general care experience and the quality of the care they received.

CHNA participants also spoke at length about issues of access to mental healthcare and substance use treatment, which is covered in the Behavioral Health need description, below.

Behavioral Health (including domestic violence and trauma)

Behavioral Health, which includes mental health and trauma as well as consequences such as substance use and domestic violence, ranked high as a health need, being prioritized by more than three-quarters (77%) of the CHNA's focus groups and key informants combined.

CHNA participants frequently noted increases in feelings of loneliness and isolation among community members of all ages, including older adults and youth. Participants emphasized that isolation and loneliness among older adults has worsened since the COVID-19 pandemic, exacerbating mental health issues. One expert highlighted the connection between loneliness, lack of social engagement, and cognitive decline in geriatric populations. Participants also expressed great concern regarding youth mental health. They mentioned high levels of anxiety and depression among youth and young adults, with particular emphasis on students of color and English language learners. Based on public health statistics, mental diseases/disorders are the primary reason for child hospitalizations in Santa Clara County.

Many participants suggested that economic stressors and structural inequities, such as those created by systemic discrimination, have heightened poor mental health overall. One of the common barriers identified was insufficient support systems. In particular, postpartum depression and anxiety were common issues among participants who were mothers, with many feeling they did not receive adequate mental health support.

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[c] Rates are not age-adjusted.

Mental healthcare access is somewhat worse overall in Santa Clara County than in San Mateo County, and especially poor for youth: there are far more students per school psychologist in the county (1199:1) compared to the state ratio (1041:1) or that of San Mateo County (994:1). Specific populations that CHNA participants identified as disproportionately affected by access to mental/behavioral healthcare included the unhoused, rural, and limited-mobility populations, who have issues with physical access; low- and middle-income populations, whose challenges are primarily economic access; and English learners, people of color (Asian and Pacific Islander, Black, and Hispanic populations), and LGBTQ+ populations, who experience care delivery issues including linguistic and cultural mismatches. Concerns also arose over low utilization related to the stigma of poor mental health among low-income communities and Asian and Pacific Islander communities, to name a few.

There are also geographic differences to consider. Although self-harm hospitalizations are not worse for the county overall (27.2 per 100,000 population) compared to state or local benchmarks, the rate is significantly higher in the Mountain View area (32.9). Similarly, while Santa Clara County's overall suicide rate (7.7 per 100,000) is not as high as the state rate, the suicide rate in East San José (8.4) surpasses the county's rate. Overall, deaths of despair (deaths due to alcohol, drug use, or suicide) are also higher in East San José (44.8 per 100,000) compared to the county overall (30.8).

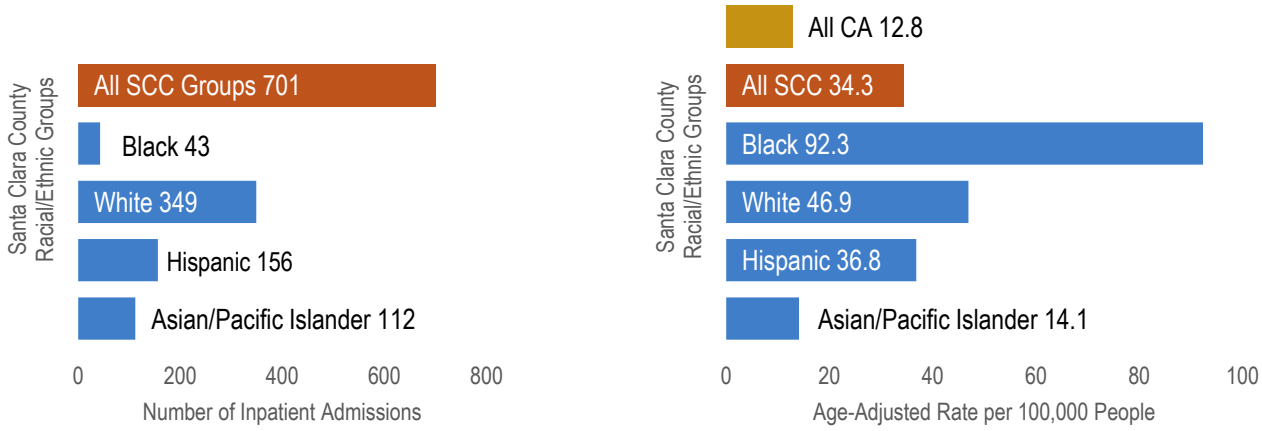
> *"You have individual trauma, you have community trauma, familial, you have generational trauma. … I also think addiction thrives in isolation and loneliness and disconnection. And when I think about this huge spike we saw of overdose deaths being driven by fentanyl and methamphetamines, I think that is a huge part of it as well. It [the combination of issues] makes it hard for folks, even when they're seeking treatment, to stay healthy and well."*
>
> —Behavioral Health Expert

Trauma was frequently cited as a root cause of substance use, mental health issues, and subsequent community violence.

Key informants and focus group attendees spoke about countywide increases in substance use, which they said was often employed as a coping behavior in situations when individuals experience social isolation, high stress, and/or discrimination (e.g., racism). Additionally, participants expressed concern about levels of use of various substances in the county (e.g., higher rates of cannabis and alcohol use among youth and LGBTQ+ populations; greater methamphetamine use among the unhoused and justice-involved populations). They reported that there is a lack of accessible substance use treatment programs (inpatient/residential), and long waiting lists for the few programs that do exist. The rise in drug potency continues to lead to higher levels of accidental fentanyl-related and other opioid-related overdoses and deaths, and was referenced multiple times among CHNA participants. Participants described Santa Clara County's low-income population as being the first in the county affected by rising opioid overdoses, followed by more affluent populations.

Among all ages, opioid overdose hospitalization rates in the county (34.3 per 100,000 people) and, specifically, in the Mountain View area (34.2), are close to triple California's rate (12.8). Although excessive alcohol use is no worse in the county than at the state level, the proportion of driving deaths with alcohol involvement is still higher in Santa Clara County than in neighboring San Mateo County (though trending down). Recent alcohol use by youth (measured as use within the past month) appears to be highest among the county's Black and Pacific Islander populations, compared to their peers of other ethnicities. Santa Clara County's American Indian/Alaskan Native population had the highest proportion of youth across all ethnic groups who tried alcohol more than seven times in their lifetime.[d]

The number of opioid hospitalizations is highest among White residents, but the rate per 100,000 population is highest for Black residents.



Source: California Department of Health Care Access & Information (HCAI), Patient Discharge Data, 2017-21.

Finally, close to two in five focus groups and interviews prioritized community and family safety. Some CHNA participants noted an increase in domestic violence cases following the COVID-19 pandemic, with cases becoming more complex and requiring more individual-level support. Statistics show that domestic violence-related 911 calls are higher in Santa Clara County (4.7 per 1,000 people aged 18–69) than in neighboring San Mateo County (4.0).[e] In addition, the rate of substantiated child abuse/neglect cases in the county is more than double that of San Mateo County. CHNA participants linked family safety concerns to economic instability and housing issues. They noted that financial stress and lack of stable housing contribute to unsafe environments. Participants identified immigrant communities and low-income families as particularly vulnerable to these issues. They said the stress from unsafe environments affects family dynamics and overall well-being.

[d] Note that of the youth in Santa Clara County's public schools (7th, 9th, 11th, and non-traditional students, aligning with the indicators shown), Black students are 1.9%, Pacific Islander students 0.5%, and Native students 0.2% of all enrolled students in those grades. Therefore, alcohol use proportions should be treated with caution.

[e] Rates are not age-adjusted.

Diabetes and Obesity

Just over one-third (35%) of key informants and focus group discussions identified Diabetes and Obesity as a top health need. Among discussion participants, there was a shared emphasis on the need for care focused on prevention through education, nutrition support, and lifestyle changes. Likewise, the importance of culturally competent health initiatives was mentioned in this context (i.e., programs that are accessible and relevant to diverse populations). Structural inequities were also seen as fundamental to the origins of diabetes and obesity; for example, some participants discussed the need for continued efforts to improve local food systems in places where diabetes is particularly prevalent.

Economic insecurity and poverty along with the high cost of living were frequently mentioned as underlying factors that exacerbate diabetes and obesity. For example, some indicated that inflation has made it more difficult for low-income families to afford nutritious food and the lack of healthy alternatives diminishes the ability of families to sustain healthy lifestyles.

> *"How do you promote healthy eating when all you have is McDonald's and Taco Bell on every corner? You have liquor stores that sell food, but it's all just processed foods. …I've had diabetics who were homeless, but they could only eat what was given to them. These shelters[,] the food banks… a lot of the times it's just carbs after carbs, or it's canned food. And I mean, I know it's something. But …it's like this terrible cycle. How do we get better nutrition to our community?"*
>
> —Healthcare Provider

Some participants further linked the experience of chronic stress to poor management of diabetes and obesity, highlighting the need for integrated care approaches.

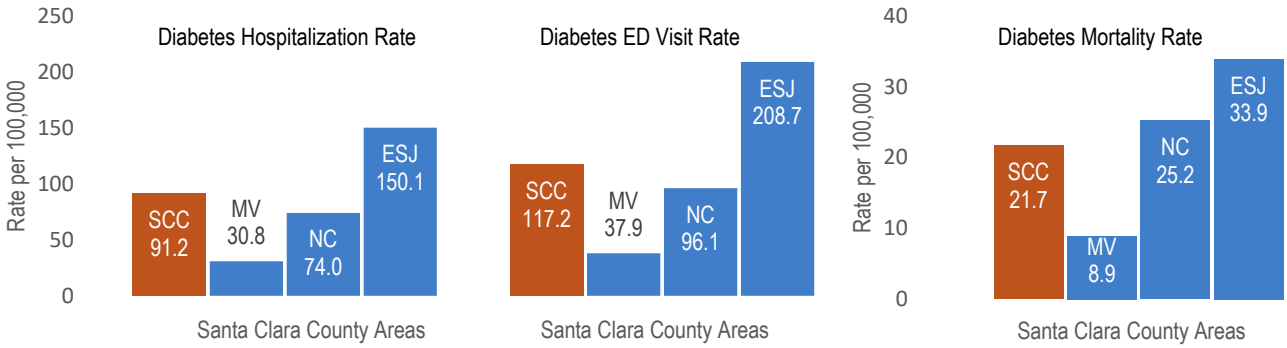
Participants noted that high copays and lack of insurance coverage for effective diabetes medications are significant barriers. They also said that access to nutritionists and proper dietary guidance is limited, making it more difficult for patients to manage chronic conditions like diabetes effectively. One participant emphasized the challenge of underdiagnosis of prediabetes among Hispanic community members despite high diabetes rates.

Diabetes mortality is 50% higher in Santa Clara County (21.7 per 100,000) compared to the state rate (14.4). It is highest in East San José (33.9), and also high in the northern part of the county (25.2). Deaths from diabetes are much higher among both the Black (41.0) and Hispanic (37.0) communities in Santa Clara County compared to other ethnic populations in the county. Tracking with the mortality rate, emergency department visit rates and hospitalizations for diabetes are also highest in East San José and among both Black and Hispanic residents of Santa Clara County. The Silicon Valley Latino Report Card states that over 20% of Hispanic children are overweight.[f] Supporting these data, some CHNA participants noted that diabetes is

[f] Hispanic Foundation of Silicon Valley. (2023). *2023 Silicon Valley Latino Report Card.*

a significant issue in East San José, with high rates of both diabetes and prediabetes, particularly among Hispanic and Asian populations.

Diabetes morbidity and mortality rates (per 100,000) are worse in East San José than Santa Clara County overall and worse than the other sub-county target areas of Mountain View and North County.



Source: Santa Clara County Public Health Department. ED Visits and Hospitalizations are 2017-21; Mortality 219-23. SCC=Santa Clara County; MV=Mountain View Corridor; SC=South County; NC=North County; ESJ=East San José.

While low overall, child diabetes hospitalizations are higher in Santa Clara County compared to San Mateo County. Physical fitness, one of the drivers of diabetes and obesity, is also lower (worse) for elementary and middle-schoolers in Santa Clara County than in San Mateo County. Although high-schoolers appear to be faring better, physical fitness among the county's ninth graders is declining, while Hispanic and Pacific Islander children are performing considerably worse than their peers of other ethnicities when it comes to physical fitness.

None of the other available statistics (e.g., adult physical activity, child diet, food environment, exercise opportunities) are worse for the county overall compared to either neighboring San Mateo County or the state as a whole. However, these state and local benchmarks are not considered particularly healthy. For example, over 20% of Santa Clara County adults are obese, compared to 21% of San Mateo County adults and 30% of CA adults. Similar proportions among adults who are physically inactive can also be found in each geography. One CHNA participant noted that physical activity is hindered by safety concerns in certain neighborhoods, making it difficult for residents to exercise freely outdoors, while others mentioned the lack of access to exercise facilities in certain areas.

Chronic Conditions (other than diabetes and obesity)

Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: overall mortality rates for Alzheimer's disease and other dementias, cancer, chronic liver disease/cirrhosis, heart disease, and stroke are all better than state benchmarks. For that reason, most of these chronic conditions were not identified as health needs in the 2025 Community Health Needs Assessment (CHNA). However, health conditions such as cancer, cardiovascular disease, and respiratory problems are among the top 10 causes of death in

Santa Clara County.[g] In addition, there are some concerning statistics and data that show significant racial/ethnic disparities for cancer and respiratory conditions. Finally, El Camino Health has a commitment to continuing to address chronic conditions as a health need, given its specific expertise and long-standing work on this issue.

About one-third (35%) of key informants and focus groups combined named a chronic condition (e.g., cancer, heart disease) as a top health need. Below are the common themes related to chronic conditions that arose during CHNA discussions.

- **Respiratory health:** Some participants described an increase in asthma cases, particularly among children. The importance of a healthy environment and climate was mentioned, with some participants mentioning that climate change and poor air quality can negatively impact respiratory health. Experts participating in the CHNA noted a significant increase in tuberculosis (TB) rates, particularly among individuals who have been in the country for over 10 years. They said the pandemic made this issue worse due to reduced testing and diagnosis.
- **Cancer:** A professional noted that the pandemic led to a decrease in routine screenings like mammograms, which may have resulted in missed or delayed cancer diagnoses. Community members' stories also illustrated potential gaps in timely and comprehensive cancer screening.
- **Cardiovascular health:** Economic instability and poverty were frequently mentioned as factors that limit access to healthy food and healthcare services, which are crucial for preventing and managing heart disease. Some participants also highlighted the high cost of accessing healthcare, including insurance and prescriptions, as a significant barrier to managing cardiovascular health.
- **Alzheimer's disease and dementias:** Many participants highlighted the issue of social isolation among older adults, which plays a factor in cognitive decline and dementias. One professional in particular described long waitlists for nursing facilities and challenges accessing in-home care, made more problematic by the general absence of family support that is often due to the economic migration of younger generations.

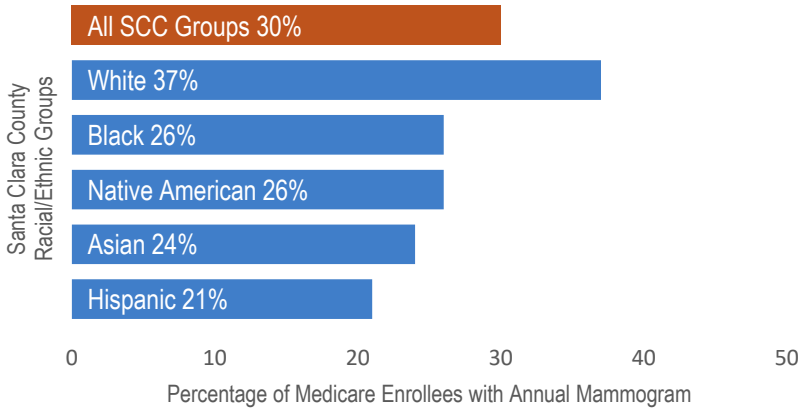
> *"When we're talking about the older adult population that is most likely to develop, say, dementia, there's usually some other kind of chronic condition that goes along with that. It's mainly manageable, but it gets more complicated by the overlay of dementia. So access to care and follow-up care is really important."*
>
> — Service Provider

Although Santa Clara County's overall cancer mortality (112.0 per 100,000) is on par or better than the state (119.8), mortality by race/ethnicity indicates substantial disparities. For example, overall cancer mortality among Santa Clara County's Black population is much higher (143.5) compared to other ethnic groups. Similarly, the county's Black population has higher rates of mortality for female breast, colorectal, and prostate cancers. While the county's White

[g] Silicon Valley Institute for Regional Studies. (2022). *Silicon Valley Indicators.* Deaths, by Cause: Santa Clara and San Mateo Counties.

population also has cancer incidence and mortality rates that exceed benchmarks, these rates are generally lower than those of the county's Black population. Mammography screening among older adults in the county is highest for White women, and lowest for Latinas.

Hispanic older adults are the least likely to have had a mammogram (breast cancer screening) compared to their peers from other racial/ethnic groups.



Source: Centers for Medicare & Medicaid Services Mapping Medicare Disparities Tool, 2020. Retrieved from County Health Rankings, June 2024.

In addition, some Santa Clara County cancer incidence rates are of marked concern. The county's liver cancer incidence rate is 10.5 per 100,000 people, higher than in neighboring San Mateo County (9.1) or statewide (9.9). The county also has a higher colorectal cancer incidence rate compared to San Mateo County. Finally, Santa Clara County has a higher overall cancer incidence rate for youth aged 15-19 compared to San Mateo County.

Mortality rates for both heart disease and stroke are much higher among the county's Black and Hispanic populations than other ethnic groups. Although Santa Clara County Whites also have a high CVD mortality rate, it is not as high as the rates for certain BIPOC populations.

With regard to respiratory health, Santa Clara County has historically had a higher TB case rate compared to California overall. The most recent data show that TB is still an issue. Asthma is also a concern, especially for children: the overall rate of all Santa Clara County children who were hospitalized for asthma is higher than the asthma hospitalization rate of all children in San Mateo County. However, Santa Clara County children aged 5-17 were hospitalized for asthma at nearly twice the rate (4.0 per 10,000 hospitalizations) of their San Mateo County counterparts (2.1). East San José has disproportionately high child hospitalizations for asthma (5.5 per 10,000 aged 0-17), and the county's Black population has an even higher rate (12.6). Child emergency department visits for asthma are similarly disproportionate.

Given these quantitative and qualitative data, El Camino Health has grouped cancer, cardiovascular disease, respiratory problems, Alzheimer's and dementia, and other chronic

conditions into an overall category that it will address called “Chronic Conditions (other than Diabetes and Obesity),” as indicated above.

El Camino Health is dedicated to contributing to its community’s good health. We will continue to monitor and share these data indicators (and others) to increase awareness of chronic conditions in Santa Clara County.

Economic Stability (including food insecurity, housing, and homelessness)

The vast majority (84%) of all focus groups and key informants identified economic stability and/or housing and homelessness as a top community priority. CHNA participants focused on the high cost of living in Santa Clara County, describing how cost is implicated in interrelated issues:

- Participants said housing market prices remain extremely high, making it difficult for many to afford housing. The data indicate that home ownership is lower in Santa Clara County (56%) than in San Mateo County (60%). Participants described how economic instability forces people to move out of the area or live in overcrowded and/or unsafe conditions (e.g., poorly maintained housing, vehicles, makeshift shelters). Housing quality is still a concern in Santa Clara County; for example, the data show that a small fraction of the county’s children and young adults aged 6-20 have very high blood lead levels (at least 9.5 mcg/dL), while San Mateo County has eradicated this issue entirely.

  "We are seeing multi-generational families living in one home. They might not have access to a kitchen. We are seeing a lot of families living in a garage with a microwave."

  “People are cutting costs on their medication, not going to the doctor’s, nothing, …and then also living in situations which [are] uninhabitable or not recommended, where there are three families, five families, people are huddled together, couch surfing and sleeping in their cars.”

  — Service Providers’ Focus Group

- Participants said wages do not keep pace with the cost of living. They explained that low wages and high living costs compel individuals as well as families to make difficult choices between essential needs like food, rent, and healthcare. The data show that the proportion of people experiencing food insecurity in Santa Clara County is higher than in San Mateo County. Participants also indicated that economic insecurity especially affected certain job sectors due to high living costs (e.g., janitorial services). And data show there is a greater gender pay gap in Santa Clara County ($0.73 to the dollar) than there is statewide ($0.86) or in San Mateo County ($0.90).

  "Economic security here is bad. The reason is that the salary is very low. Every time you go to Cárdenas, to any grocery store, the groceries are through the roof. You have to decide whether you eat or pay the rent."

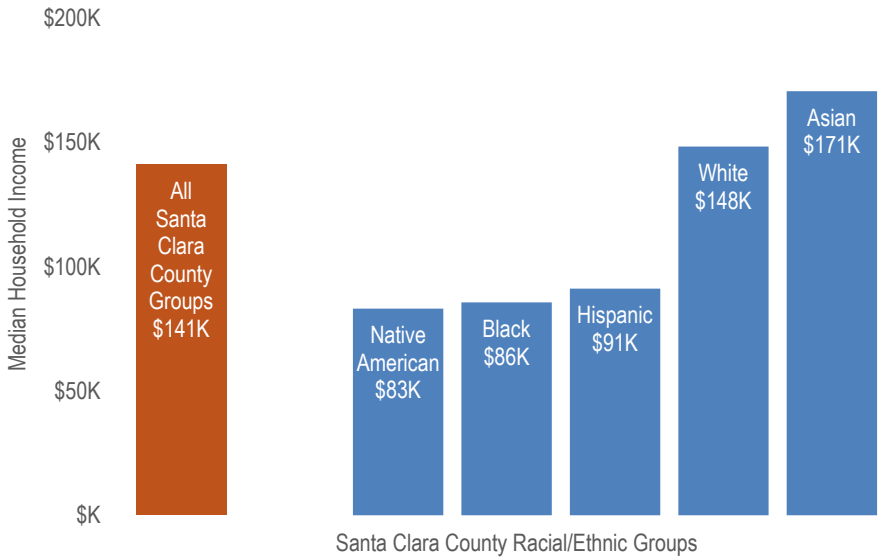
  — Spanish-speaking Community Member

Santa Clara County's percentage of households with children below the Federal Poverty Level is higher than neighboring San Mateo County's, and is rising. In Santa Clara County, Black, Hispanic, and Native American families with children are disproportionately more likely to be in poverty than their Asian or White peers.

The data indicate that childcare costs in Santa Clara County have more than doubled in the past 10 years outpacing median family income, which rose 64% over the same time period. Adequate childcare and preschool were identified by CHNA participants as crucial for economic mobility and foundational learning. Spending per pupil is lower in Santa Clara County ($14,733) compared to San Mateo County ($17,293). Research found that educational inequities, often related to neighborhood segregation[h], lead to educational disparities that begin at an early age.

CHNA participants also identified socioeconomic disadvantages and language barriers as significant inequities affecting educational attainment. Household income inequality by race/ethnicity reached an all-time high in 2022, and there are substantial disparities in median income by race/ethnicity within the county.

Median household income in Santa Clara County varies substantially by race/ethnicity, with BIPOC households earning the least.



Source: US Census Bureau Small Area Income and Poverty Estimates. Retrieved from County Health Rankings, June 2024.

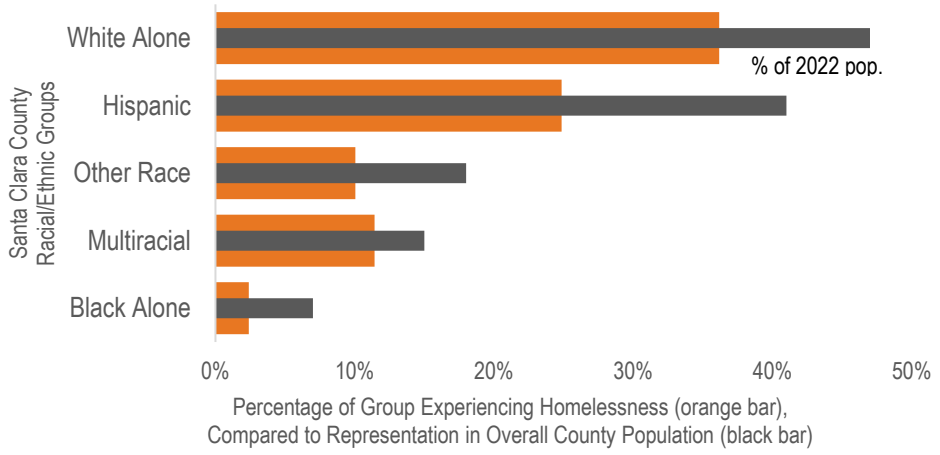
Santa Clara County's high school graduation rate was lower (83%) than the state rate (88%) in 2022, with the county's Hispanic students more likely than students of other ethnic groups to drop out before graduation. Education has generally and historically correlated directly with

[h] Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA.

income, so educational statistics that differ by race/ethnicity are particularly concerning to CHNA participants.

Specifically with regard to unhoused populations, CHNA participants indicated that mental health issues and substance use disorders can be both causes and consequences of homelessness. Participants also mentioned that parents experiencing homelessness fear losing custody of children because of their unhoused status. Participants enumerated the groups that are most vulnerable to housing instability in Santa Clara County: Black and Hispanic community members, LGBTQ+ community members, single mothers, and foster youth. Black and multiracial people are the most overrepresented in the unhoused population relative to their proportions in the county's overall population. Finally, older adults (aged 65+) and other individuals on fixed incomes can also be vulnerable. Local older adults in Santa Clara County who participated in the Community Assessment Survey of Older Adults give a "Livability Score" of 19 out of 100 for housing.[i]

Among those experiencing homelessness, Black people are the most overrepresented compared to their proportion of Santa Clara County's population.



Source: 2023 Santa Clara County Point-in-Time Count public Tableau dashboard. Population: U.S. Census Bureau. "ACS Demographic and Housing Estimates." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2022.

[i] Polco, formerly the National Research Center. (2023). *Community Assessment Survey for Older Adults: Avenidas, September 2022*.

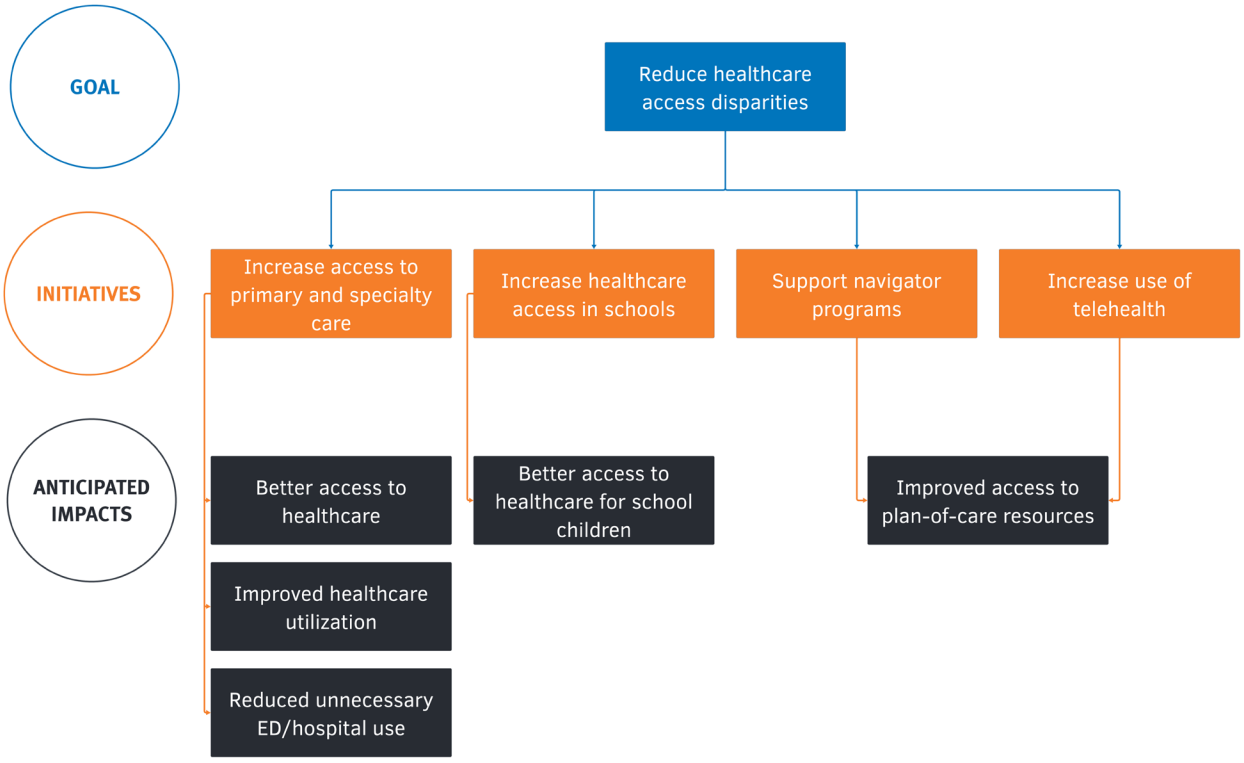
VIII. EL CAMINO HEALTH'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Health's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, our community health investment for FY 2026 will be directed to improve healthcare access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

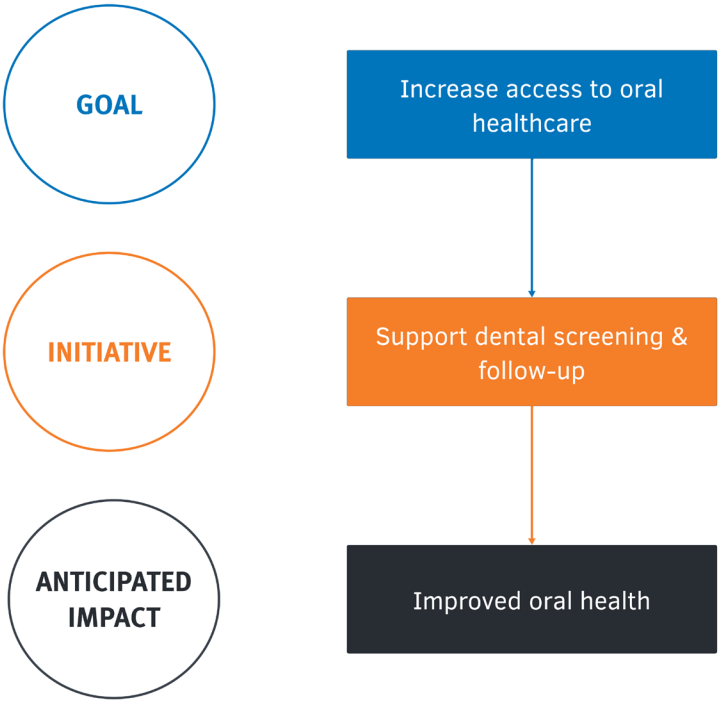
El Camino Health believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2025 CHNA process.

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

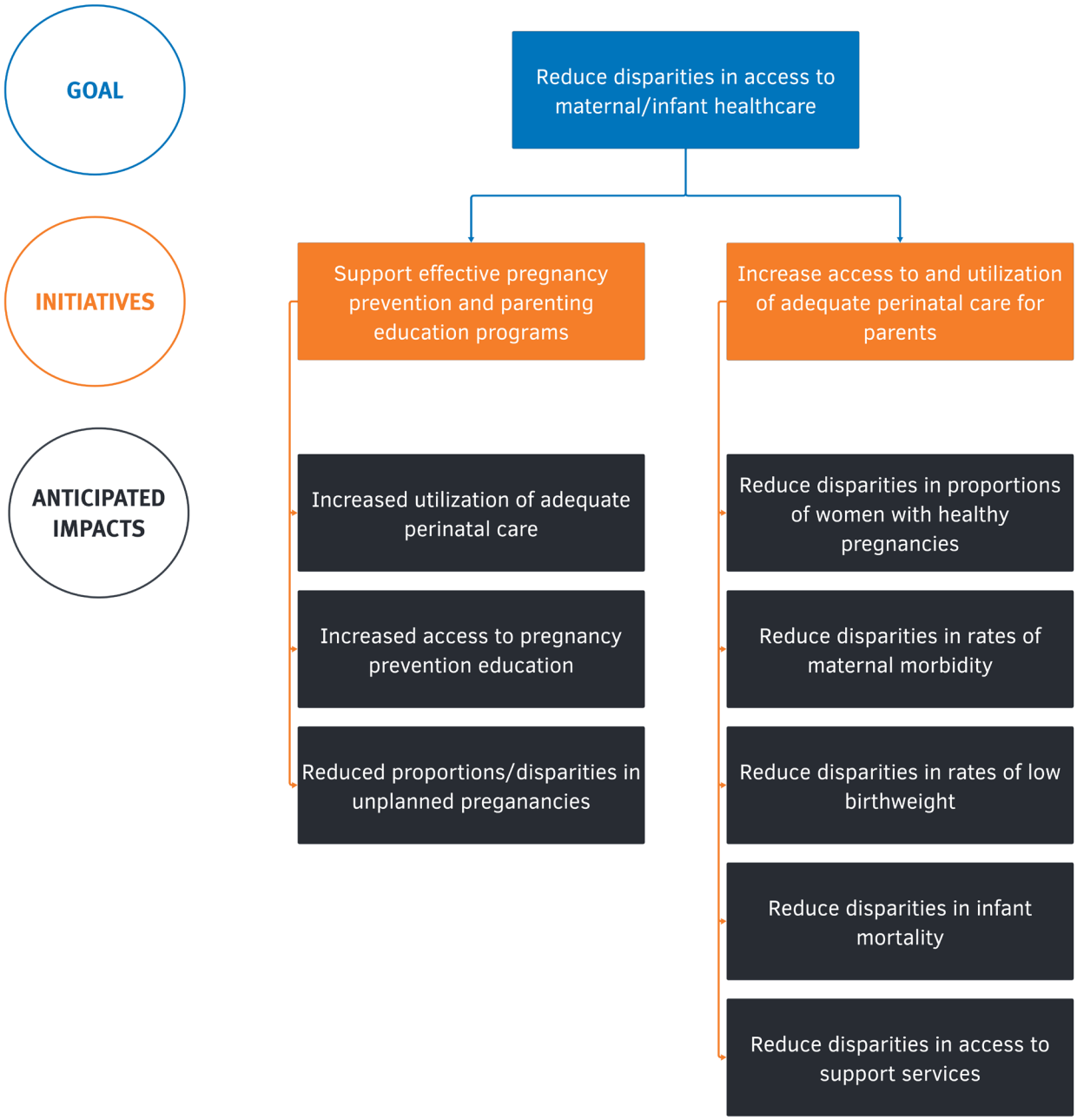
El Camino Health views efforts to ensure equitable access to high-quality healthcare and respectful, compassionate, culturally competent delivery of healthcare services as a top priority for its community benefit investments. Given the community's identification of issues of healthcare access and delivery during the 2025 CHNA, El Camino Health selected goals that support initiatives to reduce disparities in access to and delivery of primary and specialty care for community members in its service area. The goals also include improvements in access to and delivery of oral healthcare and maternal/infant healthcare based on statistical data and information provided by experts interviewed during the CHNA. The hospital expects to make a positive impact by improving healthcare access and utilization, reducing unnecessary emergency department visits and hospitalizations, and reducing disparities in health outcomes. Below and on the following pages, see diagrams for summaries and tables for details.



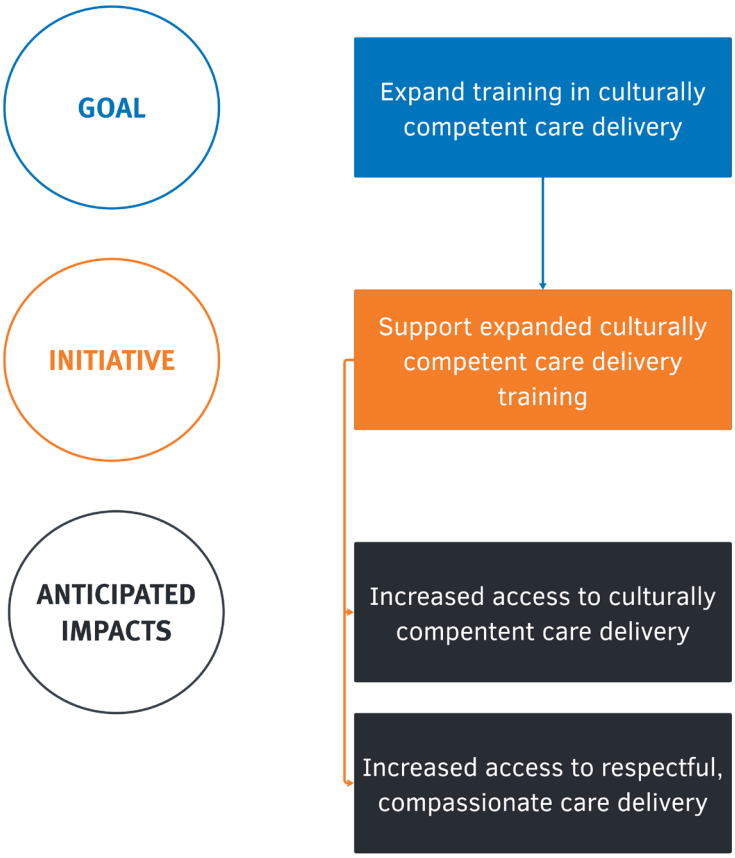
Goal	Initiative	Anticipated Impact
1. Reduce disparities in access to high-quality care	A. Support increased access to primary care and specialty care services for vulnerable individuals[1, 2, 3, 4, 5, 6, 7, 8, 9, 10]	(i) Individuals experience better access to healthcare (ii) Improved healthcare utilization (iii) Reduced unnecessary ED visits and preventable hospitalizations
	B. Support greater access to healthcare in schools[11]	(i) Improved access to healthcare for school-aged children and youth
	C. Support clinical and community health navigator programs[12, 13, 14]	(i) Community members access clinical and community resources that support their plan of care
	D. Support increased use of telehealth and other technology solutions[15, 16, 17]	



Goal	Initiative	Anticipated Impact
2. Increase access to oral healthcare for underserved community members	A. Support school- and community-based programs that offer dental screenings and care, including tele-dentistry[18, 19, 20, 21]	(i) Improved oral health among community members


GOAL
INITIATIVES
ANTICIPATED IMPACTS
Reduce disparities in access to maternal/infant healthcare
Support effective pregnancy prevention and parenting education programs
Increase access to and utilization of adequate perinatal care for parents
Increased utilization of adequate perinatal care
Increased access to pregnancy prevention education
Reduced proportions/disparities in unplanned preganancies
Reduce disparities in proportions of women with healthy pregnancies
Reduce disparities in rates of maternal morbidity
Reduce disparities in rates of low birthweight
Reduce disparities in infant mortality
Reduce disparities in access to support services

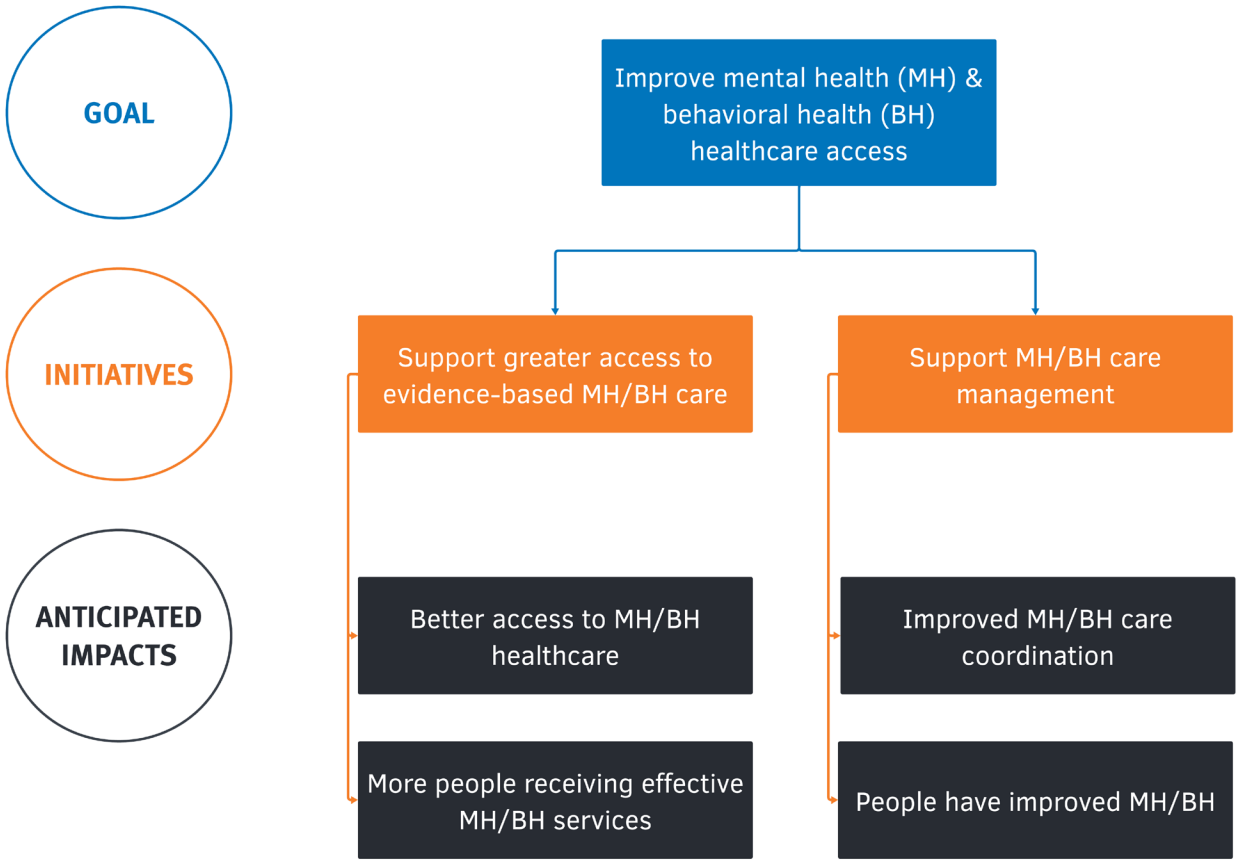
Goal	Initiative	Anticipated Impact
3. Reduce disparities and inequitable access to maternal/infant healthcare for community members	A. Support effective pregnancy prevention and parenting education programs[22, 23, 24]	(i) Increased utilization of adequate perinatal care (ii) Increased access to pregnancy prevention education (iii) Reduced proportions/ disparities in unplanned pregnancies
	B. Increase access to and utilization of adequate perinatal care for parents[25, 26, 27, 28, 29, 30]	Reduced disparities in: (i) Proportions of women with healthy pregnancies (ii) Rates of maternal morbidity (iii) Rates of low birthweight (iv) Rates of infant mortality (v) Access to support services



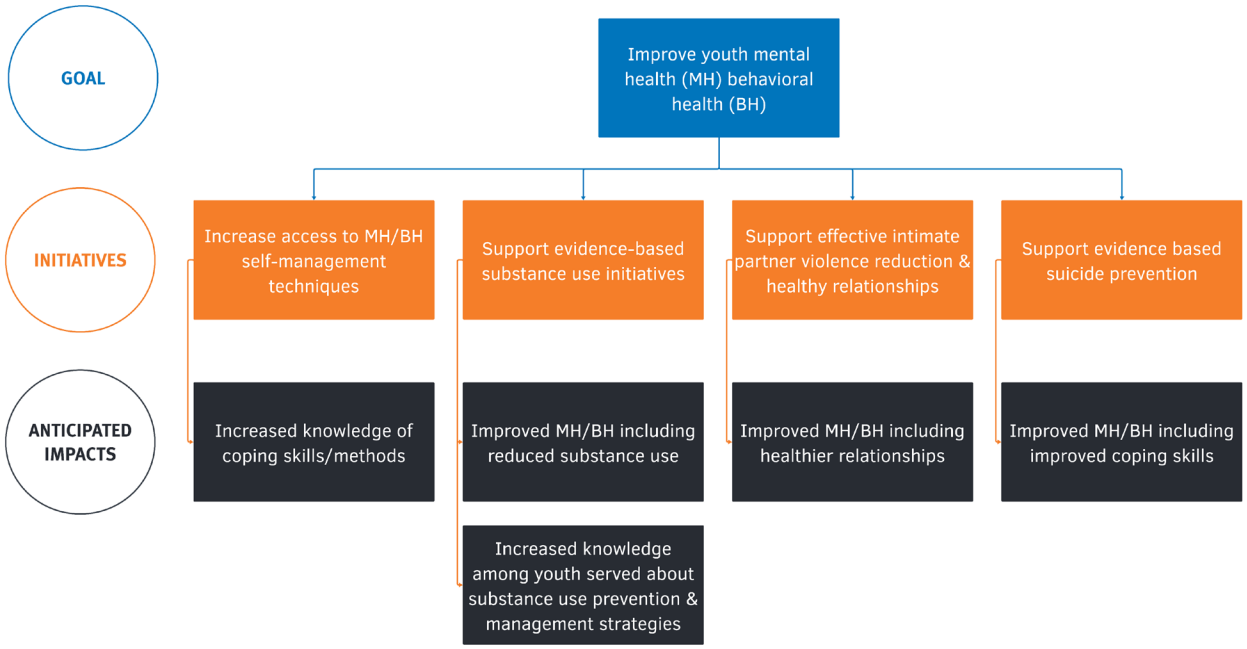
Goal	Initiative	Anticipated Impact
4. Provide/expand workforce training in cultural competence, and compassionate and respectful care delivery	A. Support workforce training in cultural competence, and compassionate and respectful care delivery[31, 32, 33, 34]	(i) Increased access to culturally competent healthcare services among underserved community members, including LGBTQ+ and community members with limited English proficiency (ii) Increased access to compassionate and respectful healthcare among underserved community members, including LGBTQ+ and community members with limited English proficiency

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

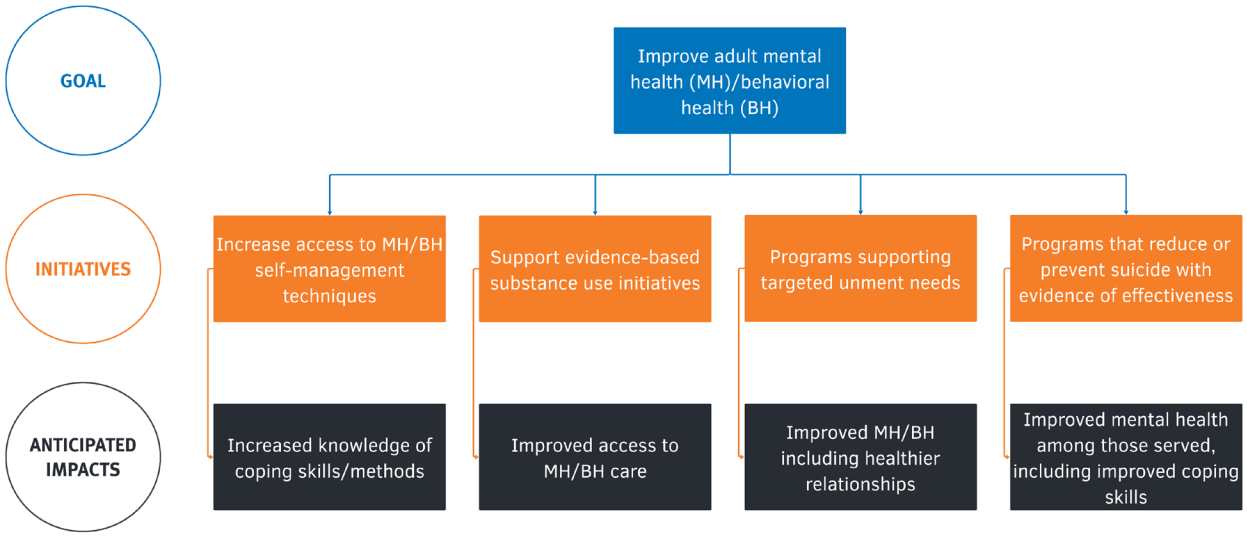
Data indicates that behavioral health (including mental health, trauma, and substance use) continues to be a significant health need, especially with respect to the supply of providers. Community input during the 2025 CHNA emphasized how much worse and more widespread behavioral health issues have become, in part due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral healthcare, El Camino Health chose goals that support more direct approaches to improving the mental and behavioral health of both youth and adult community members. By using a two-pronged approach, addressing access to care as well as care itself, El Camino Health expects to be able to make a positive impact by improving community members' mental and behavioral health, including contributing to improved coping skills, healthier relationships, and reduced substance use. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Improve behavioral healthcare access for community members	A. Support in-person and virtual expanded access to evidence-based counseling, addiction treatment, behavioral health case management, etc. [35, 36, 37, 38, 39]	(i) Improved access to mental/behavioral health programs and services (ii) More community members receiving effective mental/ behavioral health services
	B. Care management to support community members' self-management and mental health[40, 41]	(i) Improved coordination of mental/behavioral services (ii) Improved mental/behavioral health among those served



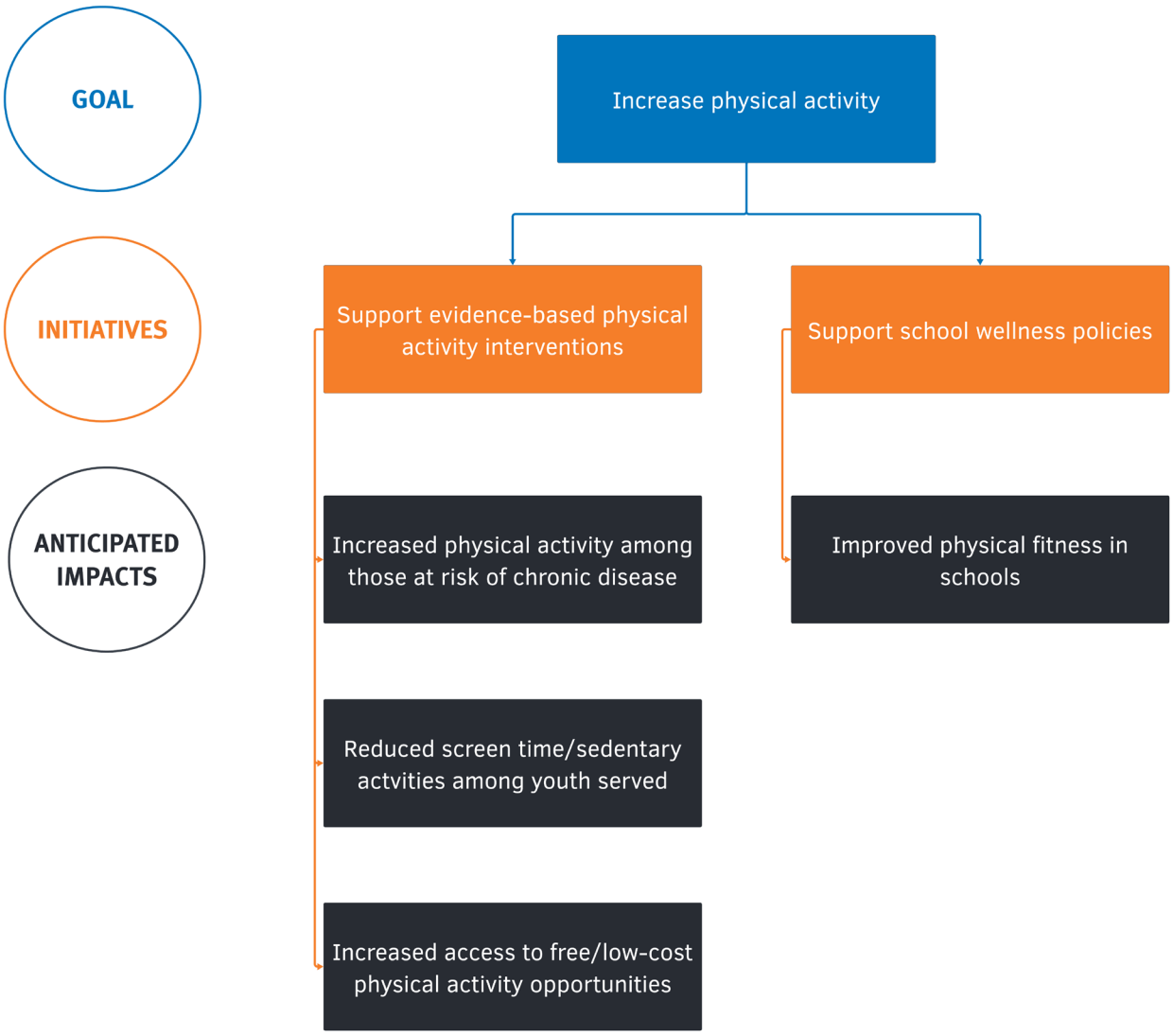
Goal	Initiative	Anticipated Impact
2. Improve behavioral health of youth in the community	A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[42 , 43]	(i) Increased knowledge among youth served about methods of coping with stress and depression
	B. Support for substance use prevention and intervention initiatives with evidence of effectiveness[44, 45, 46]	(i) Improved mental health among those served, including reduced substance use (ii) Increased knowledge among youth served about substance use prevention and management strategies
	C. Programs that prevent or reduce youth and young adult intimate partner and sexual violence and promote healthier relationships[47, 48]	(i) Improved mental health among those served, including healthier relationships
	D. Programs that reduce or prevent suicide with evidence of effectiveness[49, 50]	(i) Improved mental health among those served, including improved coping skills



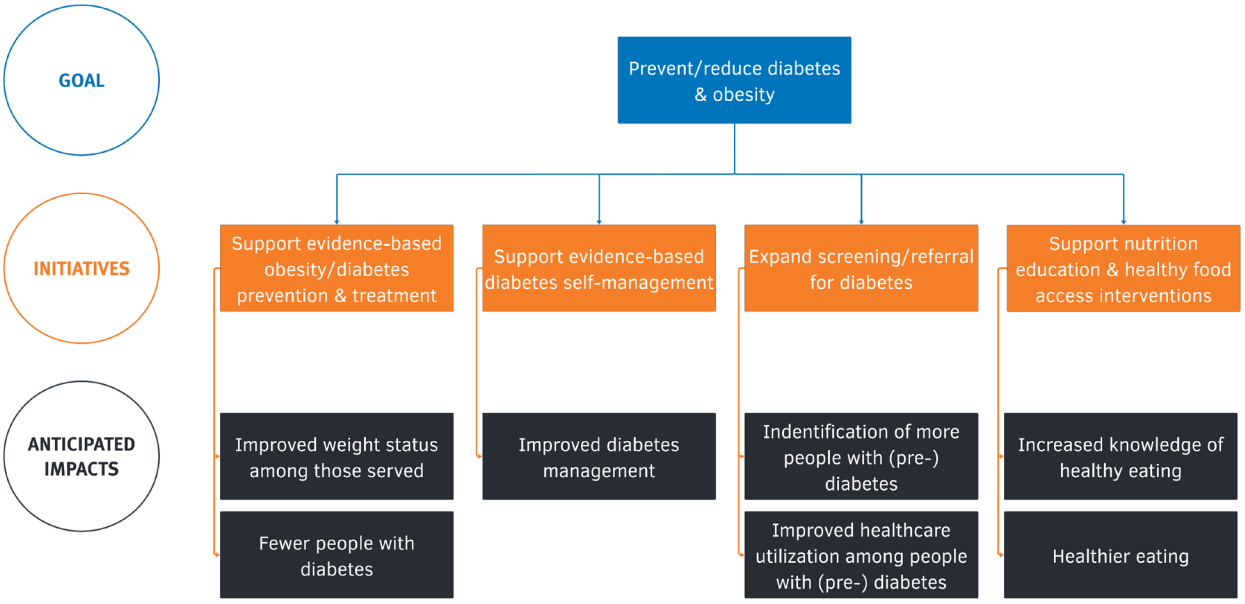
Goal	Initiative	Anticipated Impact
3. Improve behavioral health of adults in the community	A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[51, 52, 53]	(i) Increased knowledge among those served about methods of coping with depression, anxiety, and stress
	B. Support for screening, accurate diagnosis, effective treatment, and follow-up for behavioral health and substance use/addiction treatment services[54, 55, 56]	(i) Improved access to mental and behavioral health services among those served
	C. Programs that support targeted unmet needs such as supporting expectant parents and parents of infants, isolated older adults, individuals experiencing or at risk of homelessness or intimate partner violence[57, 58, 59, 60]	(i) Improved mental health among those served (ii) Improved utilization of clinical and community resources among those served
	D. Programs that reduce or prevent suicide with evidence of effectiveness [61, 62, 63]	(i) Improved mental health among those served, including improved coping skills

DIABETES & OBESITY

During the 2025 CHNA, community members provided input on prediabetes and the lack of access to safe spaces for physical activity, both of which are related to diabetes and obesity. Additionally, CHNA data indicated issues with diabetes, as well as both ethnic and geographic disparities in diabetes statistics, and youth physical fitness including ethnic disparities, among other factors. To address these issues, El Camino Health chose goals that support initiatives that prevent or reduce obesity and diabetes, as well as those that increase physical activity, reduce food insecurity, and increase healthy food access among community members. The hospital expects these efforts will make a positive impact by contributing to improved weight status, improved diabetes management, and reduced rates of obesity & diabetes in the community. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Increase physical activity among community members	A. Support physical activity interventions shown to contribute to weight loss and reduced screen time among youth and adults[64, 65, 66, 67]	(i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions (ii) Reduced screen time & time on sedentary activities among youth served (iii) Increased access to and utilization of free/low-cost opportunities for physical activity
	B. Support implementation of school wellness policies for promoting physical activity[68]	(i) Improved physical fitness among students in schools served

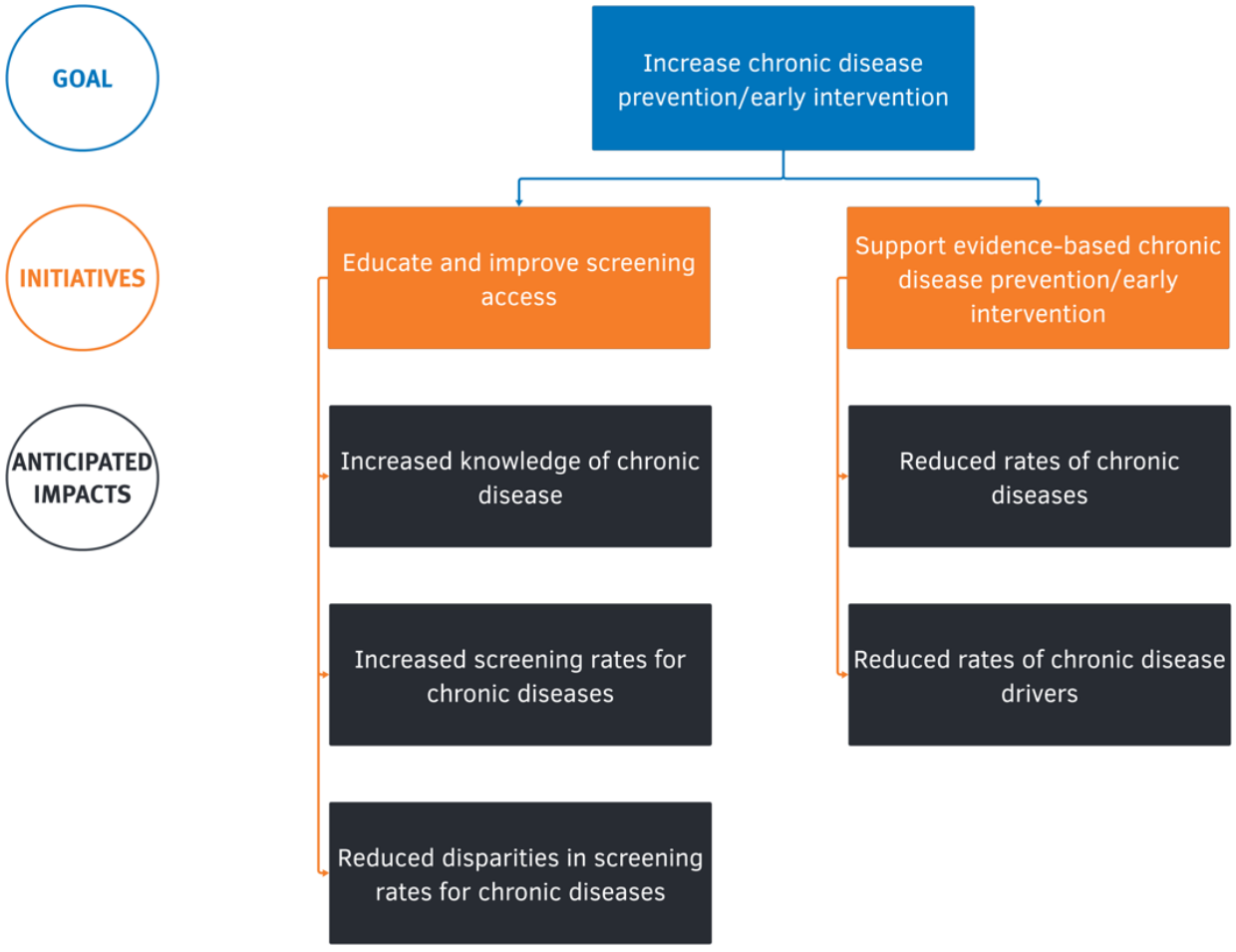


Goal	Initiative	Anticipated Impact
2. Prevent/reduce obesity & diabetes among community members	A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[69, 70, 71, 72, 73, 74, 75, 76, 77]	(i) Improved weight status in youth and adults served (ii) Long-term reduction in the number of community members with diabetes
	B. Support diabetes treatment/ self-management programs with evidence of effectiveness[78, 79, 80, 81, 82]	(i) Improved diabetes management in participants served
	C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[83, 84]	(i) Identification of more individuals with diabetes and pre-diabetes (ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes

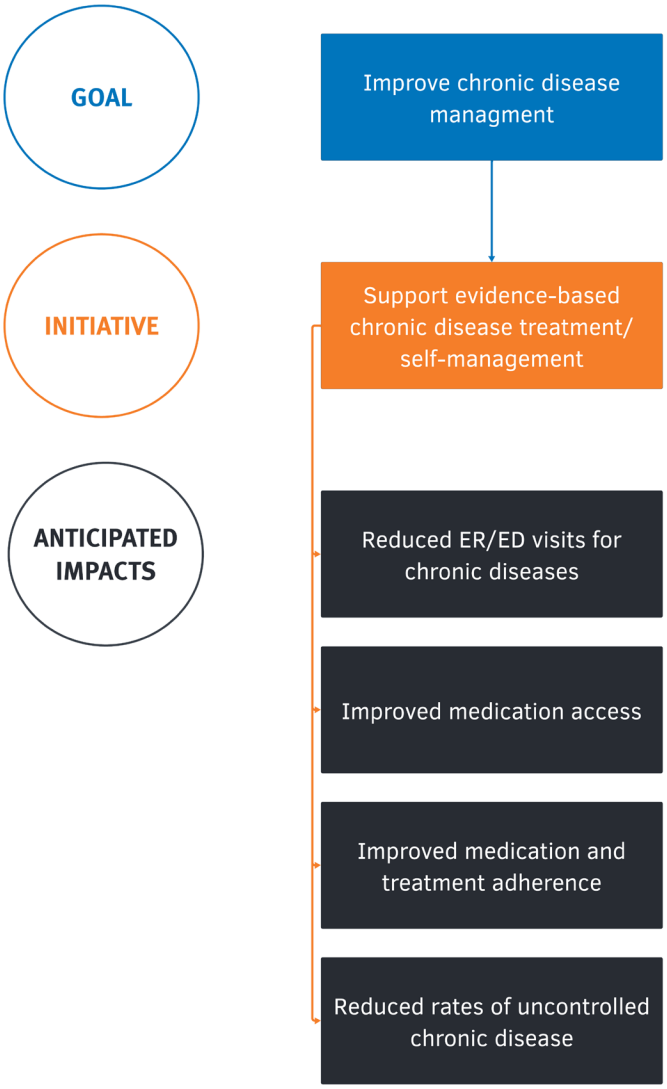
Goal	Initiative	Anticipated Impact
	D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/ community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[85, 86, 87, 88]	(i) Increased knowledge and understanding about healthy eating among people served (ii) Healthier eating among community members receiving interventions

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

Many chronic diseases are among the top causes of death in Santa Clara County. CHNA data show there are disparities in chronic conditions such as cancer, asthma, heart disease, and stroke. Therefore, El Camino Health chose goals that support initiatives to increase prevention and early intervention of chronic diseases and to improve chronic disease management among community members. By addressing these issues, El Camino Health believes it will make a positive impact through improved screening for chronic conditions, reduced rates of uncontrolled chronic diseases, lower levels of the drivers of chronic conditions, and, in the long term, reduced rates of chronic diseases. Below and on the following pages, see diagrams for summaries and tables for details.



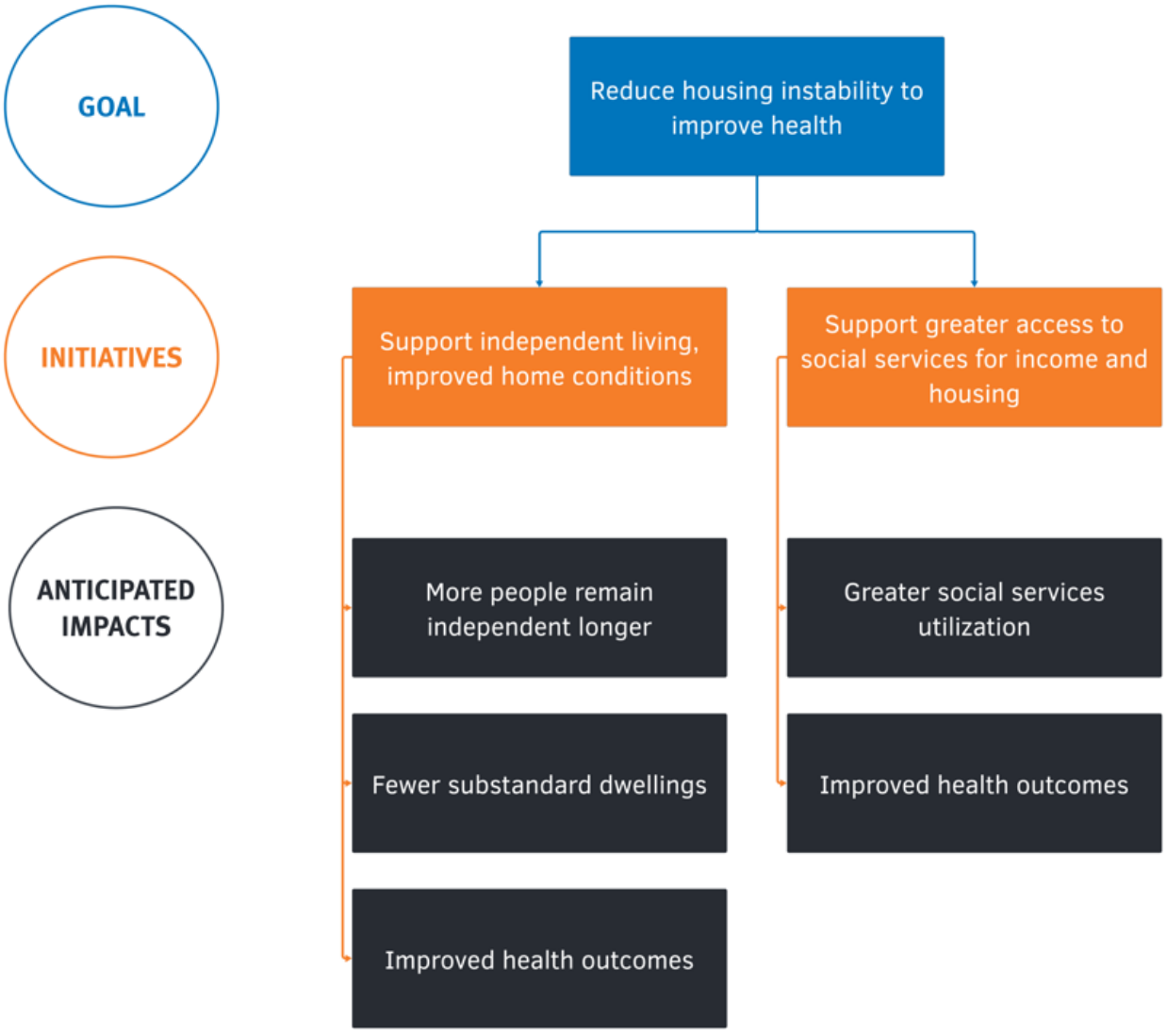
Goal	Initiative	Anticipated Impact
1. Increase prevention and early intervention of chronic diseases in the community	A. Provide education and improve access to screenings[89, 90, 91, 92, 93, 94, 95]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening for chronic disease (iii) Reduced disparities in chronic disease screening rates
	B. Support evidence-based chronic disease prevention and early intervention programs[96, 97, 98]	(i) Reduced rates of chronic diseases (ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc.



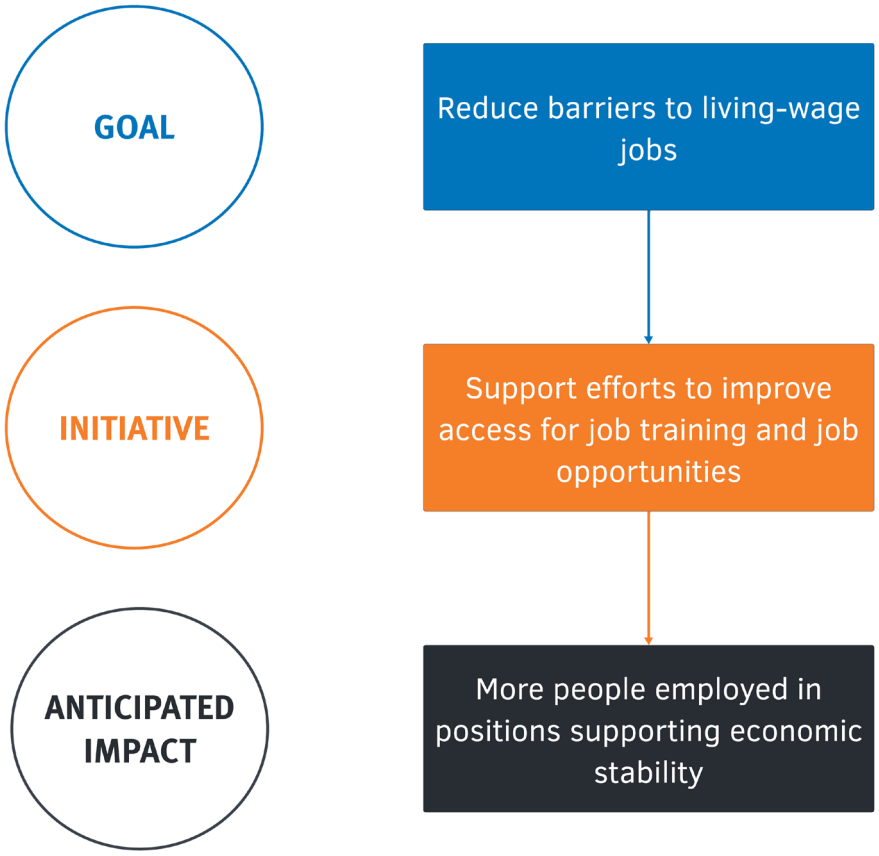
Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[99, 100, 101]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication access (iii) Improved medication and treatment adherence (iv) Reduced rates of uncontrolled chronic disease

ECONOMIC STABILITY (INCLUDING FOOD SECURITY, HOUSING, AND HOMELESSNESS)

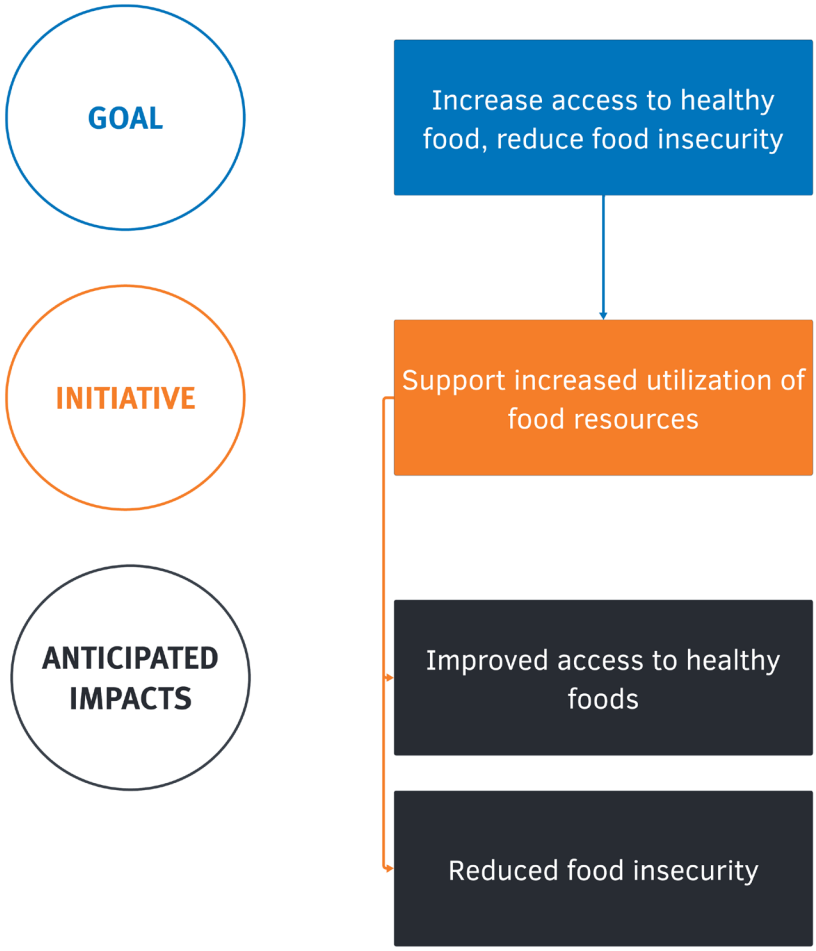
Economic stability was a top priority for the community in the 2025 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and healthcare are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Health chose goals that support initiatives to reduce housing instability, food insecurity, and barriers to living-wage employment. Through efforts to address community members' basic needs, El Camino Health believes it will make a positive impact via increased utilization of social services and improved well-being and health outcomes among community members. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Reduce housing instability among community members	A. Support independent living and efforts to improve substandard living conditions[102, 103, 104]	(i) More community members remain independent longer (ii) Reduced number of sub-standard dwellings (iii) Improved health outcomes for those at-risk of and/or experiencing homelessness
	B. Support efforts to improve access to social services that address income and housing insecurity[105, 106, 107]	(i) Increase in social services utilization (ii) Improved health outcomes for those at-risk of and/or experiencing homelessness



Goal	Initiative	Anticipated Impact
2. Reduce barriers to employment/ careers that provide community members with a living wage	A. Support efforts to improve access to workforce training and employment opportunities for underrepresented populations[108, 109, 110, 111]	(i) More community members employed in positions that support economic stability



Goal	Initiative	Anticipated Impact
3. Reduce food insecurity and increase healthy food access for low-income community members	A. Support increased utilization of healthy/ culturally appropriate food through CalFresh/SNAP enrollment, existing food banks, and other sites[112, 113]	(i) Improved access to healthy food options (ii) Reduced food insecurity

LIST OF APPROVED PROGRAMS

FISCAL YEAR 2026

Community Benefit Grant Funding

El Camino Health®

$3.3 Million invested to address unmet health needs and improve the health of the people in our community.

Healthcare Access & Delivery
(Including Oral Health)

Behavioral Health
(Including Domestic Violence & Trauma)

Diabetes & Obesity

Chronic Conditions
(Other than Diabetes & Obesity)

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Healthcare Access & Delivery

AINAK — Provides free comprehensive eye exams and corrective eyeglasses to underprivileged communities

Asian Americans for Community Involvement (AACI) — Increasing access to care through bicultural and bilingual medical assistants and a patient navigator in Santa Clara County

Cambrian School District — Transitional Kindergarten through 8th grade student health services

Campbell Union School District — Transitional Kindergarten through 8th grade student health services

Cupertino Union School District — Transitional Kindergarten through 5th grade student health services

Health Mobile – Mobile comprehensive dental services for low-income, senior, and homeless individuals, serving all ages throughout San Jose

Healthier Kids Foundation — Dental and hearing screenings for children in San Jose and Campbell

Mount Pleasant School District — Pre-K-8 student health services

Santa Clara County Public Health Department: Better Health Pharmacy — No-cost medication program for low-income, uninsured, and underinsured individuals in Santa Clara County

Via Services — Camp Via West healthcare services, a summer camp for youth with developmental disabilities who reside in San Jose and surrounding cities

Vista Center for the Blind and Visually Impaired — Self-sufficiency services for those who are blind or visually impaired

Behavioral Health

Adolescent Counseling Services — Mental health services for at-risk, low-income youth

Almaden Valley Counseling Service — Mental and emotional health counseling for high-risk K-12 students

Bill Wilson Center — Psychotherapy for youth who are victims of child abuse

Cancer CAREpoint — Counseling services for cancer patients, survivors, family members, and caregivers

Child Advocates of Silicon Valley — Advocacy and support services for foster youth

Cupertino Union School District — 6th through 8th grade student mental health counseling program

Jewish Family Services of Silicon Valley — Care management and behavioral health support services for vulnerable older adults

LifeMoves — Behavioral health services for homeless individuals and families in interim housing communities in San Jose

Los Gatos Education Foundation (Los Gatos Union School District) — Transitional Kindergarten through 8th grade mental health counseling program

Los Gatos-Saratoga Recreation: 55 Plus Program — Guided activities and support groups to address social isolation among older adults

Momentum for Health: La Selva Community Clinic — Bilingual behavioral health services for underinsured and uninsured

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El Camino Health

Behavioral Health *(Continued)*

Next Door Solutions to Domestic Violence — Crisis counseling, advocacy services, support groups, and self-sufficiency case management for victims of domestic or intimate partner violence

Pacific Clinics — Mental health counseling and substance abuse prevention services at Campbell Union High School District

Parents Helping Parents — Bilingual mental health support groups for parents of children with special needs

Peninsula Healthcare Connection — Psychiatric services and medication management for homeless and at-risk community members

To Be Empowered — Mental health services and physical fitness classes for underserved, low-income female youth ages 14-24

Diabetes & Obesity

African American Community Service Agency: Family Health Services — Health workshops, cooking and exercise classes, screenings, and referrals for low-income children and families in San Jose and other cities in Santa Clara County

Bay Area Women's Sports Initiative (BAWSI): BAWSI Girls — Physical activity and self-esteem program for girls from under-resourced households in Campbell Union School District

Chinese Health Initiative — Culturally and linguistically competent hypertension and diabetes screening and education

Gardner Family Health Network: Down with Diabetes — Bilingual diabetes management for underserved teens and adults

Indian Health Center of Santa Clara Valley: Healthy Futures Program — Clinical services and healthy behavior change program for youth with, or at-risk of, pre-diabetes or diabetes

Playworks — Physical activity and positive school climate program for K-5th grade in Campbell Union School District

South Asian Heart Center — Culturally competent heart disease and diabetes prevention program

Valley Verde: San Jose Gardens for Health — Home gardens and nutrition education for low-income households

West Valley Community Services: Community Access to Resources and Education (CARE) — Multilingual case management, food assistance, and wrap-around services for low-income families

West Valley Community Services: Senior Community Access to Resources and Education (CARE) — Case management, food assistance, and wrap-around services for low-income seniors

Chronic Conditions

Breathe California of the Bay Area: Children's Asthma Services — Asthma management and education support for low-income children and families

Hearts & Minds Activity Center: Caregiver Support and Education — Support groups for caregivers of people living with dementia

Latinas Contra Cancer — Culturally and linguistically responsive community health outreach, education, screening, and navigation services to decrease cancer-related health disparities among the Santa Clara County Latinx community

Pink Ribbon Girls — Healthy meals, rides to treatment, housecleaning, education, and peer support for breast and gynecological cancer patients

Economic Stability

Abode — Program provides move-in baskets and ongoing purchases of home essentials to older adult residents of senior supportive housing apartment facilities

El Camino Health: Economic Opportunity Internship Program — Internship and mentorship program providing professional opportunities in healthcare for local, underrepresented high school students and young adults

Hope Services — Job readiness training, placement and coaching for individuals with intellectual developmental disabilities

Loaves & Fishes Family Kitchen — Food prep, package and weekly delivery program for disabled, homebound, low-income, elderly individuals as well as weekly wellness checks and periodic assessments

Midtown Family Services — Credit counseling, budgeting, benefits, and rent and affordable housing navigation services for individuals and families at risk of losing their housing in West San Jose

School of Arts and Culture at MHP: Los Mercaditos Hunger Relief Program — Through bi-monthly farmers market events, providing healthy food to low-income, working class Latinx families and older Asian residents

IX. EVALUATION PLANS

As part of El Camino Health's ongoing community health improvement efforts, we partner with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through our triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

El Camino Health will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, El Camino Health will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report mid-year and year-end performance on annual outcomes metrics, which are shared broadly with the public as well as state and federal regulatory bodies.

X. HEALTH NEEDS THAT EL CAMINO HEALTH DOES NOT PLAN TO ADDRESS

Cancer: El Camino Health merged the Cancer health need into the "Other Chronic Conditions" health need and will address cancer through addressing other chronic conditions.

Communicable Diseases: Issues related to Communicable Diseases issues were entirely contained within Respiratory Health and Sexual Health. See Respiratory Health and Sexual Health justifications below.

Community Safety (i.e., violence): This need was of lower priority to the community than those selected by El Camino Health. While El Camino Health lacks the expertise necessary to address this health need, behavioral health issues such as substance abuse, stress, and anxiety have been shown to be drivers of violence. El Camino Health believes that initiatives intended to address the community's behavioral health need have the potential to increase community safety as well.

Education: This topic is outside of El Camino Health's core competencies (i.e., El Camino Health has little expertise in this area) and the hospital feels it cannot make a significant impact on this need through community benefit investment. Additionally, this need was of lower priority to the community than the needs that El Camino Health selected.

Heart Disease & Stroke: El Camino Health merged the Heart Disease & Stroke health need into the "Other Chronic Conditions" health need and will address these issues through addressing other chronic conditions.

Maternal & Infant Health: El Camino Health merged the Maternal & Infant Health need into the "Healthcare Access & Delivery" health need and will address maternal and infant health through healthcare access and delivery initiatives.

Respiratory Health: El Camino Health merged the Respiratory Health need into the "Other Chronic Conditions" health need and will address respiratory health through addressing other chronic conditions.

Sexual Health: This need was of lower priority to the community than the needs that El Camino Health selected. Moreover, El Camino Health is better positioned to address this need via healthcare access and delivery.

Unintended Injuries/Accidents: This need was of lower priority to the community than the needs that El Camino Health selected. Moreover, El Camino Health is better positioned to address this need via initiatives related to education about healthy lifestyles (i.e., physical fitness) and healthcare access and delivery.

APPENDIX A: IRS IMPLEMENTATION STRATEGY CHECKLIST

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
(1) Implementation Strategy	The implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, either: (i) describes how the hospital facility plans to address the health need; or (ii) identifies the health need as one it does not intend to address and explains why the hospital facility does not intend to address the health need (Treas. Reg. § 1.501(r)-3(c)(1)).		
	A hospital facility will have described a plan to address a significant health need identified through a CHNA if the implementation strategy: (i) describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;	Y	Section VIII
	(ii) identifies the resources the hospital facility plans to commit to address the health need; and	Y	Section VIII
	(iii) describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need (Treas. Reg. § 1.501(r)-3(c)(2)).	Y	Section VIII
	In explaining why the hospital facility does not intend to address a significant health need, a brief explanation for the hospital facility's reason for not addressing the need is sufficient. Under	Y	Section X

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
	the final regulations, such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority and/or a lack of identified effective interventions to address the need (Treas. Reg. § 1.501(r)-3(c)(3)).		
(2) Joint implementation strategies	A hospital facility may develop an implementation strategy in collaboration with other hospital facilities or other organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific resources. However, a hospital facility that adopts a joint CHNA report (described in Checklist § 3(9), above) may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how one or more of the collaborating facilities or organizations plan to address the health need or identifies the health need as one the		

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
	collaborating facilities or organizations do not intend to address and explains why they do not intend to address the health need. For a collaborating hospital facility to meet the implementation strategy adoption requirement, such a joint implementation strategy adopted for the hospital facility must—		
	(i) Be clearly identified as applying to the hospital facility;	N/A	N/A
	(ii) Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and	N/A	N/A
	(iii) Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility. (Treas. Reg. § 1.501(r)-(3)(c)(4))	N/A	N/A
(3) Adoption of the implementation strategy	Under the final regulations, an implementation strategy must be adopted by an "authorized body of the hospital facility" (see Checklist § 3(1), above) on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA, regardless of whether the hospital facility	Y	Section I

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
	began working on the CHNA in a prior taxable year (Treas. Reg. § 1.504(r)-3(a)(2) and (c)(5)(i)).		

Additional regulations not applicable to this hospital:

- Section 6: Exception for acquired, new, and terminated hospital facilities (Treas. Reg. § 1.501(r)-3(d))

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