



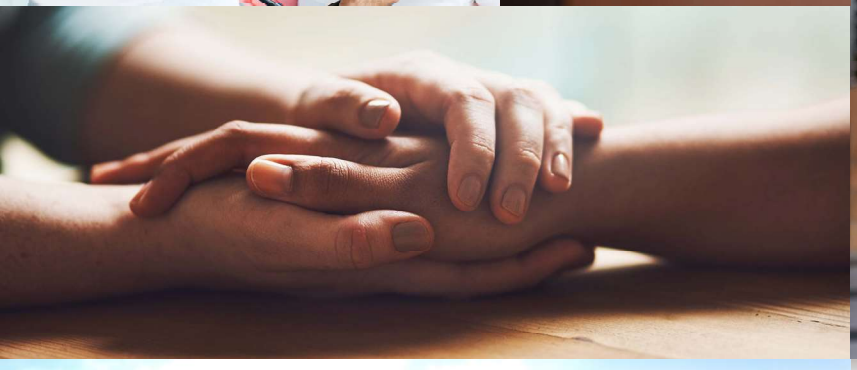


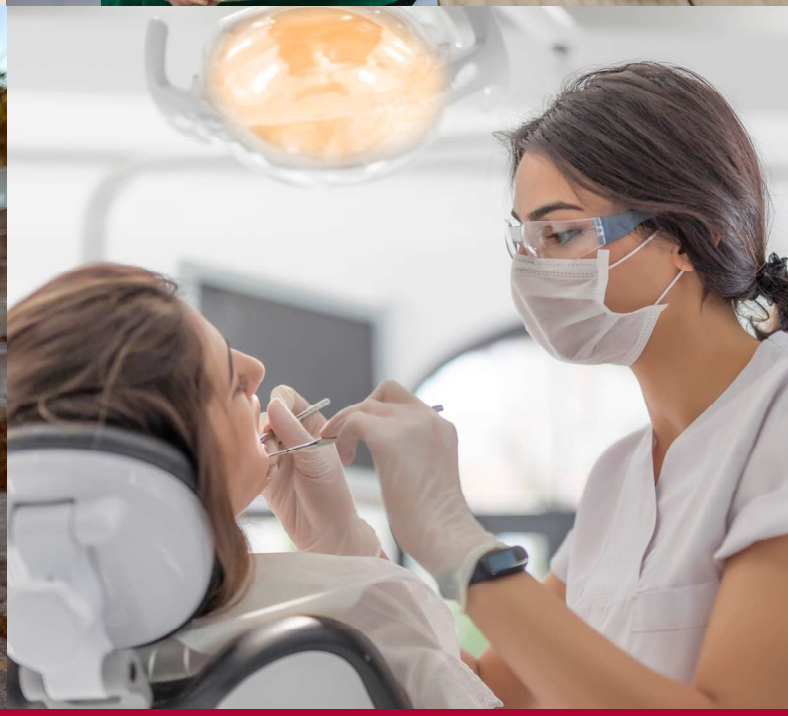

Community Health Needs Assessment

2022 REPORT

Stanford HEALTH CARE

STANFORD MEDICINE

ACKNOWLEDGEMENTS

The 2022 Community Health Needs Assessment report was prepared by the research firm Actionable Insights, LLC.

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- Jennifer van Stelle, PhD, Co-Founder and Principal

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TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The Community Health Needs Assessment (CHNA) is designed as a tool for guiding policy, advocacy, and program-planning efforts. For hospitals, it also supports the development of community benefit plans mandated by California State Senate Bill 697, and it meets the IRS requirements for Community Health Needs Assessment and Implementation Strategies mandated by the 2010 Affordable Care Act. The CHNA report is available to the public for review and comment.

To identify and address the critical health needs of the community, coalitions formed in San Mateo and Santa Clara counties in 1995. The Healthy Community Collaborative of San Mateo County (HCC) and the Santa Clara County Community Benefit Hospital Coalition (CBHC) brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, Stanford Health Care (SHC) collaborated with these two groups to conduct an extensive CHNA.

In 2019, two nonprofit hospital members of the CBHC were sold to Santa Clara County[1], and in 2020, a nonprofit healthcare system member of the HCC was acquired by a for-profit company.[2] Therefore, beginning in 2021, four of the remaining nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[3] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), collaboratively conducted a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA builds upon the earlier assessments conducted by these entities, distills new qualitative and quantitative research, prioritizes local health needs, reports on the impact of implemented strategies from prior years and identifies areas for improvement. The CHNA findings will be used to develop strategies that address critical health needs and to improve the health and well-being of community members. As with prior CHNAs, this assessment also lists San Mateo and Santa Clara counties' assets and resources related to identified health needs.

PROCESS AND METHODS

Planning for the 2022 Community Health Needs Assessment began in January 2021 and data collection began in spring 2021. In both counties, the research firm Actionable Insights (AI) obtained community input through interviews with local experts and focus groups with community members

[1] County of Santa Clara, Office of Communications and Public Affairs. (2019). *Acquisition Information.* Retrieved from https://news.sccgov.org/office-public-affairs/hospital-acquisition-update/acquisition-information

[2] Woo, E. (2020). "AHMC Healthcare finalizes purchase of Seton Medical Center." *San Jose Mercury News.* Retrieved from https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/

[3] The four entities are El Camino Hospital, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

and people who serve community members. AI culled secondary data from various sources, including the public Community Health Data Platform sponsored by Kaiser Permanente and the two county public health departments. *(See Attachment 1: Secondary Data Indicators for a complete list and Attachment 2: Secondary Data Tables for secondary data collected.)*

For the purposes of this assessment, the definition of "community health" goes beyond traditional measures to include indicators about not only the physical health of the county's residents, but also broader social and environmental determinants of health (including access to health care, affordable housing, child care, education, and employment). This more inclusive definition reflects SHC's understanding that myriad factors impact community health and commitment to supporting community health improvement through upstream (social determinants of health) and downstream (health conditions) interventions.

AI identified health needs by (1) synthesizing primary qualitative research and secondary data and (2) filtering those needs against a set of criteria (below). On October 21, 2021, SHC gathered community health experts across Stanford Health Care, Stanford University School of Medicine, and the local community to learn about the 10 health needs identified during the CHNA process and participate in the prioritization process. *(The individuals who participated are listed in Section 5: Process and Methods.)*

The group used these criteria to prioritize the list of health needs:

- **Community priority:** the community prioritizes the health need over other health needs; based on the frequency with which the key informants expressed concern about each health outcome during the CHNA primary data collection.
- **Assets & resources:** there is a lack of sufficient assets and/or resources to address the health need. For example, a lack of specialty care, health facilities, affordable healthy behaviors, or information.
- **Clear disparities or inequities:** recognizable differences in health outcomes exist among subgroups of people (based on geography, language, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender identity, or other factors).
- **Multiplier effect:** a successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity decrease, diabetes rates may also decrease .

PRIORITIZED 2022 COMMUNITY HEALTH NEEDS

Based on the criteria described above, the group prioritized the health needs through an online survey. The outcomes are listed below in priority order. *(For summarized descriptions of each health need , see Section 6: Prioritized 2022 Community Health Needs.)*

1. Economic Insecurity
2. Housing & Homelessness

3. Behavioral Health
4. Health Care Access & Delivery
5. Diabetes & Obesity
6. Maternal & Infant Health
7. Climate & Natural Environment
8. Community Safety
9. Cancer
10. Sexually Transmitted Infections

NEXT STEPS

SHC will make its board-approved 2022 CHNA report publicly available on the Community Health and Partnerships webpage in May 2022 and solicit written comments until two subsequent reports are published.[4] The hospital will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by January 15, 2023.

[4] See https://stanfordhealthcare.org/about-us/community-partnerships.html. Stanford Health Care's fiscal year 2022 ends August 31, 2022, which is the IRS deadline for posting.

2. INTRODUCTION/BACKGROUND

CHNA PURPOSE

To identify and address the critical health needs of the community, coalitions formed in San Mateo and Santa Clara counties in 1995. The Healthy Community Collaborative of San Mateo County (HCC) and the Santa Clara County Community Benefit Hospital Coalition (CBHC) brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, Stanford Health Care collaborated with both groups to conduct an extensive community health needs assessment.

In 2019, two nonprofit hospital members of the CBHC were sold to Santa Clara County[5], and in 2020, a nonprofit healthcare system member of the HCC was acquired by a for-profit company.[6] Therefore, beginning in 2021, four nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties,[7] with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), collaboratively conducted an extensive, dual-county, triennial Community Health Needs Assessment (CHNA) in compliance with current state and federal requirements (see details below).

The 2022 CHNA builds upon earlier assessments, using prior years' findings as a foundation for refining research protocols, refocusing the scope of various health needs, and filling information gaps. The CHNA also distills new qualitative and quantitative research, prioritizes current local health needs, and identifies areas for improvement. The CHNA findings will be used to develop strategies that address critical health needs and improve the health and well-being of community members. As with prior CHNAs, the 2022 assessment also highlights San Mateo and Santa Clara counties' assets and resources.

The CHNA process, completed in fiscal year 2022 and described in this report, was conducted in compliance with all current state and federal requirements. The 2022 CHNA will serve as the basis for implementation strategies that are required to be filed with the IRS as part of Stanford Health Care's 2022 Form 990, Schedule H, four and a half months into the next taxable year.

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[5] County of Santa Clara, Office of Communications and Public Affairs. (2019). *Acquisition Information.* Retrieved from https://news.sccgov.org/office-public-affairs/hospital-acquisition-update/acquisition-information

[6] Woo, E. (2020). "AHMC Healthcare finalizes purchase of Seton Medical Center." *San Jose Mercury News.* Retrieved from https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/

[7] The four entities are El Camino Hospital, Lucile S. Packard Children's Hospital Stanford, Stanford Health Care, and Sutter Health.

ACA REQUIREMENTS

Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a community health needs assessment every three years. The CHNA report must document how the assessment was done, a description of the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community's health needs that were identified and prioritized as a result of the assessment. Final CHNA requirements were published in December 2014.

The definition of a community health need includes social determinants of health in addition to morbidity and mortality. For the purposes of this assessment, the definition of "community health" goes beyond traditional measures to include indicators about the physical health of the county's residents, in addition to broader social and environmental determinants of health, such as access to health care, affordable housing, child care, education, and employment. This more inclusive definition reflects SHC's understanding that many factors impact community health. SHC is committed to supporting community health improvement through upstream (social determinants of health) and downstream (health condition) intervention.

In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, the ACA created more incentives for health care providers to focus on prevention of disease by including lower or no co-payments for preventative screenings. Also, funding has been established to support community-based primary and secondary prevention efforts.

SB 697 AND CALIFORNIA'S HISTORY OF ASSESSMENTS

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the California Department of Health Care Access and Information (HCAI)[8] that includes, but is not limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals shall describe the process by which they involved the community (comprised of community groups and local government officials) in helping to identify and prioritize the community needs to be addressed. This community needs assessment shall be updated at least once every three years.[9]

[8] HCAI is formerly known as California Office of Statewide Health Planning and Development (OSHPD) "HCAI is committed to expanding equitable access to health care for all Californians—ensuring every community has the health workforce they need, safe and reliable health care facilities, and health information that can help make care more effective and affordable." Retrieved from https://hcai.ca.gov

[9] California Office of Statewide Health Planning and Development (1998). Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697), Report to the Legislature. Retrieved from https://oshpd.ca.gov/wp-content/uploads/2018/07/SB-697-Report-to-the-Legislature-Community-Benefit.pdf

The 2022 CHNA meets both State of California (SB 697) and federal (IRS) requirements mandated by the ACA.

BRIEF SUMMARY OF 2019 CHNA REPORT

In 2019, the hospital participated in a collaborative process to identify significant community health needs and to meet the IRS and SB 697 requirements. The resulting 2019 CHNA report is posted on the Community Health and Partnerships page of Stanford Health Care's website.[10]

The health needs that were identified and prioritized through the 2019 CHNA process were (in prioritized order): 1) Housing and Homelessness, 2) Behavioral Health, 3) Health Care Access and Delivery,4) Diabetes and Obesity, 5) Economic Stability, and 6) Oral/Dental Health.

WRITTEN PUBLIC COMMENTS TO 2019 CHNA

To offer the public a means to provide written input on the 2019 CHNA report, Stanford Health Care maintains an email account at communitypartnerships@stanfordhealthcare.org. A link to this inbox is posted on the Community Partnerships page of the hospital's website.[11]

At the time this CHNA report was completed, SHC had not received written comments about the 2019 CHNA report. The hospital will continue to track any submissions made and will ensure that all relevant comments are reviewed and addressed by appropriate hospital staff.

[10] https://stanfordhealthcare.org/about-us/community-partnerships.html
[11] https://stanfordhealthcare.org/about-us/community-partnerships.html

Stanford Health Care

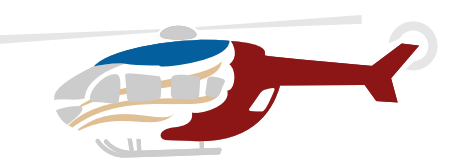
FY21

Stanford HEALTH CARE
STANFORD MEDICINE

Stanford Health Care seeks to heal humanity through science and compassion, one patient at a time, through its commitment to care, education, and discovery. Stanford Health Care delivers clinical innovation across its inpatient services, specialty health centers, physician offices, virtual care offerings, and health plan programs.

The only **Level-1 Trauma Center** between San Francisco & San Jose

Life Flight transports **450** patients annually



53 Operating Rooms

605 Licensed Beds

101 Licensed ICU Beds

Combined between 300 & 500 Pasteur Drive

EMERGENCY DEPARTMENT ADMISSIONS

Adult emergency visits **72,532**

Pediatric emergency visits **16,316**

2,016,490 Outpatient Visits

695,263 Video Visits

COMMUNITY SUPPORT

$464M Community Benefit Investment

$95M COVID-19 Response Investment

Stanford Hospital

500 Pasteur Drive opened for patient care in 2019 with 824,000 sq. ft. of space

Our People

15,207 Employees

3,118 Medical Staff

3,643 Nurses

1,483 Residents & Fellows

96.3% of our physicians have a star rating of 4.5 or higher

93.4% of our nurses have a BSN, MSN, or Doctorate Degree

8 All-time Stanford Medicine Nobel Laureates

Patient Experience

Interpreters

Staff interpreters are available on demand in person, by phone, and by video in the most commonly requested languages, including Spanish, Mandarin, Cantonese, Vietnamese, Russian, American Sign Language (ASL), Farsi/Dari, and Korean.

*Access to **200+** other languages is also available upon request.*

HEALTH EDUCATION, ENGAGEMENT, AND PROMOTION (HEEP)

17,000+ individuals annually sought out Stanford Health Care's HEEP content

WITH

82.3% having attended an online class or virtual consultation

AWARDS & RECOGNITION

U.S. News & World Report Best Hospitals
Honor Roll 2021–22

The **Stanford Stroke Center** is designated as a **Comprehensive Stroke Center**, providing the most advanced and rapid stroke care for patients nationwide

The **Stanford Medicine Cancer Center** includes the Stanford Cancer Institute, the only **NCI-Designated Comprehensive Cancer Center** between San Francisco and Los Angeles

Vizient Quality Leadership Award 2021 Winner
Ranked in the top ten percent for both inpatient and ambulatory care

Stanford Health Care was first designated as a Magnet Hospital in 2007 and was redesignated in 2012, 2016, and 2020

Magnet Recognition is a prestigious award developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that provide nursing excellence. Fewer than 7% of U.S. health care organizations achieve this honor.

Stanford Health Care is part of Stanford Medicine, a leading academic health system that includes the Stanford University School of Medicine, Stanford Health Care, and Stanford Children's Health. Stanford Medicine is renowned for breakthroughs in treating cancer, heart disease, brain disorders, and surgical and medical conditions.

SHC'S COMMUNITY BENEFIT PROGRAM

Stanford Health Care dedicates considerable resources to improve the health and well-being of the community through its Community Partnership Program. The program is a multiyear, strategic investment in community health based on the latest CHNA findings. From 2020 to 2022, SHC's Community Partnership Program adopted three major health initiatives:

- Access to Care, with a special emphasis on addressing access gaps for behavioral health (mental health and substance use), obesity and diabetes, and oral health: SHC's interventions improved access to affordable, high-quality health care services for underserved community members.
- Housing and Homelessness: SHC's interventions supported homelessness prevention, expanded supportive care and social services for self-sufficiency, and improved access to care for those experiencing and/or at-risk for homelessness
- Economic Stability: SHC's interventions increased access to high-quality, healthy foods for vulnerable populations, reduced transportation-related barriers to good health and quality of life, and reduced barriers to high-quality employment.

COMMUNITY SERVED

As an academic medical center, Stanford Health Care provides primary care and highly specialized adult health care for patients throughout California, across the country, and internationally. However, due to its location in Palo Alto, at the northern end of Santa Clara County bordering San Mateo County, more than half of SHC's patients reside in San Mateo and Santa Clara counties. While Stanford Health Care's primary community benefit service area spans Santa Clara and San Mateo counties, Stanford Health Care also supports community health needs across a nine-county network of care. For purposes of its primary community benefit initiatives, SHC has identified Santa Clara and San Mateo counties as its target community.

San Mateo County comprises 19 cities and more than two dozen unincorporated towns and areas. It is far less populous than Santa Clara County, with approximately 746,752 residents in 2019. Daly City is San Mateo County's largest city by population, with just over 106,000 people (14% of the total). The population of the county is substantially denser than the state, with 9,206 people per square mile compared to 8,486 per square mile in California. The median age in San Mateo County is 40.3 years. Over 20% of the county's residents are under the age of 18, and nearly 16% are 65 years or older. Among the population aged 75 and older, more than two in five (46%) are living with a disability.

Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2019, approximately 1.92 million people lived there, making it the sixth largest county in California by population. San José is its largest city, with over 1.02 million people (53% of the total). The population of the county is substantially denser than the state, with 9,115 people per square mile

compared to 8,486 per square mile in California. The median age in Santa Clara County is 38.1 years. More than 22% of the county's residents are under the age of 18, and over 13% are 65 years or older. Among the population aged 75 and older, nearly half (48%) are living with a disability.[12]

The ethnic makeup of both counties is extremely diverse. In total, the non-white population of San Mateo County represents about 62% of its total population, while 70% of Santa Clara County's total population is non-white. About 4% of people in both counties communities are uninsured.

Race/Ethnicity in Hospital Service Area

Race/Ethnicity	San Mateo County Total Percent of County (Alone or in Combination with Other Races)*	Santa Clara County Total Percent of County (Alone or in Combination with Other Races)*
American Indian/Alaskan Native	0.1%	0.2%
Asian	30.1%	38.5%
Black	2.2%	2.3%
Hispanic/Latinx	24.2%	25.1%
Pacific Islander/Native Hawaiian	1.3%	0.3%
White	37.8%	29.9%
Multiracial	4.0%	3.4%
Some Other Race	0.4%	0.2%

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
*Percentages do not add to 100% because they overlap.

More than 34% of community members in San Mateo County and more than 39% of community members in Santa Clara County are foreign-born. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[13]

[12] Census data in prior paragraphs from https://www.census.gov/quickfacts.
[13] Data from https://www.census.gov/quickfacts

Two key social determinants, income and education, are closely connected,[14] and have a significant impact on health outcomes, including poor birth outcomes, functional health (hearing, vision, and speech), asthma, obesity, and mental health.[15] Both counties not only earn some of the highest annual median incomes in the U.S., but also bear some of the highest costs of living. Median household incomes are $130,820 in San Mateo County and $129,210 in Santa Clara County, both far higher than California's median of $82,053.

Yet the California Self-Sufficiency Standard,[16] set by the Insight Center for Community Economic Development, suggests that many households in San Mateo and Santa Clara counties are unable to meet their basic needs.[17] (The Standard in 2021 for a family with two children was $166,257 in San Mateo County and $144,135 in Santa Clara County.) The minimum wage in San Mateo County[18] was $14–$15.90 per hour in 2021, and in Santa Clara County[19] was $14–$16.30 per hour, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 26% increase in the cost of living in San Mateo County and a 27% increase in Santa Clara County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 5.4% per year average increase in wages in the San José-Sunnyvale-Santa Clara metropolitan area between 2018 and 2020.

Housing costs are high: In 2021, the median home price was $1.6 million[20] and the median rent was $2,451 in San Mateo County; this compares to $1.4 million[21] and $2,374 in Santa Clara County.

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[14] Vilorio, D. (2016). Education Matters. *Career Outlook.* U.S. Bureau of Labor Statistics, March 2016.

[15] Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The Impact of Poverty on the Current and Future Health Status of Children. *Pediatric Child Health.* 12(8): 667–672.

[16] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

[17] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org/node/44

[18] Bay City News Foundation. (2021). Several San Mateo County cities hike minimum wage for 2021. *The Daily Journal.* Retrieved from https://www.smdailyjournal.com/news/local/several-san-mateo-county-cities-hike-minimum-wage-for-2021/article_47e4717a-4f0b-11eb-ac74-6fa7c18ed062.html

[19] Alaban, L. (2021). Minimum wage goes up in South Bay -- with mixed reaction. *San José Spotlight*. Retrieved from https://sanjosespotlight.com/minimum-wage-in-san-jose-goes-up-splitting-business-and-economic-leaders/

[20] Redfin. (2021.) *San Mateo County Housing Market.* Retrieved from https://www.redfin.com/county/343/CA/San-Mateo-County/housing-market

[21] Redfin. (2021.) *Santa Clara County Housing Market*. Retrieved from https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market

Area Household Income Ranges

Source: Census Reporter, https://censusreporter.org/profiles (American Community Survey, 2015–2019).

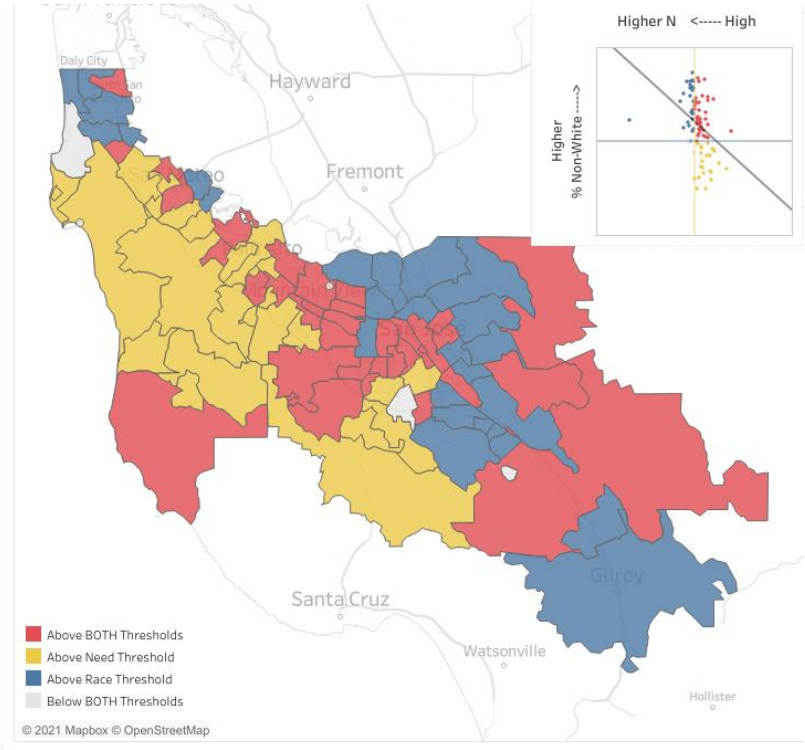
In both counties, 26% of the children are eligible for free or reduced-price lunch and close to one quarter of children live in single-parent households (22% of children in San Mateo County and 23% of children in Santa Clara County).

The Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, indicates that both counties' populations overall are healthier than the national average.[22] Although San Mateo and Santa Clara counties are quite diverse and have substantial resources (see Appendix 6: Assets and Resources), there is significant inequality in their populations' social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality[23], is higher in certain Zip Codes compared to others (see map on the next page).

[22] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while both San Mateo and Santa Clara counties are scored at -0.8. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. Journal of Urban Health, 83(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

[23] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality.

Correlation Between Income Inequality and Non-White Population, By Zip Code



Map: Parts of both counties exhibit income inequality (red and yellow areas). In many places where income inequality is high, non-white community members are also in the majority (red areas). “Need Threshold” is the U.S. Gini Index, 0.4. “Race Threshold” is 50% non-white.

Certain areas also have poorer access to high speed internet (e.g., Zip Codes 95013, 94074), or to walkable neighborhoods (e.g., Zip Codes 95002, 94060), or jobs (e.g., Zip Codes 95020, 94044). In this assessment of the health needs in the community, there is a focus particularly on disparities and inequities within the community rather than simply in comparison to California or the nation as a whole.

Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

4. ASSESSMENT TEAM

HOSPITALS AND OTHER PARTNER ORGANIZATIONS

Stanford Health Care collaborated with the following health systems and organizations to prepare the 2022 CHNA:

- El Camino Health
- Lucile Packard Children's Hospital Stanford
- Sutter Health (including Menlo Park Surgical Hospital, Mills-Peninsula Medical Center, and Palo Alto Medical Foundation)

IDENTITY AND QUALIFICATIONS OF CONSULTANTS

Actionable Insights, LLC, an independent local research firm, completed the CHNA.

For this assessment, Actionable Insights (AI) assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

The project managers for this assessment were Melanie Espino and Jennifer van Stelle, PhD, the co-founders and principals of AI. AI helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, housing, STEM (science, technology, engineering, and math) education, youth development, and community collaboration efforts. AI conducted community health needs assessments for seven hospitals during the 2021–2022 CHNA cycle.

More information about AI is available on the company's website.[24]

[24] https://actionablellc.com/

5. PROCESS AND METHODS

The hospitals and health systems listed in Section 4 collaborated on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over ten months in 2021 and culminated in this report, written in late 2021 and early 2022.

Actionable Insights (AI) was contracted by the collaborating hospitals and health systems (collectively, "the Assessment Team") to gather primary qualitative data (through key informant interviews and focus groups) and secondary qualitative and statistical data. The phases of the CHNA process are depicted below and described in this section.

RACISM & HEALTH

Racism, both structural and interpersonal, are fundamental causes of health inequities, health disparities and disease. The impact of these inequities on the health of Americans is severe, far-reaching, and unacceptable. Across the country and locally, racial and ethnic minority populations experience higher rates of poor health and disease in a range of health conditions, when compared to their white counterparts. [25] This assessment considers systemic racism as a root cause of racial and ethnic health inequities, which are detailed in the health need descriptions on pages 31-40 of this report.

SECONDARY DATA COLLECTION

Data sources were selected to understand general county-level health, specific vulnerable populations, and to fill previously identified information gaps. Also, data on potential health disparities by geographic area and ethnicity were analyzed.

The Assessment Team analyzed over 250 quantitative health indicators to assist with understanding health needs in San Mateo and Santa Clara counties and assessing priorities in the community. The Assessment Team collected data from existing sources using the public Community Health Data Platform sponsored by Kaiser Permanente and other online sources. The Assessment Team also used findings from the previous community health needs assessment (2019), reports from Joint Venture Silicon Valley, and available sub-county data (cities and neighborhoods) when available.

In addition, the Assessment Team collected quantitative and qualitative secondary data from multiple sources, such as KidsData.com, the California Department of Public Health and the U.S. Census Bureau, as well as the two county public health departments.

[25] Centers for Disease Control and Prevention (CDC). (2021). *Racism and Health*. Retrieved from https://www.cdc.gov/healthequity/racism-disparities/index.html

For the CNHA, there is a particular focus on disparities and inequities within the community rather than in comparison to the state or nation as a whole. Local data were compared to state benchmarks (California averages and rates) to help determine the severity of a health problem and to identify disparities. The following questions were asked:

- How do these indicators perform against accepted benchmarks?
- What are the inequitable outcomes and conditions for community members?

PRIMARY DATA COLLECTION (COMMUNITY INPUT)

Actionable Insights (AI) conducted primary research for this assessment through key informant interviews and focus groups. The Assessment Team used three strategies for collecting community input: 1) key informant interviews with health experts and community service experts, 2) focus groups with professionals who represent and/or serve the community, and 3) a dual-county focus group with community members. Individuals representing vulnerable populations[26] (e.g., low-income, minority, and medically underserved[27]) were included.

In generating primary research protocols, the Assessment Team consulted and built upon prior CHNAs by focusing the primary research on topics and subpopulations that are less well understood by the statistical data. For example, the experiences of the Black population in San Mateo and Santa Clara counties are often obscured by statistics that represent an entire county's population rather than the Black population as a particular sub-group. The 2022 CHNA convened a focus group of Black professionals to better understand the health needs of the Black population in both counties.

Each interview and focus group was conducted virtually and recorded. Recordings were transcribed and qualitative research software tools were used to analyze the transcripts for common themes. The Assessment Team also tabulated the number of times health needs had been prioritized by each of the focus groups or described as a priority in a key informant interview and used this tabulation to help assess community health priorities.

Input from nearly 100 community members, community leaders, health experts and representatives of various organizations and sectors informed the CHNA. These representatives either work in the

[26] "Vulnerable" populations, communities, and individuals were formerly referred to as "high-need" populations, communities, and individuals. This term has changed due to statewide regulatory changes under AB 1204. California Department of Health Care Access and Information (2022). *HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations.* Retrieved from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf

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

health field or in a community-based organization that focuses on improving health and quality-of-life conditions by serving those from vulnerable populations.

Key Informant Interviews

In March and April 2021, the Assessment Team interviewed 15 experts from various organizations in San Mateo and Santa Clara counties. Interviews were conducted virtually via Zoom for approximately one hour. Prior to each interview, participants were asked to complete a short online survey, in which they were asked to identify the health needs they felt were the most pressing among the people they serve. Interviewees could choose up to three needs from the list of needs presented to them, which had been identified in one or both counties in 2019, or could submit needs that were not on the combined 2019 list. Also in the survey, participants were advised of how their interview data would be used and were asked to provide consent to be recorded.[28] Finally, participants were offered the options of being listed in the report and to provide some basic demographic information.

The discussions centered around four questions for each health need that was prioritized by interviewees in the online pre-survey:

1. How do you see this need playing out in the community?
2. Which populations are experiencing inequities with respect to this need?
3. How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?
4. What is needed (including models/best practices) to better address this need?

Focus group participants also provided responses to these questions (modified appropriately for each audience) via the pre-survey.[29] Focus group discussions centered on the needs that had received the most votes from prospective participants in the pre-survey. *See Attachment 3: Community Leaders, Representatives, and Members Consulted for a list of key informants and focus group or interview details. See Attachment 4: Qualitative Research Protocols for complete protocols and questions, including pre-surveys.*

Focus Groups

The Assessment Team conducted eight focus groups across San Mateo and Santa Clara counties with a total of 76 professionals and four community members between April and June 2021. The questions were identical to those asked of key informants.

[28] Only individuals who consented to be recorded were interviewed.

[29] Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

List of Focus Groups Conducted for CHNA 2022

Topic	Focus Group Host/Partner	Date	Number of Participants
Adult mental/behavioral health	El Camino Health & Sutter Health	4/12/2021	13
Health equity	Stanford Health Care	4/14/2021	10
Santa Clara County social services	El Camino Health	4/19/2021	12
Safety net clinics and their patients	Stanford Health Care & Sutter Health	4/26/2021	12
Youth mental health	Lucile S. Packard Children's Hospital-Stanford	4/29/2021	12
San Mateo County social services	Samaritan House	5/12/2021	10
Health of safety net clinic patients*	Gardner Health Services	6/7/2021	4
Black health	Bay Area Community Health Advisory Council (BACHAC)	6/14/2021	7

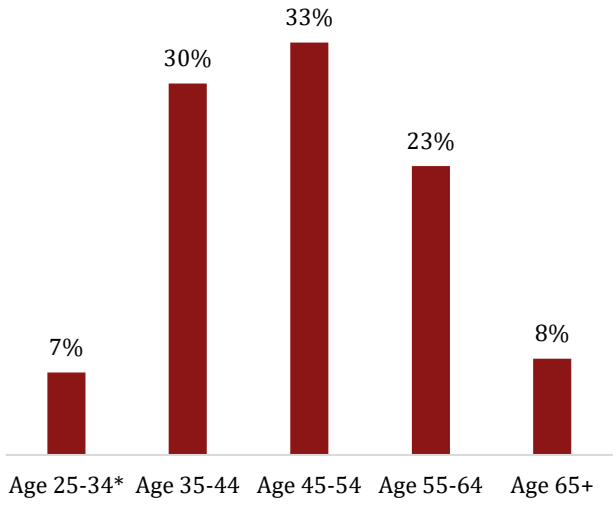
* Indicates community member group.

CHNA Participant Demographics

A total of 95 people participated in focus groups or interviews for the CHNA. More than three out of every five (62%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder represented either San Mateo County only (19%) or Santa Clara County only (another 19%).

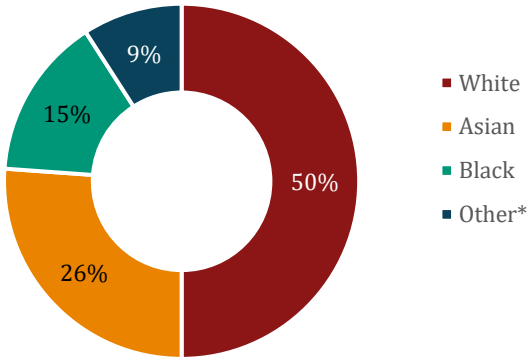
The charts below show the age ranges of participants, as well as their race; note that individuals could choose more than one race (N=90). More than one in five (22%) participants were of Hispanic/Latinx ethnicity (N=93). Two-thirds of participants (67%) identified as female, with almost all of the remaining identifying as male (N=92). On average, participants were aged 48 (N=92).

Participant Age Groups



* One participant was 24 years of age.

Participant Racial/Ethnic Groups



* "Other" includes American Indian/AK Native & Native HI/Pacific Islander.

INFORMATION GAPS AND LIMITATIONS

A lack of data limited the ability to fully assess some health issues that were identified as community needs during the 2022 CHNA process. Conducting the 2022 CHNA presented unique challenges for data collection:

1. As was the case across the nation due to the COVID-19 pandemic, public health departments' epidemiologists lacked sufficient resources to conduct data analyses in the same way they had in years past. This affected assessment of data on infectious diseases, cancer, etc.

2. SHC's CHNA, as it has since 2012, employed data from the publicly available Kaiser Permanente Community Health Needs Dashboard. As of 2021, the platform no longer provides data breakdowns by race/ethnicity and instead offers correlations between race and poor health outcomes (which are presented in this report).

3. In both cases, when current data were lacking, the Assessment Team relied upon data from previous CHNAs.

4. In years past, SHC's CHNAs relied on the California Healthy Kids Survey (CHKS) for data about child and adolescent mental health and emotional wellbeing. However, Santa Clara County has not opted in to conduct the CHKS in recent years. Therefore, these data are available for San Mateo County, but not for Santa Clara County.

5. Because of the pandemic, it was not safe to bring community members together in person. Moreover, while it was possible to conduct focus groups and interviews virtually (i.e., via Zoom), the most vulnerable community members often did not have access to the technology needed for a virtual meeting. Also, nonprofit partners advised that the community was severely stressed (financially and emotionally) by the pandemic and felt it was inappropriate to burden them with CHNA data collection requests. While the Assessment Team conducted one focus group with safety net clinic patients, it relied upon the input offered by nonprofit staff who work with vulnerable populations to supplement the perspectives and experiences of vulnerable community members.

6. Lastly, some indicators are difficult to measure or are just emerging. Statistical information related to the following topics was scarce:

    - Caregiver impact data (unpaid care, health effects)
    - Cognitive decline data, including Alzheimer's Disease prevalence rate and hospice admissions for dementia
    - Data breakdowns by income/socioeconomic status
    - Domestic violence and related community safety data
    - Economic inequities within key zip codes
    - Experiences of discrimination
    - Health conditions associated with COVID-19 infection
    - Impact of social media on adolescent mental health
    - Oral health data
    - Recent marijuana use and related behavioral health data
    - Youth cigarette and e-cigarette use

COVID-19

This assessment incorporates COVID-19 data in two ways: 1. Statistical data detailing the disease and associated health conditions and 2. Qualitative data provided by community experts and residents. As a novel virus, statistical data is limited at this time; however, community experts and residents offered ample qualitative data on the economic and social impacts of COVID-19 on local vulnerable communities. SHC will continue to monitor and address the health effects, trends, and health care needs of COVID-19 as more is learned about the disease, its progression, and its short- and long-term impacts.

DATA SYNTHESIS: IDENTIFICATION OF COMMUNITY HEALTH NEEDS

In the analysis of quantitative and qualitative data, many health issues surfaced.

To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria (detailed below and depicted in the diagram on the next page):

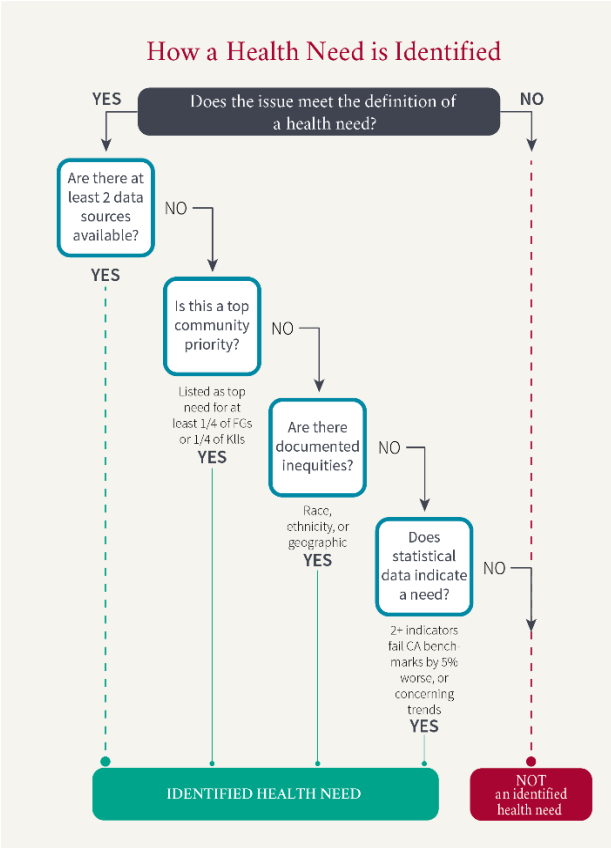
1. Meets the definition of a “health need.” (See Definitions box, below.)
2. At least two data sources were consulted.
3. Must be prioritized by multiple key informants or focus groups, or two or more direct indicators must:
    a. exhibit documented inequities by race; or
    b. show worsening trends; or
    c. fail the benchmark by 5 percent or more.

Health Needs Identification Criteria

The Assessment Team analyzed data on a variety of issues, including statistics from the California Department of Health, as well as other secondary data and qualitative data from focus groups or key informant interviews.

Then, the Assessment Team synthesized data for each issue and applied the criteria listed above to evaluate whether each issue qualified as a prioritized health need. In 2022, this process led to the identification of 10 community health needs that met all of the criteria. The list of needs, in priority order, is found on pages 28-29.

For further details about each of these health needs, including statistical data, see Section 6: Prioritized 2022 Community Health Needs and Attachment 2: Secondary Data Tables for detailed statistical data.



DEFINITIONS

Data source: Either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from interviews and focus groups.

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

Health need: A poor health *outcome* and its associated *risk(s)*, or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

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

PRIORITIZATION OF HEALTH NEEDS

Per IRS requirements, Stanford Health Care gathered leaders with knowledge and expertise in local community health needs and trends to prioritize (rank) the health needs list generated from the Community Health Needs Assessment.

Leaders met on October 21, 2021 to prioritize the health needs:

- Alpa Vyas, Chief Patient Experience Officer, Stanford Health Care
- Amy Lu, MD, Assistant Chief Quality Officer of Health Equity, Stanford Health Care
- Colleen Johnson, Director of Community Partnerships, Stanford Health Care
- Jaclyn Liu, Community Health Program Manager, Stanford Health Care
- Jason Wong, MD, Medical Director of Health Services, Samaritan House
- Jonathan Shaw, MD, Associate Chair of Medicine for Community Partnership, Stanford University School of Medicine
- Matthew Chappell, Care Coordination Manager, Stanford Health Care
- Michelle Williams, PhD, RN, Executive Director & Research Scientist, Office of Research, Stanford Health Care
- Peter Shih, SMCHS, Senior Manager of Delivery System Planning, San Mateo County Health
- Rachelle Mirkin, Administrative Director, Health Education, Engagement and Promotion, Stanford Health Care
- Sang-Ick Chang, MD, Associate Dean and Division Chief, Primary Care & Population Health, Stanford University School of Medicine
- Tim Morrison, Executive Director, Ambulatory Care & Service Lines, Stanford Health Care

After making a presentation of the data that support the health needs list, the prioritization criteria (below) were agreed upon and distributed using an online survey to leaders.

The following criteria and scoring methods were used to prioritize the health needs.

Criterion	Scoring Key
Community priority. The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process.	Score generated by Actionable Insights: "3" – Prioritized as one of the top three needs by either one-quarter of focus groups or one-quarter of key informants "1" – Not prioritized by at least one one-quarter of focus groups or one-quarter of key informants.

<table>
<tr><th>Criterion</th><th>Scoring Key</th></tr>
<tr><td>Lacking sufficient community assets and/or resources. The IRS requires that hospitals take into consideration whether existing assets/ resources are available to address the issue.</td><td>Score generated by Actionable Insights based on number or assets/resources per need each county:

Score | SCC N | SMC N
3.0 – Insufficient | 0-9 | 0-5
2.0 – Moderately sufficient | 10-19 | 6-10
1.0 – Fully sufficient | 20+ | 11+

Actionable Insights took the average score by health need across both counties.</td></tr>
<tr><td>Disparities/inequities exist. This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender identity, or others.</td><td>Scored by leaders based on expertise and knowledge:

“3” – Strong multiplier effect
“2” – Moderate multiplier effect
“1” – Weak/no multiplier effect</td></tr>
<tr><td>Multiplier effect. A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.</td><td>Scored by leaders based on expertise and knowledge:

“3” – Strong/concerning disparities/inequities (very big differences)
“2” – Somewhat strong/concerning disparities/inequities
“1” – Less strong/concerning disparities/inequities</td></tr>
</table>

Based on the criteria described above, SHC prioritized the following 10 health needs, presented below in priority order (with 1 being the highest priority). (*See Section 6: Prioritized 2022 Community Health Needs for a summarized description of each need.*)

1. Economic Security
2. Housing and Homelessness
3. Behavioral Health
4. Health Care Access and Delivery
5. Diabetes and Obesity

6. Maternal and Infant Health
7. Climate and Natural Environment
8. Community Safety
9. Cancer
10. Sexually Transmitted Infections

6. PRIORITIZED 2022 COMMUNITY HEALTH NEEDS

The processes and methods described in Section 5 resulted in the prioritization of 10 community health needs (*see list on previous page*). Each description below summarizes the data, statistics, and community input collected during the community health needs assessment.

ECONOMIC SECURITY

Nearly all focus groups and over three quarters of all key informants identified economic security as a top community priority. Data available on economically precarious households shows that while half of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion is higher among households in both San Mateo and Santa Clara counties. Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. In SHC's 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic precariousness can force people to choose between paying rent and accessing health care; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

Income inequality in Silicon Valley is 1.5 times higher than the state level. Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English-language arts standards compared to California 11th graders overall. Also, smaller percentages of both counties' Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of both counties' Black, Latinx, and Pacific Islander high school graduates, and San Mateo County's Filipinx high school graduates, completed college-preparatory courses than high school graduates statewide. The high school drop-out rate is particularly high among Santa Clara County's Latinx youth, about double than all California youth. In SHC's 2019 CHNA report, we described similar inequities in educational attainment.

Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that community members often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also

"overrepresented in both frontline and hardest-hit sectors" of the economy.[30] Before the pandemic, the cost of childcare may also have been a limiting factor; the annual costs of infant child care (ages 0-2) and pre-K child care (ages 3-5) were substantially higher in both counties than the state average.

HOUSING AND HOMELESSNESS

More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo and Santa Clara counties are extremely high. Both counties' median home rental costs are more than 40% higher than the median state home rental cost. The home ownership affordability indices for both counties are substantially worse than for the state overall. Moreover, while homeowners statewide are spending approximately just under one-third of their income on their mortgages, homeowners in San Mateo and Santa Clara counties are spending more than one-third of their income on their mortgages.

Most feedback about housing from key informants and focus group participants concerned housing affordability. The housing affordability indices[31] for both counties are worse than for the State of California. CHNA participants reported the difficulty individuals in poverty, who were described as more likely to be BIPOC, have in affording housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. In both counties, homelessness rose in 2019 (the most recent homeless count). Experts noted that during COVID, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

Other CHNA participants said high housing costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID. However, housing quality is also a concern; for example, children and young adults ages 6-20 in Santa Clara County have worse blood lead levels than California children overall.

BEHAVIORAL HEALTH

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 three-quarters of focus groups and more than two-thirds of key informants.

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[30] Bohn, S., Cuellar Mejia, M., & Lafortune, J. (2021). *Multiple Challenges for Women in the COVID-19 Economy.* Public Policy Institute of California. Retrieved from https://www.ppic.org/blog/multiple-challenges-for-women-in-the-covid-19-economy/

[31] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median valued home." See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. *ESRI ArcGIS Blog*, December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported increased demand for services; however, children and adolescents were of particular concern. The most recent available statistics (dating pre-pandemic) suggest that youth mental health is an issue: students in Santa Clara County have lower access to psychologists at school than students statewide. Perhaps in part due to these access issues, Santa Clara County's self-harm injury hospitalization rate for youth is significantly higher than the state's rate. Experts noted the lack of mental health providers and addiction services overall, especially those providing services in non-English languages.

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data before the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic. Drug overdose deaths have been rising in both counties.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among San Mateo and Santa Clara counties' Black populations occur at nearly twice the rate as all Californians. Both counties' white suicide rate for all ages remains persistently higher than the state rate. Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[32] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[33] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) are substantially higher for Black and Latinx youth in both counties than for California youth overall.

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African

[32] McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, 27(2), 393–403. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

[33] Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services, and there are very few inpatient psychiatric beds for acute/high needs. Experts stated that services for people without health insurance can be expensive and difficult to access.

HEALTH CARE ACCESS AND DELIVERY

Health care access and delivery, which affects various other community health needs, was identified as a top health need by more than half of the focus groups and over one-third of key informants in San Mateo and Santa Clara counties. Experts and community members felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Health care access may be especially problematic for youth in the community: In both counties' schools, the ratio of students to each school nurse substantially exceeds the state ratio. In San Mateo County, the ratio of other primary care providers (i.e., not primary care physicians) is also worse than the state's ratio. In addition, community members in both counties who are Black, Indigenous, or other people of color (BIPOC) experience significantly worse health than community members of other races; for example, a higher rate of preventable hospital stays may be a sign of inequitable access to high-quality care.

Many key informants and focus group participants connected health care access with economic instability. For example, some mentioned that low-income community members might be required to prioritize rent and food over health care. Some reported that low-income and undocumented community members especially have difficulty accessing insurance. Affordability, both of insurance premiums and of health care itself, especially preventive care, was a particular concern; in SHC's 2019 CHNA report, community members of Latinx and "Other" ancestries[34] in both counties were significantly less likely to have health insurance than others. In 2021, CHNA participants identified the lack of information about health care costs for patients as another barrier to accessing care.

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide (in which some have easy access to computers and the Internet, while others experience barriers, usually due to income constraints) and patients' lack of privacy. They also expressed concern about the lower reimbursement rate for telephone appointments (i.e., without video). Once in-person

[34] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

appointments were more common again, transportation returned as a barrier to care for those living on the Coastside.

The need for health care workforce training to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas identified included: LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients with mental health issues, who are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included the education of health care workers around public charge issues and the need for more providers who speak patients' languages. More than one in ten Santa Clara County community members speak limited English, compared to fewer than one in ten in San Mateo County and in California overall. Limited English proficiency can restrict health care access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility to retain coverage were specific concerns. Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to health care among these groups.

Access issues related to oral health arose as well. An oral health expert described the lack of preventive dental care for low-income and underserved populations as a driver of poor access and suggested integrating oral health care into whole-person care as a way to improve access. Other data from SHC's 2019 CHNA suggest that Santa Clara County's adults were more likely to experience dental decay than Californians overall, and had a higher rate of emergency department visits for non-traumatic dental conditions than the state rate.

DIABETES AND OBESITY

More than one quarter of key informants and one focus group identified diabetes and obesity as top health needs. Two Santa Clara County Public Health experts in specifically highlighted that diabetes rates continue to rise in the community. Deaths due to diabetes is trending down in both counties, most clearly in San Mateo County. Key informants and focus group participants identified the need for nutrition education, particularly from a young age. Some key informants further noted the cost of healthy food as a barrier to good nutrition. Obesity rates for adults remain flat in Santa Clara County while worsening in San Mateo County.[35]

The lack of physical activity was cited as a driver of obesity by multiple key informants, primarily in the context of the pandemic's interference with regular activities. Associated with this concern, the walkability index in both counties is worse than the state's. Both counties' Black, Latinx, and Pacific

[35] Robert Wood Johnson Foundation. (2021). *County Health Rankings.*

Islander middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide.[36]

Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. Data show that, among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in both counties than the state rate. Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2-11 in both counties eat adequate amounts of fruits and vegetables daily than children statewide. Multiple community members suggested there was a connection between mental health and unhealthy eating—what's going on "in their head and their heart."

SHC's 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates than the state, and Santa Clara County's Black population also experiencing higher rates of diabetes. Although key informants and focus group participants did not connect diabetes and obesity with health disparities or inequities, experts writing on behalf of the American Diabetes Association describe placing "socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations."[37]

MATERNAL AND INFANT HEALTH

Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinxs in both counties and young Black women in San Mateo County than all females ages 15-19 statewide. A maternal and child health expert suggested that cultural norms and access issues may contribute to these differences.

As another example, low infant birth weight is a more frequent issue among Asian and Black babies born in both counties than all babies statewide, and the overall trend is worsening in Santa Clara County. Low birth weight is also more of an issue for San Mateo County Native American babies. Additionally, a smaller proportion of Black and Latinx mothers in Santa Clara County receive early prenatal care than all California mothers. CHNA participants felt that BIPOC people who are pregnant or have recently given birth need improved access to care. A maternal and child health expert indicated that these inequities may also be traced back not only to health care access and delivery barriers but also to social determinants of health such as racism. A public health expert identified

[36] With one exception: Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards

[37] Ogunwole, S. M. & Golden, S. H. (2021). Social Determinants of Health and Structural Inequities—Root Causes of Diabetes Disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from https://care.diabetesjournals.org/content/44/1/11

local Black and Pacific Islander populations as "shoulder[ing] a lot of layers of disparity and inequity,... which we already saw in our maternal, child, and adolescent health indicators, whether it was low birth weight or exclusive breastfeeding."

CLIMATE/NATURAL ENVIRONMENT

Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. Both counties are at significantly greater risk of heat waves as well as coastal and river flooding than the state as a whole. Santa Clara County is also at greater risk of drought than the state overall. Public health experts cited a lack of tree canopy cover in Santa Clara County, which is reflected in the statistical data as less than the state average. Both focus group participants and key informants mentioned the adverse effects of environmental issues, particularly on low-income and BIPOC individuals, not only related to physical health but also with regard to the mental and financial stress of evacuation due to floods or wildfires.

Road network density and traffic volume were both significantly higher in San Mateo and Santa Clara counties than state averages. The environmental cost of high traffic volume includes air pollution, which can aggravate asthma. One Santa Clara County key informant noted that asthma rates have been worsening, and an expert in Black health cautioned about high rates of asthma in areas with poor air quality. Statistics suggest that asthma prevalence among people of all ages is higher in both counties than in the state, although the figure is trending higher only in Santa Clara County. Child asthma diagnoses are higher in San Mateo County than all California children. Overall, the number of unhealthy air days has been rising in Silicon Valley, from zero in 2016 to 14 days in 2020.

Another consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents. In particular, the rate of emergency department visits for bicycle accidents among children ages 0-12 is higher in Santa Clara County than the state rate. Two of the county's public health experts discussed high traffic volume and the need to prevent accidents and make roads safe for pedestrians and cyclists. By race, among children ages 0-12 countywide, ED visits for bicycle accidents are highest among whites; for motor vehicle crashes, they are highest among Black and Latinxs; and for pedestrian accidents, they are highest among Latinxs. Racial inequity in accident rates has been found nationwide, and is attributed in part to unequal access to safe transportation.[38] The absence of sidewalks in low-income neighborhoods is another factor related to pedestrian accident rates nationally.[39]

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[38] Hamann, C., Peek-Asa, C., & Butcher, B. (2020). Racial disparities in pedestrian-related injury hospitalizations in the United States. *BMC Public Health*, 20(1), 1-7. Retrieved from https://link.springer.com/article/10.1186/s12889-020-09513-8 and

[39] Lu, W., McKyer, E.L.J., Lee, C., Ory, M.G., Goodson, P., & Wang, S. (2015). Children's active commuting to school: an interplay of self-efficacy, social economic disadvantage, and environmental characteristics. *International Journal of Behavioral Nutrition and Physical Activity.* 12(1):29. Retrieved from https://ijbnpa.biomedcentral.com/articles/10.1186/s12966-015-0190-8

COMMUNITY SAFETY

While many community safety statistics are better in both counties than the state, the rate of rape in Silicon Valley is rising. In addition, the homicide rate is significantly higher among the Black population in both counties than the state rate. This latter difference may, in part, be attributed to residential segregation[40], which has been shown to be related to structural discrimination (see Housing and Homelessness description).

In San Mateo County, bullying and harassment, including cyberbullying, are worse for 7th and 9th graders than all California students in those grades.[41] San Mateo County's 9th graders are also nearly twice as likely to fear being beaten up at school than all California 9th graders.[61] Two experts noted that the shift to virtual education during the pandemic benefited youth who had been bullied at school and said that some did not want to return when schools reopened. Indeed, rates of bullying and harassment at school are higher for most non-white youth (Asian, Black, Filipinx, Latinx, Native American, and Pacific Islander youth) in San Mateo County versus the state. In addition, cyberbullying rates are higher for the county's Black, Latinx, and Native American middle-schoolers than middle-schoolers in California overall.[42]

Some experts expressed concern about COVID-related stress contributing to domestic violence and/or sexual abuse; one mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety. There are disparities in domestic violence: Black children ages 0-17 in both counties and Latinx children in Santa Clara County are more likely to be the subject of a substantiated child abuse case than children statewide. Researchers attribute these disparities to differences in family circumstances that put children at greater risk of abuse (e.g., being young and/or single parents, experiencing poverty).[43] Building on the differences in child abuse statistics, both counties' Black children (ages 0-20) are also more likely to be in foster care than are California children on average. Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.[44] Statistics show that juvenile felony arrests

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[40] Knopov, A., Rothman, E.F., Cronin, S.W., Franklin, L., Cansever, A., Potter, F., Mesic, A., Sharma, A., Xuan, Z., Siegel, M. and Hemenway, D. (2019). The role of racial residential segregation in black-white disparities in firearm homicide at the state level in the United States, 1991-2015. *Journal of the National Medical Association*, 111(1), pp.62-75. Retrieved from https://www.researchgate.net/profile/Anita-Knopov/publication/326323244_The_Role_of_Racial_Residential_Segregation_in_Black-White_Disparities_in_Firearm_Homicide_at_the_State_Level_in_the_United_States_1991-2015

[41] Note, comparable data are not available for Santa Clara County.

[42] Note, comparable data are not available for Santa Clara County.

[43] Font, S. A., Berger, L. M., & Slack, K. S. (2012). Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review,* 34(11), 2188-2200. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3439815/. See also: Black Child Legacy Campaign. (2021). *Child Abuse and Neglect.* Retrieved from https://blackchildlegacy.org/resources/child-abuse-and-neglect/

[44] See, for example, Cutuli, J.J., Goerge, R.M., Coulton, C., Schretzman, M., Crampton, D., Charvat, B.J., Lalich, N., Raithel, J., Gacitua, C. and Lee, E.L., 2016. From foster care to juvenile justice: Exploring characteristics of youth in three cities. *Children and Youth Services Review*, 67, pp.84-94. Retrieved from

(ages 10-17) are higher in Santa Clara County than the state, and, specifically, higher for Black and Latinx youth in both counties. In Santa Clara County, Latinx youth are substantially overrepresented in the county's juvenile detention center population.[45] These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.[46]

CANCER

Mortality rates for cancer in both counties are better than state benchmarks. However, indicators of concern include the breast cancer incidence rate among Santa Clara County women, which is greater than California women overall; the prostate cancer incidence rate among San Mateo County men, which is greater than California men overall, and rising prostate cancer mortality rates in San Mateo County. In addition, the rate of cancer incidence among children ages 0-19 is slightly higher in both counties than the state and highest among white and Asian/Pacific Islander children. SHC's 2019 CHNA report indicated that compared to California residents, Black community members in both counties have a higher incidence of breast cancer, lung cancer, prostate cancer, and a higher prevalence of cancer of all sites combined, while Latinx community members have a substantially higher incidence of cervical cancer. Finally, mammography screening levels, an early cancer detection measure, are lower for Santa Clara County's Black and Native American women and Latinxs, and San Mateo County's Black women, than California's women overall.

The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, community members are more likely to be obese, which is a cancer risk factor). The Institute states, "Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and/or institutional inequalities."[47]

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https://www.aisp.upenn.edu/wp-content/uploads/2020/11/From-Foster-Care-to-Juvenile-Justice.pdf . And see Yi, Y., & Wildeman, C. (2018). Can foster care interventions diminish justice system inequality?. *The Future of Children*, 28(1), 37-58. Retrieved from https://files.eric.ed.gov/fulltext/EJ1179175.pdf

[45] County of Santa Clara. (2020). *Santa Clara County Juvenile Justice Annual Report.* Retrieved from https://probation.sccgov.org/sites/g/files/exjcpb721/files/documents/2021_09_17_Juvenile%20Justice%20Annual%20Report_2020_Final.pdf

[46] Gallegos, A. H., & White, C. R. (2013). Preventing the School-Justice Connection for Youth in Foster Care. *Family Court Review*, 51(3), 460-468. And see: Foster, M. & Gifford, E. (2004). "The Transition to Adulthood for Youth Leaving Public Systems: Challenges to Policies and Research," in *On the Frontier of Adulthood: Theory, Research, and Public Policy*, eds. Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., & Rubén G. Rumbaut. Chicago: University of Chicago Press.

[47] National Cancer Institute. (2020). *Cancer Disparities.* Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

SEXUALLY TRANSMITTED INFECTIONS

Although statistics on sexually transmitted infections are better than the state for both counties, there are concerning trends. HIV diagnoses among younger men (ages 13-24 and 25-44) are on the rise in Santa Clara County, while rates of early syphilis are increasing in San Mateo County. In SHC's 2019 report, we found that the proportion of people who were not screened for HIV was higher in Santa Clara County than statewide.

Additionally, there are disparities; for example, Black and Latinx men ages 13 and older in Santa Clara County are more than twice as likely to be diagnosed with HIV than California men overall. In SHC's 2019 report, statistics showed that the Black population in Santa Clara County was also more likely to be diagnosed with early syphilis than all Californians. The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the health care system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to "stay sexually healthy."[48]

For additional statistical data, see Attachment 2: Secondary Data Tables.

[48] Centers for Disease Control and Prevention. (2020). *STD Health Equity.* Retrieved from https://www.cdc.gov/std/health-disparities/default.htm

7. EVALUATION FINDINGS FROM 2020–2022 IMPLEMENTED STRATEGIES

STANFORD HEALTH CARE'S 2019 PRIORITIZED HEALTH NEEDS

In 2018–2019, Stanford Health Care (SHC) participated in a Community Health Needs Assessment similar to the collaborative 2022 effort. The hospital's 2019 CHNA report is posted on the Community Health and Partnership page of its public website.[49] As noted in that report, in 2019, SHC's Community Partnerships Program Steering Committee prioritized the health needs listed below. It chose to address the top three in subsequent years through strategic initiatives.

1. Housing and Homelessness
2. Behavioral Health
3. Health Care Access and Delivery
4. Diabetes and Obesity
5. Economic Stability
6. Oral/Dental Health

IMPLEMENTATION STRATEGIES FOR FISCAL YEARS 2020 AND 2021

The 2019 CHNA formed the foundation for SHC's implementation strategies for fiscal years 2020 (September 1, 2019–August 31, 2020) and 2021 (September 1, 2020–August 31, 2021), which were initiated in FY20. The IRS requires hospitals to report on the impact of implementation strategies. The following sections describe the evaluation of community benefit programs put forth in the implementation strategies. Due to timing constraints that require the adoption and public posting of this report by the end of the fiscal year, evaluation results for fiscal year 2022 (September 1, 2021–August 31, 2022) are forthcoming and not yet available for inclusion at the time of this report. For more information, see the Community Health and Partnership webpage .[50]

COMMUNITY BENEFIT INVESTMENTS IN FISCAL YEARS 2020 AND 2021

SHC's annual community investment focuses on improving the health of its community's most vulnerable populations. To accomplish this goal, all community grant investments in FY20–FY22 supported the three prioritized community health needs: Housing and Homelessness, Behavioral Health, and Health Care Access and Delivery.

Community Benefit Investment Highlights in Fiscal Years 2020 and 2021

- Over $1.3 billion in community benefit, excluding uncompensated Medicare
- More than $780 million in charity care and other financial assistance programs

[49] https://stanfordhealthcare.org/about-us/community-partnerships.html
[50] https://stanfordhealthcare.org/about-us/community-partnerships.html

- Over $273 million in community health improvement research and training of the next generation of physicians and other health care professionals
- More than $176 million in community programs that support the underserved and community health improvement activities
- $95 million in COVID-19 response

Impact of Implemented Strategies in Fiscal Years 2020 and 2021

This section describes the impact of SHC's community benefit investments in FY20 and FY21, based on its implementation strategies for the 2019 prioritized health needs.

Access to Care

Based on SHC's 2019 Community Health Needs Assessment findings, SHC's interventions to improve access to care in its community include behavioral health (mental health and substance abuse), obesity and diabetes, and oral health interventions.

Partner	Program	Program Details and FY20 Impact
Asian Americans For Community Involvement (AACI)	Patient Navigation	Through a full-time, Vietnamese-speaking Patient Navigator, the program supports better health outcomes through interventions supporting clinical care (engagement with medical practices, medication adherence, appointment scheduling) and social determinants of health (insurance enrollment, connection to food, transportation, etc.). • 286 previously uninsured patients were enrolled in health insurance • 229 patients were linked with community-based social services • 545 interpretation services were provided • 94% of patients were able to accurately understand after visit summary, including follow-up care, medication adherence, and at-home care. Persons served: 670
Avenidas – Rose Kleiner Center	Nurse Navigator/ Community-Based Home Health Program	The program provides intensive care coordination for low-income seniors with highly complex medical, cognitive, and behavioral health conditions. • Reduced Emergency Department visits by 90% • Reduced hospital stays by 88%

Partner	Program	Program Details and FY20 Impact
		• No 30-day readmissions for 90% of participants Persons served: 32
Cardinal Free Clinics	Free Laboratory and Radiology Services	This program provides laboratory and radiology services free of charge to uninsured and underinsured individuals. In 2019, approximately 93% of Cardinal Free Clinics clients were uninsured. • 1,923 free lab tests were provided • 508 free radiology services were provided, including x-ray, CT, MRI, and ultrasound Persons served: 1,971
Gardner Family Health Network	Beyond Clinic Walls	Through the Our Voice Discovery Tool, Gardner Family Health Network patients, physicians, and clinic administrators will identify and remove barriers to good health for patients and families. Projects will result in solution-oriented improvements that impact short and long-term health outcomes. *Because of the pandemic, this project was significantly delayed. Project outcomes were not available at the time of reporting.*
Operation Access	Care Navigation and Access to Specialty Care and Outpatient Surgical Services	The program partners with local hospitals and health systems to link donated surgical preventive care to uninsured and underinsured patients in San Mateo and Santa Clara Counties at no charge to patients. • 125 surgical procedures and diagnostic services completed • 96% of patients reported improved health and quality of life as a result of services provided Persons served: 102
Peninsula Healthcare Connection	Backpack Medicine Team Expansion and Clinic Billing Support	Through 0.5 FTE Medical Assistant, the Backpack Medicine team provides expanded access to primary care, mental health, and COVID-19 services. Through 1.0 FTE Billing Specialist, clinic sustainability and patient access to local health care services is improved.

Partner	Program	Program Details and FY20 Impact
		• 6% increase in patients served from the prior year • 14% increase in patients that received depression screenings during primary care physician visit • 20% increase in behavioral health referrals made following screening during primary care physician visit • 25% reduction in behavioral health appointment "no-show rate" from the prior year • Prescription and refill request issues remedied within 24 hours of the request • 5% increase in diabetic patients with regular HbA1c checks Persons served: 250 with 1,113 visits
Puente	Access to Care Program Expansion	The program increases local health care services, improves client linkage to health care and social services, and reduces client barriers to accessing care for very vulnerable and medically underserved community members who live in the coastal region of San Mateo Country. • 20% increase in Puente clients accessing preventive care services and health education programs • 80% increase in preventive care program enrollment • 97 high-risk individuals were tested for COVID-19 • 6,000 masks were distributed to farmworkers • 12 low-income families, who would have deferred or declined health care because of financial barriers, received emergency medical funds • 5 new partnerships provided direct health services in San Mateo County's southern coastal communities of Pescadero, La Honda, Loma Mar, and San Gregorio) Persons served: 929
Ravenswood Family Health Center	Electronic Health Record Migration	Successfully transitioned from NextGen electronic health record to EPIC, which provides stronger population health management and care coordination opportunities with local health systems and hospitals. Initial electronic health record monthly reports to improve population health management and care coordination:

Partner	Program	Program Details and FY20 Impact
		• Emergency Department usage for asthma patients • Colorectal cancer screenings • Diabetes screenings and management • Provider health information exchange usage
Samaritan House	Free Clinic Care Coordination and Care Delivery Redesign	Adopting the Rush University Total Health Collaborative model, the program improves health outcomes through reduced inequities caused by social, economic, and structural determinants of health. • 163 patients were linked with community-based social services, including financial assistance and food access • 89% of patients saw improved diabetes management (BP<140/90) • 5 patients had improved economic stability • 30% of patients reported improved oral health Persons served: 163
Sonrisas Dental Health	Oral Health Access to Care Program Expansion	The program increases local oral health care services for low-income adults. • An additional 345 patients established a dental provider • 61 patients were admitted off the county waitlist • Less than 1% of Sonrisas Dental Health patients visited the emergency department for dental pain • During the COVID-19 shut-down established a 24/7 emergency advice line, which served 724 patients with emergency, teledentistry, and oral health coaching Persons served: 345

Partner	Program	Program Details and FY21 Impact
Avenidas – Rose Kleiner Center	Community-Based Home Health Program	This program provides intensive care coordination for low-income seniors with highly complex medical, cognitive, and behavioral health conditions.

Partner	Program	Program Details and FY21 Impact
		• 82% reduction in participants' emergency room visits over previous year • 92% reduction in participants' hospital admissions over previous year • 95% of family caregivers reported reduced stress levels due to interaction with the Community-Based Home Health Program Persons served: 35
Operation Access	Access to Surgical Services and Specialty Care	The program partners with local hospitals and health systems to link donated surgical, preventive, and specialty care to uninsured and underinsured patients in San Mateo and Santa Clara Counties at no charge to patients. • Provided 128 surgical procedures and diagnostic services • 96% of patients reported improved health or quality of life • 87% of patients reported reduced pain post-procedure • Emergency department use reduced by 33% Persons served: 97
Peninsula Healthcare Connection	Backpack Medicine Team Expansion and Clinic Billing Support	Through a full-time Medical Assistant, the Backpack Medicine Team has considerably helped expand COVID-19 services. Through a 0.5 FTE Medical Biller, clinic services have grown, which has expedited clients receiving affordable services and resources, such as essential prescriptions. • Wait times for prescription refills decreased by 25% • 100% of patients received screening for depression • As of June 30, 2021, 16 outreach events resulted in 421 COVID-19 tests conducted among chronically homeless patients. Persons served: 1,605
Ravenswood Family Health Center	Ultrasound Machine Upgrade	Through the purchase of three new ultrasound machines, Ravenswood Family Health Network (a local Federally Qualified Health Center) expanded

Partner	Program	Program Details and FY21 Impact
		access to and reduced wait time for women's health services. • Provided 312 OB/GYN ultrasounds • Reducing the need for a referral to a specialist, — 50% of 1st trimester bleeding was diagnosed and/or treated during the primary care physician visit — 95% of common gynecological complaints were diagnosed and treated in the primary care physician office Persons served: 254
Rotacare Bay Area, Inc.	San Jose Free Clinic Re-Opening Support	Following the clinic's closure due to COVID-19, funding supported access to care and clinic operations, including implementation of telemedicine services and expanded diabetes and hypertension prevention and treatment services. • 56 unduplicated diabetic patients received 160 telemedicine visits • 100% of patients were screened for health insurance and received enrollment support as eligible • 100% of patients received blood pressure, blood glucose, and urinalysis testing Persons served: 124
Samaritan House	Free Clinic Care Coordination and Care Delivery Redesign	Adopting the Rush University Total Health Collaborative model, the program improves health outcomes through reduced inequities caused by social, economic, and structural determinants of health. • 38 patients accessed additional supportive services • Provided 3,703 medical and dental visits • Provided 398 visits for diabetes care • 75% of participants with diabetes were controlled <140/90 Persons served: 864
Sonrisas Dental	Oral Health Access	The program increases critical access to high-quality

Partner	Program	Program Details and FY21 Impact
Health, Inc.	to Care Program Expansion	dental and oral health care for low-income adults in San Mateo County. The Access to Care Program provides a range of high-quality dental services, including diagnostic, preventative, and restorative procedures, for patients facing financial barriers. • 382 new patients received dental care • 75% of new patients established a dental home with 2+ visits within the previous 12 months • 100% of patients received oral health prevention education at time of visit • Less than 1% of patients visited the emergency department for a dental issue Persons served: 80
	Operatory Build Out	As the leading independent dental provider for Medi-Cal Dental and uninsured patients in San Mateo County, funding supported the construction of two new dental operatories. • Increased access to specialty and emergency dental care, including dental implants, dentures, treatment of gum disease, and oral surgery • Increased access to preventive and routine dental care • Developed new partnerships with local federal qualified health centers to support specialty and emergency dental care needs of patients Additional annual patient visits: ~2,300

Housing and Homelessness

Based on Stanford Health Care's 2019 Community Health Needs Assessment findings, SHC's interventions to housing and homelessness outcomes in its community include homelessness prevention, expanded supportive care and social services for self-sufficiency, and access to care for those experiencing and/or at-risk for homelessness.

Partner	Program	Program Details and FY20 Impact
Destination: Home	Homelessness	The program offers a coordinated system for

Partner	Program	Program Details and FY20 Impact
	Prevention System	preventing homelessness across Santa Clara County. Through intensive case management, services include immediate and flexible financial assistance, supportive services, employment development, and rehousing and legal aid when necessary. • 95% of households remained stably housed while receiving assistance • 94% of households remained stably housed at least 12 months after termination of assistance • 90% of households did not re-enter assistance within two years after termination of assistance Persons served: 1,076
Downtown Streets Team	Work Exchange Program for Chronically Homeless Individuals	Unhoused team members volunteer in work experience teams, beautifying their community in exchange for basic needs stipends, case management, and employment services. • 61 team members gained permanent employment • Team waitlists reduced from four to less than two weeks Persons served: 142
Medical Respite Program	Intensive Case Management and Behavioral Health Services	Program provides health care and supportive care services to address the “total health” needs of homeless patients post-hospital discharge, intensive case management, behavioral health (mental health and substance abuse) services, and linkage to community-based social services. • Saved 736 avoided hospital days • 82% of patients received neuropsychiatric testing as indicated by MoCA score • 1,255 individual cognitive behavioral therapy sessions conducted • 44 patients linked to intensive case management, resulting in 43 patients securing temporary housing post-discharge and 2 patients securing permanent housing post-discharge

Partner	Program	Program Details and FY20 Impact
		Persons served: 184

Partner	Program	Program Details and FY21 Impact
Destination: Home	Homelessness Prevention System	The program offers a coordinated system for preventing homelessness across Santa Clara County. Through intensive case management, services include immediate and flexible financial assistance, supportive services, employment development, and rehousing and legal aid when necessary. • 93% of households remained stably housed while receiving assistance • 96% of households remained stably housed at least 12 months after receiving assistance • 90% of households did not return for services within two years after receiving assistance Households served: 2,841
Downtown Streets Team	Work Exchange Program for Chronically Homeless Individuals	Unhoused team members volunteer in work experience teams, beautifying their community in exchange for basic needs stipends, case management, and employment services. • Team waitlists reduced from four to less than two weeks • 849 team members achieved self-sufficiency and overcame employment barriers (Examples: enrolled in government programs, received personal identification and employment application support) Persons served: 180
Medical Respite Program	Intensive Case Management and Behavioral Health Services	This program provides health care and supportive care services to address the “total health” needs of homeless patients post-hospital discharge, intensive case management, behavioral health (mental health and substance abuse) services, and connections to community-based social services. • 606 hospital days avoided • 782 individual behavioral therapy sessions provided

Partner	Program	Program Details and FY21 Impact
		• 43 patients linked to intensive case management services upon program discharge, resulting in: — 98% of patients secured temporary housing — 23% of patients secured permanent housing Persons served: 148

Economic Stability

Based on Stanford Health Care's 2019 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve economic stability in its community are focused on healthy food access and transportation.

Partner	Program	Program Details and FY20 Impact
Avenidas	Senior Transportation Program	Pre-COVID-19: Adult Day Program • Provided 8,850 rides for seniors to attend the Adult Day Program • 91% of riders reported feeling healthier and more independent by using service Avenidas Village • Provided 3,600 rides for seniors to attend medical appointments, grocery stores, pharmacies, and social activities • 97% of riders reported feeling healthier and more independent by using service Post-COVID-19: Adult Day Program • Provided weekly grocery delivery for 15 vulnerable seniors • Made 60 medication deliveries • Delivered bi-weekly activity packets for 15 cognitively impaired participants • 100% of families reported that COVID-19 services kept them safer, healthier, and more independent Avenidas Village • Provided phone check-ins for 257 vulnerable seniors • Provided weekly grocery delivery for 37 vulnerable seniors • Made 59 medication deliveries

Partner	Program	Program Details and FY20 Impact
		Persons served: 1,077
City Of Half Moon Bay	Half Moon Bay Transportation and Transit Equity Project	Using the Our Voice Discovery Tool, the City of Half Moon Bay brought together a coalition of local groups and individuals to make public services broadly accessible, decrease the use of single-occupancy vehicles, and promote safe and healthy alternatives to driving. • Citizen scientists collected data from individuals and organizations representing youth, seniors, immigrants, and grassroots constituencies • 17 transportation improvement recommendations were developed • City of Half Moon Bay commits to implement 100% of recommendations Persons served: 118
Second Harvest Food Bank	Lean Proteins for Local Food Distribution Centers	The program provided a one-year supply of lean proteins (dairy, eggs, poultry, fish, peanut butter, and almonds) for local food bank sites. • Proteins provided at 47 local affordable and supportive housing sites • 12 new food security screening partners added • 1,895 CalFresh applications approved for SHFB clients • Linked 1,788 new clients referred from health providers with foodbank services Persons served: 196,176
The Health Trust	Food is Medicine	The Meals on Wheels (MOW) program provides daily delivered meals and wellness checks for isolated, vulnerable, and disabled seniors. • Served 192 individuals under the age of 60 with no other meal delivery option • 32% of MOW clients were enrolled in the Medically Tailored Meals program • 99% of MOW clients reported the program was

Partner	Program	Program Details and FY20 Impact
		"extremely important" to their daily well-being Medically Tailored Meals (MTM) programs support patients with customized nutrition to support the dietary needs associated with chronic and acute health conditions, including diabetes and congestive heart failure. MTM program is part of a California study to assess the efficacy of medically tailored meals as a Medi-Cal covered benefit. • 67% of participants were not readmitted to the hospital during the 12-week program • Provided 211 nutrition education and therapy sessions with a Registered Dietician Persons served: 1,201

Partner	Program	Program Details and FY21 Impact
Avenidas – Rose Kleiner Center	Senior Planet Program	This program delivers instruction and information to help older adults master the technology they want and need to make their lives better. • 400 interactive sessions delivered • 89% of those who enrolled in health sessions achieved one health goal • 92% of those who enrolled in a financial literacy class reported a new financial skill mastered • 97% reported feeling more connected and less isolated Persons served: 150
Second Harvest Food Bank	Lean Proteins for Local Food Distribution Centers	The program provided a 5-month supply of lean proteins (dairy, eggs, poultry, fish, peanut butter, and almonds) for local food bank sites. • Provided proteins to 38 local affordable and supportive housing sites • Linked 346 new clients referred from health providers to food bank services • 2,596 clients received CalFresh screening and connections to eligible services

Partner	Program	Program Details and FY21 Impact
		Persons served/month: 29,437
The Health Trust	Food is Medicine	Meals on Wheels The Meals on Wheels (MOW) program provides daily delivered meals and wellness checks for isolated, vulnerable, and disabled seniors. • 298,189 meals provided to 1,180 clients under the age of 60 with no other meal delivery option • 121 clients were enrolled in the Medically Tailor Meals program • 99% of clients reported the program was important to their daily well-being Medically Tailored Meals Medically Tailored Meals (MTM) programs support patients with customized nutrition to support the dietary needs associated with chronic and acute health conditions, including diabetes and congestive heart failure. MTM program is part of a California study to assess the efficacy of medically tailored meals as a Medi-Cal covered benefit. • 85 new clients enrolled in MTM • 64% of MTM clients were not readmitted to the hospital during the 12-week program • 88 MTM clients received nutrition education and therapy sessions with a Registered Dietician Persons served: 1,168

COVID-19 Response

Stanford Health Care remains committed to supporting the broad community needs emerging from the COVID-19 pandemic, particularly through contributions that increase equitable access to COVID-19 health care and resources.

Fiscal Year 2020

In partnership with federal, state, and local government and public health agencies, other health care providers, and local community-based organizations, during FY20, Stanford Health Care's COVID-19 response activities included:

- Expanded access to care and community-based COVID-19 testing
- Launched cutting-edge COVID-19 research
- Provided community-level emergency management expertise, supplies, and resources
- Supported community health improvement activities for patients and the broad community

Additionally, SHC financially supported operations and capacity-building for local social services providers responding to the increased needs resulting from the COVID-19 pandemic.

Partner	Program Details and FY20 Impact
Avenidas	Developed remote services for the Rose Kleiner Adult Day Care Program
Downtown Streets Team	Supported additional basic living stipends for homeless clients
Medical Respite Program Of Santa Clara County	Purchased laptops so that staff could work from home
Operation Access	Purchased laptops so that staff could work from home
Peninsula Healthcare Connection	Supported access to COVID-19 testing, medical care, and linkage to social services for homeless patients
Ravenswood Family Health Center	Supported clinic and exam room safety upgrades to reduce the spread of COVID-19 among patients and staff
Second Harvest Food Bank	Purchased additional healthy proteins to support the increase in food bank clients
Sonrisas Dental Health	Purchased personal protective equipment for dental clinic staff
The Health Trust	Purchased additional meals to support the increase in Meals on Wheels clients

Partner	Program Details and FY20 Impact
Covid-19 Regional Response Fund	Direct financial assistance for low-income individuals impacted by COVID-19 supported • Rent and utility assistance • Medical expenses assistance • Purchase of food and clothing • Transportation and employment assistance • Legal assistance
Destination: Home	
Samaritan House	
San Mateo County Strong	
Silicon Valley Strong	

Fiscal Year 2021

One-third of Stanford Health Care's more than 500,000 COVID-19 vaccine doses administered to-date were provided at community vaccination sites located in and in partnership with local underserved communities. Improved health equity and vaccine access was achieved at these sites through a new strategic partnership model involving Stanford Health Care, local public health departments, and community partners. While vaccination is a cornerstone of Stanford Health Care's FY21 COVID-19 response, broad COVID-19 support includes:

CUTTING EDGE CLINICAL CARE AND RESEARCH. Stanford Health Care offers emerging COVID-19 treatments such as monoclonal antibody therapies (mAb). In partnership with Stanford University School of Medicine, Stanford Health Care studies the effectiveness of new COVID-19 prevention, diagnosis, and treatment interventions.

COVID-19 VACCINATION AND TESTING. Twelve community sites provided high-quality, equitable, and convenient COVID-19 vaccination and testing. To overcome access barriers identified by the community, sites offered interpreters and multilingual support, extended and weekend hours, walk-in availability, and community health worker outreach and on-site education and navigation.

MOBILE VACCINE SERVICES. Mobile clinics supported vaccination and testing for populations with barriers to accessing community-based sites. These populations included homebound seniors and underserved schools.

VACCINE APPOINTMENT SCHEDULING. When vaccine supply was extremely limited, Stanford Health Care provided dedicated and barrier-free scheduling to high-risk and vulnerable populations as identified by local public health departments and community nonprofits.

EMERGENCY MANAGEMENT. Provided personnel, expertise, supplies, and resources to support federal, state, and local government agencies' emergency pandemic management efforts.

HEALTH EDUCATION. Offered accurate, timely, easily accessible, and culturally competent information related to COVID-19 prevention, testing, treatment, and vaccination. For more information, please consult the Stanford Health Library.

PERSONAL PROTECTIVE EQUIPMENT AND MEDICAL SUPPLIES. Stanford Health Care donated supplies to local safety-net providers and nonprofits to ensure that critical health care and social services remained available and operating safely.

VOLUNTEERS. Stanford Medicine faculty, providers, and staff were connected with community-based organizations that sought support for various clinical and operational needs to address challenges presented by COVID-19.

Stanford Health Care also financially supported operations and capacity-building for local social services providers responding to the increased community health needs resulting from the COVID-19 pandemic.

Partner	Program Details and FY21 Impact
Avenidas Rose Kleiner Center	Supported Avenidas' site re-opening preparation and operations costs
Destination: Home	Supported financial assistance for households served through Destination: Home's financial assistance network
Downtown Streets Team	Supported basic living stipends for homeless clients
Operation Access	Supported patient financial assistance fund supporting ancillary costs and patient reimbursements
Peninsula Healthcare Connection	Supported access to COVID-19 testing, medical care, vaccination, and connection to social services for homeless patients
Ravenswood Family Health Network	Supported COVID-19 related health and safety upgrades for the Ravenswood Family Health Center's clinics
Roots Community Health Center	Supported COVID-19 community vaccination events

Partner	Program Details and FY21 Impact
Samaritan House	Financial Assistance to support basic needs of individuals and families impacted by COVID-19. Funds support: rent, utilities, medical expenses, food, etc.
Second Harvest Food Bank	Supplied two months of healthy proteins for local food bank sites to meet increased demand for services
The Health Trust	Provided a one-year supply of Asian and Vietnamese-diet meals for Meals on Wheels program clients

8. CONCLUSION

Stanford Health Care worked with its local hospital and health system partners, combining expertise and resources, to conduct the 2022 Community Health Needs Assessment. By gathering secondary data and conducting new primary research as a team, the partners were able to understand the community's perception of health needs as well as prioritize health needs with an understanding of how each compares against benchmarks. SHC further prioritized health needs in its area based on a set of defined criteria.

The 2022 CHNA, which builds upon prior assessments dating to 1995, meets federal (IRS) and California state requirements.

Next steps for Stanford Health Care:

- CHNA adopted by hospital board and made publicly available on SHC's website by August 31, 2021.[51]
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs.
- Strategies are adopted by the hospital board and filed with the IRS by January 15, 2023.[71]

[51] See https://stanfordhealthcare.org/about-us/community-partnerships.html. Stanford Health Care's fiscal year 2022 ends August 31, 2022, which is the IRS deadline for posting.

9. LIST OF ATTACHMENTS

1. Secondary Data Indicators List
2. Secondary Data Tables
3. Community Leaders, Representatives, and Members Consulted
4. Qualitative Research Protocols
5. Community Assets and Resources, San Mateo County
6. Community Assets and Resources, Santa Clara County
7. IRS Checklist

ATTACHMENT 1: SECONDARY DATA INDICATORS LIST

Category	Indicator	Indicator Description	Data Source
Behavioral Health	11th Graders Who Had Depression-Related Feelings in the Previous Year	Estimated percentage of public school students in grade 11 in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	11th Graders Who Seriously Considered Attempting Suicide in the Previous Year	Students in grade 11 who seriously considered attempting suicide in the previous year	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	7th Graders Who Had Depression- Related Feelings in the Previous Year	Estimated percentage of public school students in grade 7 who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey. California Department of Education. 2020.
Behavioral Health	7th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes	Estimated percentage of public school students in grade 7 who have ever consumed one or more full drinks of alcohol, by grade level and number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	7th Graders Who Used Alcohol or Drugs in the Previous Month	Estimated percentage of public school students in 7th grade who have used alcohol or drugs in the past month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	7th Graders Who Used Marijuana 20-30 Days in the	Estimated percentage of public school students in 7th grade who have used	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
	Previous Month	marijuana for 20-30 days out of the previous month	
Behavioral Health	7th Graders with a Low Level of Caring Relationships with Adults at School	Estimated percentage of public school students in grade 7 who have a low level of caring relationships with adults at school, by level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	9th Graders Who Had Depression- Related Feelings in the Previous Year	Estimated percentage of public school students in grade 9 who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	9th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes	Estimated percentage of public school students in grade 9 who have ever consumed one or more full drinks of alcohol, by grade level and number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	9th Graders Who Seriously Considered Attempting Suicide in the Previous Year	Estimated percentage of public school students in grade 9 who seriously considered attempting suicide in the previous year	WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education. 2020.
Behavioral Health	9th Graders Who Used Alcohol or Drugs in the Previous Month	Estimated percentage of public school students in 9th grade who have used alcohol or drugs in the past month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	9th Graders Who Used Marijuana 20-30 Days in the Previous Month	Estimated percentage of public school students in 9th grade who have used marijuana for 20-30 days out of the previous month	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Behavioral Health	9th Graders with a Low Level of Caring Relationships with Adults at School	Estimated percentage of public school students in grade 9 who have a low level of caring relationships with adults at school, by level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Behavioral Health	Adults with 1-3 Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to one to three adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.
Behavioral Health	Adults with 4 or More Adverse Childhood Experiences	Estimated percentage of adults 18 and older exposed to four or more adverse childhood experiences before age 18, by household type	UC Davis Violence Prevention Research Program, tabulation of data from the California and American Community Survey. 2020.
Behavioral Health	Children with 2 or More Adverse Experiences (ages 0-17, parent reported)	Estimated percentage of children ages 0-17 who have experienced two or more adverse experiences	Population Reference Bureau, analysis of data from the National Survey of Children's Health and the US Census Bureau, American Community Survey. 2012-16. (Jan. 2021).
Behavioral Health	Current Smokers	Percentage of adults who are current smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
Behavioral Health	Deaths Due to Chronic Liver Disease and Cirrhosis	Percentage of deaths that occurred due to liver disease and Cirrhosis	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Behavioral Health	Deaths of Despair	Rate of deaths of despair	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral Health	Drug Induced Deaths	Percentage of deaths that occurred due to drugs	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Behavioral	Drug Overdose Deaths	Percentage of deaths that occurred due	National Center for Education Statistics-Mortality Files

Category	Indicator	Indicator Description	Data Source
Health		to drug overdoses	NCES. 2015-16.
Behavioral Health	Excessive Drinking	Percentage of Adults Drinking Excessively	Centers for Disease Control and Prevention, Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.
Behavioral Health	Frequent Mental Distress, Adults (14+ days per month)	Percentage of adults who report frequent mental distress (14 or more mentally unhealthy days) in the past 30 days	Santa Clara County Public Health Department- Behavioral Risk Factor Survey. 2013-14.
Behavioral Health	Impaired Driving Deaths	Estimated deaths that occurred due to impaired driving	National Highway Traffic Safety Administration Fatality Analysis Reporting System. 2014-18.
Behavioral Health	Insufficient Sleep	Percentage of population with insufficient sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
Behavioral Health	Mental Health Hospitalizations among Children (ages 5-14) (per 1,000)	Number of hospital discharges for mental health issues per 1,000 children and youth ages 5-14	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Behavioral Health	Mental Health Hospitalizations among Youth (ages 15-19) (per 1,000)	Number of hospital discharges for mental health issues per 1,000 children and youth ages 15-19	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Behavioral Health	Mental Health Providers	Number of mental health providers per populations of 100,000	Chronic Conditions prevalence State/County Level: All Beneficiaries by Age, 2007-2018
Behavioral Health	Opioid Overdose Deaths	Estimated deaths that occurred due to opioid overdose deaths	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral	Poor Mental Health (days per	Average Number of Mentally Unhealthy	Centers for Disease Control and Prevention, Behavioral

Category	Indicator	Indicator Description	Data Source
Health	month)	Days per Month	Risk Factor Surveillance System. 2006-12.
Behavioral Health	Population 65 & Older Living Alone	Estimated number of the population who is 65 and older that are living alone	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.. 2012-16.
Behavioral Health	Ratio of Students to School Psychologists	Ratio of the number of students compared to the number of number of school psychologists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Behavioral Health	Ratio of Students to School Social Workers (N students per social worker)	Number of public school students per full-time equivalent (FTE) social worker	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Behavioral Health	Social Associations (per 10,000)	Estimated number of social Associations per 10,000 people	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.
Behavioral Health	Suicide Deaths	Rate of Deaths due to Suicide	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Behavioral Health	Youth Self-Harm Injury ED Visits (age 0-17)	Percent of youth self-harm reported in children ages 0-17	California Department of Public Health, California EpiCenter. 2013-14.
Behavioral Health	Youth Self-Harm Injury Hospitalization	Percent of hospitalizations reported from youth self-harm	California Department of Public Health, California EpiCenter. 2013-14.
Cancer	Breast Cancer Incidence	Estimate number of Breast Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Breast Cancer Screening (Mammogram)	Estimated number of breast cancer screenings (mammograms) performed	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Cancer	Cancer Incidence among Children (ages 0-19)	The amount of cancer incidents that occurred among children ages 0-19	National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).

Category	Indicator	Indicator Description	Data Source
Cancer	Colorectal Cancer Incidence	Estimate number of Colorectal Cancer incidents that were reported	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Deaths Due to All Cancers	Estimated number of deaths reported that were caused by all cancers	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Colorectal Cancer[3]	Estimated number of deaths that occurred due to colorectal cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Female Breast Cancer	Estimated number of deaths that occurred due to female breast cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Lung Cancer	Estimated number of deaths that occurred due to lung cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Deaths Due to Prostate Cancer	Estimated number of deaths that occurred due to prostate cancer	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Cancer	Lung Cancer Incidence	Estimated number of incidents reported that occurred due to lung cancer	National Cancer Institute State Cancer Profiles. 2013-17.
Cancer	Prostate Cancer Incidence	Estimated number of incidents reported that occurred due to prostate cancer	National Cancer Institute State Cancer Profiles. 2013-17.
Climate/ Natural Environment	% Change in Mean Travel Time to Work (minutes) - Silicon Valley	The change in mean travel time to work in the silicon valley by percent	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Air Pollution: PM2.5 Concentration (parts per million)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Harvard University Project (UCDA). 2018
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 0-4) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (0-4)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Hospitalizations among Children (ages 5-17) (per 10,000)	Rate of asthma hospitalizations per 10,000 children/youth, by age group (5-17)	California Breathing, tabulation of data from the California Office of Statewide Health Planning and Development. 2020.
Climate/ Natural Environment	Asthma Prevalence, Adults	Percent Adults with Asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Asthma Prevalence, All Ages	Percent of population with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Asthma Prevalence, Seniors Aged 65+	Percent of population 65 and older with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Children Ever Diagnosed with Asthma (ages 1-17)	Percentage of children ages 1-17 whose parents report that their child has ever been diagnosed with asthma	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Climate/ Natural Environment	Coastal Flooding Risk	Coastal Flooding Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Deaths Due to Chronic Lower Respiratory Disease	Rate of deaths due to Chronic Lower Respiratory Disease	UCLA Center for Health Policy Research, California Health Interview Survey. 2020.

Category	Indicator	Indicator Description	Data Source
Climate/ Natural Environment	Drought Risk	Drought Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Heat Wave Risk	Heat Wave Risk Index	FEMA Hazards Index. 2020.
Climate/ Natural Environment	Respiratory Hazard Index	Respiratory Hazard Index	EPA National Air Toxics Assessment. 2014.
Climate/ Natural Environment	River Flooding Risk	River Flooding Risk Index	FEMA Hazards Index. 2020
Climate/ Natural Environment	Road Network Density (miles of road per square mile of land)	Total road network density in terms of road miles per square mile	Environmental Protection Agency, EPA Smart Location Database. 2011.
Climate/ Natural Environment	Traffic Volume (per meter of roadway	Average traffic Volume per meter of roadway	EJSCREEN: Environmental Justice Screening and Mapping Tool
Climate/ Natural Environment	Travel Time to Work (minutes) - Silicon Valley	How much time is taken in minutes traveling to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Tree Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011.
Climate/ Natural Environment	Workers Commuting by Transit, Biking or Walking	Percentage of commuters commuting by transit, biking or walking	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Workers Driving Alone to Work	Percentage of worker who drive alone to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Climate/ Natural Environment	Workers Driving Alone with Long Commutes	Percentage of workers with long commute who drive alone to work	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Community Safety	7th Graders Bullied or Harassed at School in the Previous Year	Estimated percentage of public school students in grade 7 who were bullied or harassed at school for any reason in the previous year	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Cyberbullied 4 or More Times in the Previous Year	Estimated percentage of public school students in grade 7 who had mean rumors or lies spread about them on the internet by other students in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Who Consider Themselves Gang Members	Estimated percentage of public school students in grade 7 who consider themselves gang members	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year	Estimated percentage of public school students in grades 7 who were afraid of being beaten up at school in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	7th Graders Who Feel Very Unsafe at School	Level of perceived school safety among public school students in grade 7	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Bullied or Harassed at School in the Previous Year	Estimated percentage of public school students in grade 9 who were bullied or harassed at school for any reason in the previous year	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Cyberbullied 4 or More Times in the Previous Year	Estimated percentage of public school students in grade 9 who had mean rumors or lies spread about them on the internet by other students in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.

Category	Indicator	Indicator Description	Data Source
Community Safety	9th Graders Who Consider Themselves Gang Members	Estimated percentage of public school students in grade 7 who consider themselves gang members	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year	Estimated percentage of public school students in grades 9 who were afraid of being beaten up at school in the previous year, by number of occasions	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	9th Graders Who Feel Very Unsafe at School	Level of perceived school safety among public school students in grade 9	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019.
Community Safety	Children in Foster Care (ages 0-20) (per 1,000)	Number of children and youth under age 21 in foster care per 1,000	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Children with Substantiated Cases of Abuse or Neglect (ages 0-17) (per 1,000)	Number of substantiated cases of abuse and neglect per 1,000 children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports, UC Berkeley Center for Social Services Research. 2019.
Community Safety	Deaths Due to Homicide	Percentage of Deaths due to homicide	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Community Safety	Domestic Violence-Related Calls for Assistance among Adults (ages 18-69) (per 1,000)	Number of domestic violence calls for assistance per 1,000 population	California Dept. of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (Jul. 2019); California Dept. of Finance, Population Estimates and Projections. 2019.
Community Safety	Felony Arrests among Juveniles (ages 10-17) (per 1,000)	Number of juvenile felony arrests per 1,000 youth ages 10-17	California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. 2019.
Community	Firearm Related Deaths Rate	Number of Firearm related deaths (per	County Health Status Profiles. California Department of

Category	Indicator	Indicator Description	Data Source
Safety		100,000 Pop)	Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Community Safety	Median Length of Stay (months) in Foster Care among Children Entering Foster Care (ages 0-17)	Median length of stay in foster care, in months, for children under age 18	Webster, D., et al. California Child Welfare Indicators Project Reports. UC Berkeley Center for Social Services Research. 2019.
Community Safety	Rapes Rate - Silicon Valley	Number of Rapes in the Silicon Valley (per 1000,000 Pop)	California Department of Justice; California Department of Finance. 2018.
Community Safety	Violent Crimes Rate	Violent Crime Rate (Per 100,000 Pop.)	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2012-14.
COVID-19	14-day average test positivity rate	Percentage of COVID-19 tests reported as positive, 14-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Cumulative total cases	Cumulative count of total number of cases of COVID-19	San Mateo County: San Mateo County Health. (2022). County Data Dashboard. Data retrieved from https://www.smchealth.org/data-dashboard/county-data-dashboard Santa Clara County: Santa Clara County Public Health. (2022). COVID-19 Data and Reports. County of Santa Clara Emergency Operations Center. Data retrieved from https://covid19.sccgov.org/dashboards California: The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html

Category	Indicator	Indicator Description	Data Source
			January 2020 to March 14, 2022.
COVID-19	Cumulative total deaths	Cumulative count of total number of deaths from COVID-19	San Mateo County: San Mateo County Health. (2022). County Data Dashboard. Data retrieved from https://www.smchealth.org/data-dashboard/county-data-dashboard Santa Clara County: Santa Clara County Public Health. (2022). COVID-19 Data and Reports. County of Santa Clara Emergency Operations Center. Data retrieved from https://covid19.sccgov.org/dashboards California: The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html
COVID-19	Current rate of spread (R-eff)	Average number of people an infected person will infect. Value less than 1 means decreasing spread. Value greater than 1 means increasing spread.	CalCAT. (2022). California COVID Assessment Tool. Data retrieved from https://calcat.covid19.ca.gov/cacovidmodels/ March 14, 2022.
COVID-19	Fully vaccinated (age 5+)	Cumulative percentage of population (of county or state) age 5 or older who have received one (J&J) or two (mRNA) vaccinations and a booster shot (if last vaccination was at least six months prior)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Fully vaccinated (age 65+)	Cumulative percentage of population (of county or state) age 65 or older who have received one (J&J) or two (mRNA)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-

Category	Indicator	Indicator Description	Data Source
		vaccinations and a booster shot (if last vaccination was at least six months prior)	covid-cases.html March 14, 2022.
COVID-19	Fully vaccinated (all ages)	Cumulative percentage of population (of county or state) who have received one (J&J) or two (mRNA) vaccinations and a booster shot (if last vaccination was at least six months prior)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Rate of deaths since January 2020	Ratio of total number of people who have died from COVID-19 compared to region's population (county or state)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 14, 2022.
COVID-19	Rate of infection since January 2020	Ratio of total number of people who have been infected with COVID-19 compared to region's population (county or state)	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html January 2020 to March 14, 2022.
COVID-19	Seven-day average number of daily cases	Number of new daily cases, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Seven-day average number of daily deaths	Number of deaths daily, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Seven-day average number of people hospitalized daily	Number of people hospitalized daily, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.

Category	Indicator	Indicator Description	Data Source
COVID-19	Seven-day average rate of daily cases	Rate of new daily cases per 100,000 people, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
COVID-19	Seven-day average rate of daily deaths	Rate of daily deaths per 100,000 people, seven-day average	The New York Times. (2022). California Coronavirus Tracker. The New York Times. Data retrieved from https://www.nytimes.com/interactive/2021/us/california-covid-cases.html March 14, 2022.
Diabetes and Obesity	5th Graders Body Composition at Health Risk (worst rating)	Percent of 5th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes and Obesity	5th Graders Meeting All Fitness Standards	Percentage of public school students in grade 5 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	7th Graders Body Composition at Health Risk (worst rating)	Percent of 7th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes and Obesity	7th Graders Meeting All Fitness Standards	Percentage of public school students in grade 7 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.
Diabetes and Obesity	7th Graders Who Did Not Eat Breakfast in the Previous Day	Estimated percentage of public school students in grade 7 who did not eat breakfast in the previous day	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Diabetes and Obesity	9th Graders Body Composition at Health Risk (worst rating)	Percent of 9th graders whose body composition health is at risk	California Department of Education, FITNESSGRAM® Physical Fitness Testing. 2013-14.
Diabetes and Obesity	9th Graders Meeting All Fitness Standards	Percentage of public school students in grade 9 meeting six of six fitness standards	California Dept. of Education, Physical Fitness Testing Research Files. 2018.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	9th Graders Who Did Not Eat Breakfast in the Previous Day	Estimated percentage of public school students in grade 9 who did not eat breakfast in the previous day	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Diabetes and Obesity	Convenience Stores (per 1,000 population)	Rate of Convenience Stores per populations of 1,000	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015
Diabetes and Obesity	Deaths Due to Diabetes	Percent of deaths due to diabetes	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2014-16. 2019.
Diabetes and Obesity	Diabetes Prevalence	Percentage Adults with Diagnosed Diabetes (Age-Adjusted)	University of California Center for Health Policy Research, California Health Interview Survey. 2017.
Diabetes and Obesity	Diabetes, Share of Hospitalizations among Children (ages 0-17)	Percentage of hospital discharges among children ages 0-17 for diabetes	California Office of Statewide Health Planning and Development custom tabulation. 2019.
Diabetes and Obesity	Exercise Opportunities	Percent of the population that live in close proximity to a park or recreational facility	Esri Business Analyst. 2020.
Diabetes and Obesity	Food Environment Index	Food Environment Index	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Fruit/Vegetable Consumption among Children (age 2-11), 5 or More Servings in Previous Day	Estimated percentage of children ages 2-11 who eat five or more servings of fruits and vegetables (excluding juice and fried potatoes) daily	UCLA Center for Health Policy Research, California Health Interview Survey. 2018.
Diabetes and Obesity	Grocery Stores (per 1,000 population)	Grocery Stores rate (Per 100,000 Population)	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.

Category	Indicator	Indicator Description	Data Source
Diabetes and Obesity	Low Access to Grocery Store (percent population)	Percentage of population with low access to a grocery store	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Obesity (Adult)	Percentage of adults who were ever diagnosed with diabetes	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	National Center for Chronic Disease Prevention and Health Promotion. 2018.
Diabetes and Obesity	Supercenters & Club Stores (per 1,000 population)	Supercenters & Club Stores rate (per 1,000 population	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
Diabetes and Obesity	Walkability Index	Walkability Index	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	Percentage of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts	California Dept. of Education, Test Results for California's Assessments. 2020.
Economic Stability	11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	Percent of 11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics	California Dept. of Education, Test Results for California's Assessments. 2020.
Economic Stability	7th Graders with a Low Level of Meaningful Participation at School	Estimated percentage of public school students in grade 7 who have opportunities for meaningful participation at school, by low level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Stability	7th Graders with a Low Level of School Connectedness	Estimated percentage of public school students in grade 7 who have low levels of school connectedness	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.

Category	Indicator	Indicator Description	Data Source
Economic Stability	9th Graders with a Low Level of Meaningful Participation at School	Estimated percentage of public school students in grade 9 who have opportunities for meaningful participation at school, by low level of agreement	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Stability	9th Graders with a Low Level of School Connectedness	Estimated percentage of public school students in grade 7 who have low levels of school connectedness	WestEd, California Healthy Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education. 2019-20.
Economic Stability	Adults Without a College Degree	Percent of adults who did not receive a college degree	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Adults Without a High School Diploma	Percent of adults who did not receive a high school diploma	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center	Estimated annual cost of full-time licensed child care for infant children ages 0-2	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Stability	Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center	Estimated annual cost of full-time licensed child care for preschool children ages 3-5	California Child Care Resource and Referral Network, California Child Care Portfolio. 2020.
Economic Stability	Children Eligible for Free and Reduced-Price Lunch	Percentage of children who are eligible for free and reduced- price lunch	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Economic Stability	Children in Single-Parent Households	Percentage of Children who reside in Single-Parent households	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Children in Working Families for Whom Licensed Childcare is Available (ages 0-12)	Percentage of children ages 0-12 in working families whom are able to access licensed childcare	California Child Care Resource and Referral Network, California Child Care Portfolio (Apr. 2020); U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. public use

Category	Indicator	Indicator Description	Data Source
			Microdata. 2020.
Economic Stability	Children Living in Food Insecure Households (ages 0-17)	Percentage of children living in food insecure household under the age of 18	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.
Economic Stability	Children Living in Poverty	Percent Population Under Age 18 in Poverty	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Children Without Secure Parental Employment (ages 0-17)	Estimated percentage of children under age 18 living in families where no resident parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey	Population Reference Bureau, analysis of data from US Census Bureau, American Community Survey. 2012-16. microdata files. 2019.
Economic Stability	Economically Precarious Households by Education Level, High School Diploma or GED	Percent of Economically Precarious Households with Education Levels of High School Diploma or GED	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Education Level, Less Than High School	Percent of Economically Precarious Households with education levels Less Than High School	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Education Level, Some College or Associate's	Percent of economically precarious households with education levels of some college or associate's	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Employment Status, Full Time Full Year, 2 Adults	Percent of economically precarious households with employment status of full time, full year and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.

Category	Indicator	Indicator Description	Data Source
Economic Stability	Economically Precarious Households by Employment Status, Not in Workforce, 2 Adults	Percent of economically precarious households with employment status of not being in the workforce with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Employment Status, Part Time Part Year, 2 Adults	Percent of economically precarious households with employment status of part time, part year, and with 2 adults	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Gender (men)	Percent of economically precarious households with men	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Economically Precarious Households by Gender (women)	Percent of economically precarious households with women	The Self-Sufficiency Standard for California, Center for Women's Welfare, University of Washington. 2021.
Economic Stability	Elementary School Proficiency Index	Elementary School Proficiency index	HUD Policy Development and Research. 2016.
Economic Stability	Food Insecure	Percentage of Total Population with Food Insecurity	Gundersen, C., et al. Map the Meal Gap 2019. Feeding America. 2019.
Economic Stability	Free and Reduced-Price Lunch Enrollment	Percentage of Total Population with Reduced- Price Lunch	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Economic Stability	High School Graduates Completing College Preparatory Courses	Percentage of public school 12th grade graduates completing courses required for UC and/or CSU entrance, with a grade of C or better..	California Dept. of Education, Graduates by Race and Gender (May 2018).
Economic Stability	Income Inequality	Number of the total population with income inequality	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Economic Stability	Income Inequality - Gini Index	Gini Index Value	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Job Proximity Index (neighborhood)	Job proximity index	US Department of Housing and Urban Development Job Proximity Index. 2014.
Economic Stability	Math Scores (3rd graders)	Average 3rd grade math scores	Stanford Education Data Archive. 2018.
Economic Stability	Median Household Income	Median household income	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	On-Time High School Graduation	Percent of High Schoolers who graduated on time	Dept of Education ED Facts & state data sources. 2015-16.
Economic Stability	Poverty Rate	Rate of the population in poverty	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Preschool Enrollment	Percentage of Population age 3-4 Enrolled in preschool	US Census Bureau, American Community Survey. 2012-16.
Economic Stability	Ratio of Students to Academic Counselors (N students per counselor)	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (Academic Counselor)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest. 2019.
Economic Stability	Reading Below Proficiency (4th grade)	Percent of 4th graders reading below proficiency	California Department of Education. 2015-16.
Economic Stability	Reading Scores (3rd graders)	Percent of 3rd graders reading below proficiency	Stanford Education Data Archive. 2018.

Category	Indicator	Indicator Description	Data Source
Economic Stability	SNAP Enrollment	Percent Population Receiving SNAP Benefits	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.. 2012-16.
Economic Stability	Students Not Completing High School	Percentage of public high school students who do not complete high school, based on the four-year adjusted cohort dropout rate	California Dept. of Education, Cohort Outcome Data (Jun. 2017) & Adjusted Cohort Graduation Rate and Outcome Data. 2019.
Economic Stability	Students Truant from School (per 100 enrolled)	Number of K-12 public school students reported as being truant at least once during the school year per 100 students	California Dept. of Education, Truancy Data. 2017.
Economic Stability	Unemployment Rate	Rate of population who are unemployed	US Department of Labor, Bureau of Labor Statistics. 2018.
Economic Stability	Young People Not in School and Not Working	Percentage of young people ages 18-24 who are not in school and not working	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.	Percent of Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.	University of California, Berkeley, Center for Social Sciences Research California Child Welfare Indicators Project, 2018
Health Care Access and Delivery	Children Living in Limited English-Speaking Households (ages 0-17)	Estimated percentage of children ages 0-17 living in households in which (i) no person age 14 or older speaks English only, and (ii) no person age 14 or older who speaks a language other than English speaks English very well	Population Reference Bureau, analysis of U.S. Census Bureau US Census Bureau, American Community Survey. 2012-16. public use microdata. 2019.
Health Care Access and Delivery	Children with Health Insurance Coverage (ages 0-18)	Estimated percentage of children ages 0-18 with and without health insurance coverage at the time of survey, by type of insurance and age group	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. Summary Files and Public Use Microdata. 2018.

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Deaths Due to Cerebrovascular Disease (Stroke)	Rate of deaths due to Cerebrovascular Disease (Stroke)	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Health Care Access and Delivery	Deaths Due to Coronary Heart Disease	Rate of deaths due to Coronary Heart Disease	County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.
Health Care Access and Delivery	Dentists Rate	Dentists per population of 100,000	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Health Care Access and Delivery	ED Visits for Non-Traumatic Dental Conditions	Rate of ED Visits for Non-Traumatic Dental Conditions	California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates and Projections. 2020.
Health Care Access and Delivery	Flu vaccinations (Medicare enrollees)	Percent of Medicare enrollees who received the flu shot	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.
Health Care Access and Delivery	Heart Disease Deaths	Rate of deaths due to Heart Disease	CDC, Interactive Atlas of Heart Disease and Stroke. 2016-18.
Health Care Access and Delivery	High Speed Internet	Percent of population with high speed internet	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Kindergarteners with All Required Immunizations	Percent of Kindergarteners with All Required Immunizations	California Dept. of Public Health, Immunization Branch, Kindergarten Data and Reports. 2019.
Health Care Access and Delivery	Limited English Proficiency	Percent of population with limited English Proficiency	US Census Bureau, American Community Survey. 2012-16.

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Medicaid/Public Insurance Enrollment	Percent of population enrolled in Medicaid/ Public insurance	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Never Had Dental Exam (ages 2-11)	Percent of Children Ages 2-11 who had never received a dental exam	University of California Center for Health Policy Research, California Health Interview Survey. 2016.
Health Care Access and Delivery	Other Primary Care Providers (not PCPs) (N people per provider)	Ratio of people per provider for other primary care providers (not PCPs)	Chronic Conditions prevalence State/County Level: All Beneficiaries by Age, 2007-2018
Health Care Access and Delivery	Percent Uninsured	Percent Uninsured Population	US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Population Over Age 75 with a Disability	Percent population over the age of 75 with a disability	US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Population with Any Disability	Percent population with any disability	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Health Care Access and Delivery	Premature Death (years of potential life lost before age 75)	Years of Potential Life Lost, Rate per 100,000 Population	National Center for Education Statistics, NCES - Common Core of Data. 2015-16.
Health Care Access and Delivery	Premature Mortality Rate (under age 75, age-adjusted)	Mortality Rate for population under 75 years old	National Center for Education Statistics, NCES - Mortality Files. 2015-16.
Health Care Access and Delivery	Preventable Hospital Stays (Medicare enrollees)	Age-Adjusted Discharge Rate (Per 10,000 Pop.)	U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.

Category	Indicator	Indicator Description	Data Source
Health Care Access and Delivery	Primary Care Physicians Rate	Rate of Primary Care Physicians per 100,000 population	Health Resources and Service Administration Area Resource File. 2016-18.
Health Care Access and Delivery	Ratio of Students to School Nurses	Number of public school students per full-time equivalent (FTE) pupil support service personnel, by type of personnel (School Nurse)	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Health Care Access and Delivery	Ratio of Students to School Speech/Language/Hearing Specialists	Ratio of Students to School Speech/Language/Hearing Specialists	California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).
Health Care Access and Delivery	Uninsured Children		US Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Children Living in Crowded Households (ages 0-17)	Estimated percentage of children under age 18 living in households with more than one person per room of the house	Population Reference Bureau, analysis of U.S. Census Bureau US Census Bureau, American Community Survey. 2012-16. public use Microdata. 2019.
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 0-5)	Percentage of children/youth ages 0-5 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.
Housing and Homelessness	Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels between 4.5-9.49 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 0-5)	Percentage of children/youth ages 0-5 with blood lead levels of at least 9.5 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2019.
Housing and Homelessness	Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 6-20)	Percentage of children/youth ages 6-20 with blood lead levels of at least 9.5 micrograms per deciliter, among those screened	California Dept. of Public Health, California's Progress in Preventing and Managing Childhood Lead Exposure & Childhood Lead Poisoning Prevention Branch Blood Lead Data. 2020.
Housing and Homelessness	Homeownership Rate	Percent of population that are homeowners	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Housing Affordability Index	Housing Affordability Index	Esri Business Analyst. 2020.
Housing and Homelessness	Median Rental Cost	Median rental cost in dollars per month	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Moderate Housing Cost Burden	Percent of moderate housing cost burden	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Neighborhood Deprivation Index	Neighborhood Deprivation Index	UCDA calculation with U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16. data
Housing and Homelessness	Overcrowded Housing	Percent of population living in houses with more than one person per room of the house	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Percent of Income for Mortgage	Percent of income spent on home mortgage	Esri Business Analyst. 2020.

Category	Indicator	Indicator Description	Data Source
Housing and Homelessness	Population Density (people per square mile)	Population Density measured in people per square mile	US Department of Labor, Bureau of Labor Statistics. 2018.
Housing and Homelessness	Residential Segregation - Black/White	Residential Segregation Index amongst Black and White population	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Residential Segregation - Non-White/White	Residential Segregation Index amongst Non-White and White population	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Severe Housing Cost Burden	Percent of population with a severe housing cost burden	U.S. Census Bureau, US Census Bureau, American Community Survey. 2012-16.
Housing and Homelessness	Severe Housing Problems (one or more of: overcrowding, high costs, lack of kitchen, lack of plumbing)	Percent of population with one or more of the following severe housing problems; overcrowding, high costs, lack of kitchen or lack of plumbing	Comprehensive Housing Affordability Strategy (CHAS) data. 2013-17. .
Housing and Homelessness	Students Recorded as Homeless at Some Point during the School Year	Percentage of public school students recorded as being homeless at any point during a school year	California Dept. of Education, Coordinated School Health and Safety Office custom tabulation & California Basic Educational Data System. 2019.
Maternal and Infant Health	Babies Born at a Very Low Birthweight	Percentage of infants born at very low birthweight (less than 1,500 grams or about 3 lbs., 5 oz)	California Dept. of Public Health, Birth Statistical Master Files; CDC WONDER, Natality Public-Use Data. 2019.
Maternal and Infant Health	Babies Born to Mothers Who Received Prenatal Care in the First Trimester	Percent of Babies Born to Mothers Who Received Prenatal Care in the First Trimester	California Dept. of Public Health, Birth Statistical Master Files. 2020.
Maternal and Infant Health	Babies Breastfed Exclusively in Hospital	Percent of babies breastfed exclusively in the hospital	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.

Category	Indicator	Indicator Description	Data Source
Maternal and Infant Health	Babies Breastfed in Hospital (at Any Time)	Percent of babies breastfed in the hospital at any time	California Dept. of Public Health, In-Hospital Breastfeeding Initiation Data. 2019.
Maternal and Infant Health	Infant Deaths (per 1,000 live births)	Rate of infant deaths per 1,000 live births	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Maternal and Infant Health	Population Under Age 18	Percent of the population is younger than 18 years old	US Census Bureau, American Community Survey. 2012-16.
Maternal and Infant Health	Preterm Births	Percent of births taken place before mother was at full term	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Maternal and Infant Health	Teen Births (per 1,000 females ages 15-19)	Number of births per 1,000 young women ages 15-19	California Dept. of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections, 2000-2009, 2010-2060; CDC WONDER, Natality Public-Use Data. 2019.
Sexually Transmitted Infections	Chlamydia Incidence	Chlamydia rates per 100,000 people, 2007-2016, Santa Clara County	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	Chlamydia Incidence among Youth (ages 10-19)	Number of chlamydia infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018)
Sexually Transmitted Infections	Early Syphilis	Early syphilis rates (per 100,000 people	CalREDIE & CDPH-STD

Category	Indicator	Indicator Description	Data Source
Sexually Transmitted Infections	Gonorrhea Incidence among Youth (ages 10-19)	Number of gonorrhea infections per 100,000 youth ages 10-19	California Dept. of Public Health, Sexually Transmitted Diseases Control Branch custom tabulation (Jan. 2020); Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance (Oct. 2019); U.S. Census Bureau, National Population by Characteristics: 2010-2019 (Jun. 2019) & National Intercensal Tables: 2000-2010 (Sept. 2018).
Sexually Transmitted Infections	HIV Prevalence (not including AIDS), Age 13 and Over	Rate of HIV infections (not including AIDS) per 100,000 people age 13 and over	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	HIV/AIDS Deaths	Rate of deaths caused by HIV/AIDS	US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. 2016.
Sexually Transmitted Infections	HIV/AIDS Prevalence	HIV/AIDS rates (Per 100,000 Pop.)	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.
Sexually Transmitted Infections	Syphilis	Syphilis rates (per 100,000 people)	California Department of Public Health, Sexually Transmitted Diseases Control Branch, All STDs Tables, California, 2018

ATTACHMENT 2: SECONDARY DATA TABLES

LEGEND

Statistical data tables compare county data to California state benchmarks. Tables are provided in alphabetical order.

Definitions

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

Conventions

- Core indicators are separated from drivers by a heavy border.
- Certain indicators are available by ethnicity, which shows disparities in certain populations. Those tables follow each of the overall health need tables if available. In ethnicity data tables:
    - Data that are worse than benchmarks are in yellow-shaded cells.
    - Data that are at least 5% (not five percentage points, but five percent) worse than benchmarks are in orange-shaded cells.
- Rates are per 100,000 unless otherwise noted.
- Data are rounded to the tenths if available.
- In main data tables:
    - Data that are worse than benchmarks are **emboldened**.
    - Data that are at least 5% (not five percentage points, but five percent) worse than benchmarks are marked with a diamond (♦).
    - Data where trends are available denoted with the dagger (†) symbol.
- Benchmark values represent the California state average.
- Indicator details, including the definition and original source, may be found in the "Secondary Data Indicators" list provided separately.
- We use the shorthand "Latinx" for the term "Hispanic / Latino / Latina (Any Race)," "Native Am" for the term "Native American," and "Pac Isl" for the term "Pacific Islander." Native American also encompasses Alaskan Native. Pacific Islander also encompasses Hawaiian Native.

DATA TABLES

BEHAVIORAL HEALTH

Table 1, Behavioral Health: Mental and Emotional Well-Being

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
7th Graders Who Had Depression-Related Feelings in the Previous Year[2]	23.3%	--	30.4%	↓
9th Graders Who Had Depression-Related Feelings in the Previous Year[2]	30.2%	--	32.6%	↓
9th Graders Who Seriously Considered Attempting Suicide in the Previous Year[2]	**16.3%**	--	15.8%	↓
11th Graders Who Had Depression-Related Feelings in the Previous Year[2]	35.1%	--	36.6%	↓
11th Graders Who Seriously Considered Attempting Suicide in the Previous Year[2]	**17.6%♦**	--	16.4%	↓
Adults with 1-3 Adverse Childhood Experiences[2]	44.0%	41.0%	46.0%	↓
Adults with 4 or More Adverse Childhood Experiences[2]	13.0%	11.0%	16.0%	↓
Children Ages 0-17 with 2 or More Adverse Experiences (Parent Reported)[2]	11.9%	12.4%	14.9%	↓
Deaths of Despair[1]	9.8	9.4	14.1	↓
Frequent Mental Distress, Adults (14+ days per month)[4]	10.0%	10.0%	12.0%	↓
Mental Health Hospitalizations among Children (ages 5-14) (per 1,000)[2]	**3.4♦**	2.2	2.8	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Mental Health Hospitalizations among Youth (ages 15-19) (per 1,000)[2]	**11.6♦**	8.5	9.8	↓
Mental Health Providers[1]	**375.7♦**	348.0	352.3	↑
Poor Mental Health (days per month)[1]	3.1	2.9	3.7	↓
Ratio of Students to School Psychologists[2]	994	**1,199♦**	1,041	↓
Suicide Deaths[1]	7.6	7.6	10.5	↓
Youth Self-Harm Injury ED Visits (age 0-17)[5]	66.8	73.1	100.0	↓
Youth Self-Harm Injury Hospitalization[5]	**50.1♦**	**32.7♦**	22.4	↓
7th Graders with a Low Level of Caring Relationships with Adults at School[2]	8.7%	--	11.3%	↓
9th Graders with a Low Level of Caring Relationships with Adults at School[2]	12.2%	--	16.2%	↓
Insufficient Sleep[4]	30.0%	32.0%	35.0%	↓
Population 65 & Older Living Alone[1]	**2.2%♦**	2.0%	2.0%	↓
Ratio of Students to School Social Workers (N students per social worker)[2]	--	**9,544♦**	7,308	↓
Social Associations (per 10,000)[4]	**5.8**	5.9	5.9	↑

Table 2, Behavioral Health: Tobacco/Substance Use

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
7th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes[2]	1.0%	--	1.2%	↓
7th Graders Who Used Alcohol or Drugs in the Previous Month[2]	6.5%	--	7.2%	↓
7th Graders Who Used Marijuana 20-30 Days in the Previous Month[2]	0.2%	--	0.3%	↓
9th Graders Who Have Consumed Alcohol 7 or More Times in Their Lifetimes[2]	2.6%	--	8.1%	↓
9th Graders Who Used Alcohol or Drugs in the Previous Month[2]	11.1%	--	19.7%	↓
9th Graders Who Used Marijuana 20-30 Days in the Previous Month[2]	0.5%	--	1.8%	↓
Current Smokers[1]	8.6%	8.3%	11.1%	↓
Deaths Due to Chronic Liver Disease and Cirrhosis[3]	7.0	6.8	12.1	↓
Drug Induced Deaths[3] †	10.3	9.0	14.3	↓
Drug Overdose Deaths[4] †	11.0	9.0	14.0	↓
Excessive Drinking[1]	18.8%	16.7%	19.5%	↓
Opioid Overdose Deaths[1]	4.7	3.4	5.7	↓
Impaired Driving Deaths[1]	21.1%	28.2%	28.6%	↓

Behavioral Health Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Drug-induced deaths rising in San Mateo County, falling in Santa Clara County.[3]
- Drug overdose deaths rising in both counties.[4]
- Deaths due to suicide rising in San Mateo County.[3]

- Deaths due to chronic liver disease and cirrhosis falling in both counties.[4]

Behavioral Health Race & Ethnicity Indicators

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

Table 3, Behavioral Health, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Alcohol or Drug Use, 7th/9th/11th Gr.	28.9%*	6.0%	4.9%	11.0%	6.8%	3.7%	10.8%	3.7%	11.7%
Alcohol Use (Lifetime), 7th/9th/ 11th Gr.	20%	0.8%	0.2%	3.0%	3.6%	0.0%	5.4%	3.5%	0.9%
Depression-Related Feelings, 7th/9th/ 11th Graders	36.6%	25.4%	26.7%	29.8%	28.7%	25.6%	23.0%	43.6%	23.6%
Drug Overdose Deaths	14.0	24.0	3.0	9.0	--	--	--	--	17.0
Low Level of Caring Relationships with Adults at School, 7th/9th/11th Gr.	13.8%*	5.9%	10.1%	10.0%	11.4%	5.4%	15.0%	28.9%	7.6%
Marijuana Use, 7th/9th/11th Gr.	3.5%*	0.8%	0%	0.4%	2.5%	0.0%	0.0%	0.1%	0.1%
Suicidal Ideation, 9th, 11th Graders	16.4%*	17.4%	16.9%	16.3%	22.4%	9.1%	14.0%	30.2%	14.9%
Suicide Deaths	10.5	9.0	5.0	5	--	--	--	--	11.0
Youth Self-Harm ED Visits	100.0	--	--	70.4	--	--	--	--	105.5
Youth Self-Harm Hospitalization	22.4	--	--	51.9	--	--	--	--	69.1

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

Table 4, Behavioral Health, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Depression-Related Feelings, 7th/9th/ 11th Graders	36.6%*	48.2%	20.5%	11.5%	4.3%	2.1%	0.3%	63.8%	23.1%
Drug Overdose Deaths	14.0	25.0	3.0	10.0	--	--	--	--	15.0

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Suicidal Ideation, 9th, 11th Graders	16.4%*	16.9%	38.5%	13.8%	5.1%	0.0%	0.2%	29.1%	5.7%
Suicide Deaths	10.5	6.0	4.0	5.0	--	--	--		13.0
Youth Self-Harm ED Visits	100.0	--	30.2**	78.0	--	--	--	--	128.9
Youth Self-Harm Hospitalization	22.4	--	16.2**	31.9	--	0.0	--	--	66.3

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

** Datapoint is for Asian/Pacific Islanders combined.

CANCER

Table 5, Cancer

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Breast Cancer Incidence[1]	**138.1♦**	**121.2**	120.9	↓
Cancer Incidence Among Children (ages 0-19)[2]	**18.6**	**19.0**	18.2	↓
Colorectal Cancer Incidence[1]	32.1	32.7	35.2	↓
Deaths Due to All Cancers[3 †]	105.4	107.6	131.4	↓
Deaths Due to Colorectal Cancer[3 †]	8.2	9.6	12.1	↓
Deaths Due to Female Breast Cancer[3 †]	14.2	15.5	18.7	↓
Deaths Due to Lung Cancer[3 †]	18.7	18.9	24.5	↓
Deaths Due to Prostate Cancer[3 †]	14.6	13.4	18.5	↓
Lung Cancer Incidence[1]	39.2	38.5	41.3	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Prostate Cancer Incidence[1]	**94.1**	86.2	92.8	↓
Breast Cancer Screening (Mammogram, females, ages 65-74)[4]	43%	39%	36%	↑

Cancer Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Cancer mortality is generally trending down except for prostate cancer, which is rising in San Mateo County.[3]

Cancer Race & Ethnicity Indicators

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

Table 6, Cancer, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Breast Cancer Screening (Mammo-gram, females, ages 65-74)	36%	33%	39%	35%	--	--	--	--	46%
Cancer Incidence Among Children (ages 0-19)	18.2	--	18.9*	18.1	--	--	--	--	18.3

* Datapoint is for Asian/Pacific Islanders combined.

Table 7, Cancer, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Breast Cancer Screening (Mammo-gram, females, ages 65-74)	36%	33%	35%	29%	--	33%	--	--	44%

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Cancer Incidence Among Children (ages 0-19)	18.2	--	20.2*	15.7	--	--	--	--	21.2

* Datapoint is for Asian/Pacific Islanders combined.

Cancer Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- In San Mateo County, 6.2% of the population had cancer in 2016-2016.[6]
- In Santa Clara County, 22.8% of all deaths in 2019 were due to cancer.[3]

CLIMATE/NATURAL ENVIRONMENT

Table 8, Climate/Natural Environment

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Air Pollution: PM2.5 Concentration (parts per million)[1]	11.6	11.7	11.8	↓
Coastal Flooding Risk[1]	**5.8♦**	**2.6♦**	0.7	↓
Drought Risk[1]	0.7	**0.8♦**	0.7	↓
Heat Wave Risk[1]	**12.9♦**	**10.6♦**	4.7	↓
Respiratory Hazard Index[1]	0.3	0.5	0.5	↓
River Flooding Risk[1]	**4.1♦**	**4.1♦**	2.1	↓
Road Network Density (miles of road per square mile of land)[1]	**20.8♦**	**21.5♦**	18.0	↓
Tree Canopy Cover[1]	**7.5%♦**	3.6%	4.0%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
% Change in Mean Travel Time to Work (minutes) - Silicon Valley[7]	**+25%♦**		+14%	↓
Asthma Hospitalizations among Children (ages 0-4) (per 10,000)[2]	8.2	9.3	14.9	↓
Asthma Hospitalizations among Children (ages 5-17) (per 10,000)[2]	3.4	2.8	6.0	↓
Asthma Prevalence, Adults[3 †]	8.1%	8.6%	9.1%	↓
Asthma Prevalence, All Ages[3 †]	**9.5%♦**	**9.5%♦**	8.8%	↓
Asthma Prevalence, Seniors Aged 65+[3 †]	--	9.0%	9.4%	↓
Children Ever Diagnosed with Asthma (ages 1-17)[2]	**17.2%♦**	14.5%	14.3%	↓
Deaths Due to Chronic Lower Respiratory Disease[3 †]	15.7	16.0	29.7	↓
Traffic Volume (per meter of roadway)[4]	**2,194♦**	**2,289♦**	1,991	↓
Travel Time to Work (minutes) - Silicon Valley[7]	29.6		30.2	↓
Workers Commuting by Transit, Biking or Walking[1]	14.8%	8.2%	8.1%	↑
Workers Driving Alone to Work[1]	67.9%	**74.8%**	74.0%	↓
Workers Driving Alone with Long Commutes[1]	7.1%	8.5%	11.0%	↓

Climate Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- The annual number of unhealthy air days has been rising in Silicon Valley.[7]
- The annual number of public transportation rides per capita in Silicon Valley has been decreasing.[7]

- Asthma prevalence is rising for people of all ages, including adults and seniors, in Santa Clara County.[3]
- In San Mateo County, asthma prevalence is rising for older adults (aged 65+) but falling overall (for people of all ages).[3]
- The rates of deaths due to chronic lower respiratory disease are falling in both counties.[3]

Climate Race & Ethnicity Indicators

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

Table 9, Climate, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Workers Driving Alone to Work	76.4%	66.0%	68.0%	69.0%	--	65.0%	--	--	72.0%

Table 10, Climate, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Workers Driving Alone to Work	76.4%	72.0%	75.0%	73.0%	--	72.0%	--	--	74.0%

Climate Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- Silicon Valley had 14 unhealthy air days annually as of 2020.[7 †]
- Silicon Valley community members drove approximately 22 miles per day prior to 2020.[7]
- Among all deaths in both counties, 3.1% in San Mateo County and 3.2% in Santa Clara County are due to chronic lower respiratory disease.[3]

COMMUNITY SAFETY

Table 11, Community Safety

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Children Ages 0-17 with Substantiated Cases of Abuse or Neglect (per 1,000)[2]	1.5	4.6	7.5	↓
Deaths Due to Homicide[3 †]	1.7	2.2	4.8	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Domestic Violence-Related Calls for Assistance among Adults (ages 18-69) (per 1,000)[2]	4.1	4.4	6.3	↓
Firearm Related Deaths Rate[3] †	3.9	3.7	7.5	↓
Rapes Rate - Silicon Valley[7] †	**40.0**		39.0	↓
Violent Crimes Rate[1]	209.1	264.1	418.1	↓
7th Graders Bullied or Harassed at School in the Previous Year[2]	**37.6%♦**	--	33.6%	↓
7th Graders Cyberbullied 4 or More Times in the Previous Year[2]	**5.0%♦**	--	4.4%	↓
7th Graders Who Consider Themselves Gang Members[2]	4.3%	--	4.8%	↓
7th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year[2]	3.8%	--	4.4%	↓
7th Graders Who Feel Very Unsafe at School[2]	1.5%	--	2.7%	↓
9th Graders Bullied or Harassed at School in the Previous Year[2]	**32.6%♦**	--	31.0%	↓
9th Graders Cyberbullied 4 or More Times in the Previous Year[2]	1.3%	--	4.9%	↓
9th Graders Who Consider Themselves Gang Members[2]	2.2%	--	4.8%	↓
9th Graders Who Feared Being Beaten Up at School on 4 or More Occasions in the Previous Year[2]	**4.6%♦**	--	2.8%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
9th Graders Who Feel Very Unsafe at School[2]	2.1%	--	3.0%	↓
Children Ages 0-20 in Foster Care (per 1,000)[2]	1.3	2.1	5.3	↓
Felony Arrests among Juveniles (ages 10-17) (per 1,000)[2]	4.1	**5.8♦**	4.1	↓
Median Length of Stay (months) in Foster Care among Children Entering Foster Care (ages 0-17)[2]	8.5	13.7	17.4	↓

Community Safety Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- City of San José:[8]
  - Number of assaults committed with firearms increasing
  - Number of rapes increasing
  - Number of robberies increasing
  - Number of robberies committed with firearms falling
  - Number of violent crimes increasing
- Firearm related deaths in Santa Clara County are falling.[3]
- Deaths due to homicide in Santa Clara County are falling.[3]
- Rate of rapes in Silicon Valley increasing.[7]

Community Safety Race & Ethnicity Indicators

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

Table 12, Community Safety, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Bullied or Harassed at School, 7th/9th/11th Gr.	33.6%*	63.2%	34.9%	34.8%	30.0%	59.0%	38.9%	42.3%	33.6%
Children in Foster Care (ages 0-20) (per 1,000)	5.3	12.7	0.8**	1.8	--	S	--	--	0.7

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Cyberbullied 4 or More Times, 7th/9th/11th Gr.	4.9%*	4.6%	1.6%	4.70%	2.0%	6.9%	4.2%	2.2%	3.7%
Deaths Due to Homicide	5.0	13.0	1.0	3.0	--	--	--	--	1.0
Feared Being Beaten Up at School, 7th/9th/11th Graders	4.4%*	0.5%	3.6%	3.2%	2.1%	0.9%	3.9%	30.4%	2.2%
Feel Very Unsafe at School, 7th/9th/11th Gr.	3.0%*	3.7%	1.9%	2.3%	0.3%	0.0%	1.9%	0.9%	1.4%
Felony Arrests among Juveniles (ages 10-17)	4.1	39.8	--	5.9	--	--	2.6	--	1.4
Firearm Fatalities	8.0	13.0	2.0	4.0	--	--	--	--	6.0
Gang Members, 7th/9th/11th Gr.	4.8%	2.4%	2.5%	5.8%	1.9%	4.6%	2.2%	0.9%	2.4%
Substantiated Cases of Child Abuse or Neglect (ages 0-17) (per 1,000)	7.5	8.8	0.7**	1.9	--	S	--	--	1.1

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

** Datapoint is for Asian/Pacific Islanders combined.

Table 13, Community Safety, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Children in Foster Care (ages 0-20) (per 1,000)	5.3	8.8	0.4*	4.2	--	--	--	--	1.2
Felony Arrests among Juveniles (ages 10-17)	4.1	23.0	--	9.3	--	--	--	--	2.3
Firearm Fatalities	8.0	8.0	2.0	4.0	--	--	--	--	7.0
Homicide Rate	5.0	9.0	1.0	4.0	--	--	--	--	2.0
Substantiated Cases of Child Abuse or Neglect (ages 0-17) (per 1,000)	7.5	13.9	1.7*	8.3	--	--	--	--	2.9

* Datapoint is for Asian/Pacific Islanders combined.

Community Safety Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- City of San José, 2019:[8†]
    - 647 rapes
    - 485 assaults committed with firearms
    - 1,339 robberies
    - 272 robberies committed with firearms
    - 4,561 violent crimes
- There were a total of 46 homicides in Santa Clara County in 2019.[3]

COVID-19

Table 14, COVID-19

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Cumulative total cases since January 2020[13, 16, 17]	119,845	306,473	9,044,007	↓
Seven-day average number of daily cases[16]	95	184	3,306	↓
Seven-day average rate of daily cases[16]	**12♦**	10	11	↓
Seven-day average number of people hospitalized daily[16]	118	193	2,263	↓
Rate of infection since January 2020[16]	1 in 6	1 in 6	1 in 4	↓
Current rate of spread (R-eff)[3]	**0.84**	**0.82**	0.81	↓
14-day average test positivity rate[16]	**2%♦**	**2%♦**	**1.5%**	↓
Rate of deaths since January 2020[16]	1 in 1,042	1 in 866	1 in 451	↓
Cumulative total deaths since January 2020[13, 16, 17]	736	2,158	87,665	↓
Seven-day average number of daily deaths[16]	2	3	11	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Seven-day average rate of daily deaths[16]	0.22	0.18	0.34	↓
Fully vaccinated (all ages)[16]	83%	86%	71%	↑
Fully vaccinated (age 5+)[16]	88%	91%	75%	↑
Fully vaccinated (age 65+)[16]	93%	95%	89%	↑

COVID-19 Race & Ethnicity Indicators

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

Table 15, COVID-19, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Cumulative number of cases by race/ ethnicity[17]	N/A	2,183	19,722	39,597	1,310	205	6,009	2,616	24,934
Cumulative number of deaths by race/ ethnicity[17]	N/A	35	201	178	6 (ethnicity unknown)	3	0	24	289
Fully vaccinated, age 5+ [17]	75%	63%	103%	71%	85%	97%	--	61%	79%

Table 16, COVID-19, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Percent of cases by race/ethnicity[13]	N/A	2%	38%	27%	15% (ethnicity unknown)	--	13%	1%	15%
Cumulative percent of deaths by race/ ethnicity[13]	N/A	3%	21%	31%	7% (ethnicity unknown)	--	8%	0.4%	30%

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Fully vaccinated, all ages[13]	71%	69%	93%	74%	68%	77%	95%	95%	73%

COVID-19 Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- San Mateo County:[17]
    - The areas with the highest rates of COVID cases per 10,000 population, since January 2020, were Pescadero, Colma, North Fair Oaks, and East Palo Alto.
    - 692,231 individuals were vaccinated as of March 14, 2022.
    - 641,398 individuals completed vaccine series as of March 14, 2022.

- Santa Clara County:[13]
    - Nearly seven in ten (68.9%) booster-eligible residents age 12+ had received a booster dose as of March 10, 2022.
    - The seven-day average case rate for residents age 5+ who were unvaccinated was 54.1 per 100,000, while the case rate for those who were fully vaccinated was 10.0 per 100,000 as of March 11, 2022.
    - Individuals with at least one co-morbidity made up nearly two thirds (64%) of all COVID-19 deaths in the county as of March 11, 2022.
    - 1,637,472 individuals were vaccinated as of March 10, 2022.
    - 1,016,207 individuals ages 12+ had received a booster dose as of March 10, 2022.

DIABETES & OBESITY

Table 17, Diabetes & Obesity

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
5th Graders Body Composition at Health Risk (worst rating)[10 †]	17.0%	16.8%	22.0%	↓
7th Graders Body Composition at Health Risk (worst rating)[10 †]	15.0%	15.0%	21.0%	↓
9th Graders Body Composition at Health Risk (worst rating)[10 †]	13.0%	13.1%	19.0%	↓
Deaths Due to Diabetes[3 †]	9.7	20.9	21.3	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Diabetes, Share of Hospitalizations among Children Ages 0-17[2]	0.8%	1.3%	1.4%	↓
Diabetes Prevalence[1]	21.5%	26.6%	28.2%	↓
Obesity (Adult)[1]	21.4%	19.6%	24.8%	↓
5th Graders Meeting All Fitness Standards[2]	31.6%	27.2%	24.3%	↑
7th Graders Meeting All Fitness Standards[2]	37.0%	32.3%	30.1%	↑
7th Graders Who Did Not Eat Breakfast in the Previous Day[2]	23.3%	--	28.5%	↓
9th Graders Meeting All Fitness Standards[2]	35.4%	38.7%	34.4%	↑
9th Graders Who Did Not Eat Breakfast in the Previous Day[2]	15.0%	--	37.1%	↓
Convenience Stores (per 1,000 population)[1]	0.2	0.2	0.2	↓
Exercise Opportunities[1]	99.7%	99.1%	93.1%	↑
Food Environment Index[4]	9.4	9.3	8.8	↑
Fruit/Vegetable Consumption (age 2-11) - 5 or More Servings in the Previous Day[2]	**24.3%♦**	**30.8%♦**	35.4%	↑
Grocery Stores (per 1,000 population)[1]	0.2	0.2	0.2	↑
Low Access to Grocery Store (percent population)[1]	9.7%	7.5%	11.6%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Physical Inactivity (Adult)[1]	14.6%	15.1%	17.8%	↓
Supercenters & Club Stores (per 1,000 population)[1]	**0.0♦**	**22.2♦**	48.1	↑
Walkability Index[1]	**10.2♦**	**9.9♦**	11.2	↑

Diabetes & Obesity Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- In both counties, having body composition that is a health risk is rising among 5th and 7th grade students, but falling among 9th grade students.[10]
- Deaths due to diabetes are falling in both counties.[3]

Diabetes & Obesity Race & Ethnicity Indicators

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

Table 18, Diabetes & Obesity, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
5th Gr. Body Com-position Health Risk	21.9%	24.4%	6.9%	28.1%	9.7%	27.0%	Filipino 19.6%	45.2%	8.4%
5th Gr. Meeting All Fitness Standards	24.3%	32.6%	41.1%	18.2%	42.0%	23.1%	Filipino 30%	--	40.6%
7th Gr. Body Com-position Health Risk	20.6%	22.6%	5.8%	25.7%	8.3%	30.5%	Filipino 10.6%	37.9%	8.0%
7th Gr. Meeting All Fitness Standards	30.1%	19.6%	50.5%	23.1%	42.6%	--	Filipino 41.3%	19.7%	47.7%
9th Gr. Body Com-position Health Risk	18.9%	28.5%	3.6%	20.5%	9.4%	6.7%	Filipino 16.6%	30.7%	6.6%
9th Gr. Meeting All Fitness Standards	34.4%	--	51.0%	24.0%	41.7%	--	Filipino 35.6%	24.2%	46%
Did Not Eat Breakfast in the Previous Day, 7th/9th/11th Gr.	39.7%*	36.3%	15%	25.7%	22.5%	22.6%	17.2%	11.0%	18%

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

Table 19, Diabetes & Obesity, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
5th Gr. Body Com-position Health Risk	21.9%	19.5%	7.1%	28.8%	17.0%	23.5%	Filipino 18.8%	24.7%	9.1%
5th Gr. Meeting All Fitness Standards	24.3%	19.8%	33.0%	14.4%	29.7%	20.0%	Filipino 23.1%	19.0%	31.6%
7th Gr. Body Com-position Health Risk	20.6%	19.8%	5.4%	26.2%	10.7%	15.0%	Filipino 15.4%	32.4%	8.8%
7th Gr. Meeting All Fitness Standards	30.1%	26.2%	40.5%	18.9%	34.1%	32.3%	Filipino 33.1%	25.0%	36.9%
9th Gr. Body Com-position Health Risk	18.9%	18.3%	5.5%	22.9%	6.6%	13.1%	Filipino 13.2%	28.1%	8.3%
9th Gr. Meeting All Fitness Standards	34.4%	28.6%	50.7%	24.8%	50.0%	--	Filipino 40.6%	25.0%	45.2%

Diabetes & Obesity Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- Among all deaths in both counties, 2.1% in San Mateo County and 4.8% in Santa Clara County are due to diabetes.[3]

ECONOMIC SECURITY

Table 20, Economic Security: Cost of Living, Income & Employment

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Children Living in Food Insecure Households (ages 0-17)[2]	12.9%	13.6%	18.1%	↓
Children Living in Poverty[1]	7.4%	7.6%	16.5%	↓
Children Without Secure Parental Employment (ages 0-17)[2]	17.9%	19.1%	28.2%	↓
Economically Precarious Households by Education Level, High School Diploma or GED[9]	**64%♦**	**58%♦**	50%	↓
Economically Precarious Households by Education Level, Less Than High School[9]	**89%♦**	**72%**	69%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Economically Precarious Households by Education Level, Some College or Associate's[9]	**48%♦**	**42%♦**	39%	↓
Economically Precarious Households by Employment Status, Full Time Full Year, 2 Adults[9]	23%	19%	26%	↓
Economically Precarious Households by Employment Status, Not in Workforce, 2 Adults[9]	51%	51%	58%	↓
Economically Precarious Households by Employment Status, Part Time Part Year, 2 Adults[9]	37%	35%	44%	↓
Economically Precarious Households by Gender (men)[9]	30%	24%	31%	↓
Economically Precarious Households by Gender (women)[9]	36%	34%	40%	↓
Food Insecure[1]	6.8%	7.2%	10.6%	↓
Free and Reduced-Price Lunch Enrollment[1]	25.9%	26.2%	44.2%	↓
Income Inequality[4]	5.0	5.0	5.2	↓
Income Inequality - Gini Index[1]	0.4	0.4	0.4	↓
Median Household Income[1]	$130,820	$129,210	$82,053	↑
Poverty Rate[1]	6.5%	7.5%	12.9%	↓
SNAP Enrollment[1]	3.7%	4.9%	9.7%	↓
Unemployment Rate[1]	13.7%	13.6%	15.8%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Adults Without a High School Diploma[1]	10.8%	11.9%	17.6%	↓
Adults Without a College Degree[1]	16.7%	15.1%	21.1%	↓
Annual Cost of Childcare for Infants Ages 0-2 in a Childcare Center[2]	**$21,847♦**	**$20,746♦**	$17,384	↓
Annual Cost of Childcare for Preschoolers Ages 3-5 in a Childcare Center[2]	**$16,305♦**	**$15,315♦**	$12,168	↓
Children in Single-Parent Households[1]	22.2%	22.8%	31.7%	↓
Children in Working Families for Whom Licensed Childcare is Available (ages 0-12)[2]	27.0%	31.5%	24.5%	↑
Children Eligible for Free and Reduced-Price Lunch[4]	34.0%	36.0%	59.0%	↓
Job Proximity Index (neighborhood)[1]	54.8	50.2	47.7	↑
Young People Not in School and Not Working[1]	1.2%	1.1%	2.1%	↓

Table 21, Economic Security: Education

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts[2]	66%	60%	57%	↑
11th Graders Meeting or Exceeding Grade-Level CAASPP Standard in Mathematics[2]	45%	50%	32%	↑

Elementary School Proficiency Index[1]	62.5	69.7	49.4	↑
High School Graduates Completing College Preparatory Courses[2]	53.8%	56.8%	46.8%	↑
Math Scores (3rd graders)[4]	3.2	3.2	2.7	↑
On-Time High School Graduation[1]	87.7%	85.2%	83.8%	↑
Preschool Enrollment[1]	65.5%	62.7%	51.0%	↑
Reading Below Proficiency (4th grade)[10 †]	19.9%	23.0%	31.2%	↓
Reading Scores (3rd graders)[4]	3.2	3.2	2.9	↑
Students Not Completing High School[2]	5.7%	9.5%	9.6%	↓
7th Graders with a Low Level of Meaningful Participation at School[2]	26.6%	--	29.0%	↓
7th Graders with a Low Level of School Connectedness[2]	5.5%	--	7.6%	↓
9th Graders with a Low Level of Meaningful Participation at School[2]	**41.2%♦**	--	37.5%	↓
9th Graders with a Low Level of School Connectedness[2]	10.1%	--	11.1%	↓
Ratio of Students to Academic Counselors (N stu per counselor)[2]	563	**746♦**	626	↓
Students Truant from School (per 100 enrolled)[2]	25.9	26.1	34.1	↓

Economic Security Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Fourth-grade reading proficiency is improving in both counties.[10]

Economic Security Race & Ethnicity Indicators

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

Table 22, Economic Security, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Children Living in Poverty	16.5%	11.0%	4.0%	14.0%	--	12.0%	--	--	3.0%
High School Grads Completing College Prep Courses	46.8%	21.4%	80.3%	38.9%	64.10%	--	Filipino 43.6%	25.7%	67.3%
Low Level of Meaningful Partici-pation at School, 7th/9th/11th Gr.	38.1%*	26.3%	34%	39.5%	25.4%	20.5%	36.6%	44.0%	25.8%
Low Level of School Connectedness, 7th/9th/11th Gr.	12.3%*	7.2%	3%	10.9%	3.0%	3.8%	21.4%	28.0%	4.2%
Math Scores (3rd graders)	2.7	2.3	3.6	2.5	--	--	--	--	3.6
Median Household Income	$80,400	$70,500	$141,300	$79,800	--	$72,000	--	--	$138,600
Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts, 11th Graders	57%	36%	81%	39%	77%	43%	Filipino 64%	34%	78%
Meeting or Exceeding Grade-Level CAASPP Standard in Math, 11th Graders	32%	24%	82%	28%	71%	33%	Filipino 52%	25%	72%
Reading Scores (3rd graders)	2.9	2.7	3.5	2.6	--	--	--	--	3.7
Students Not Completing High School	9.6%	--	2.3%	9.1%	--	--	Filipino 4.0%	--	3.3%

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

Table 23, Economic Security, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Children Living in Poverty	17.5%	11.0%	5.0%	14.0%	--	15.0%	--	--	3.0%
High School Graduates Completing College Prep Courses	46.8%	31.9%	78.1%	34.1%	69.4%	--	Filipino 55.5%	38.0%	62.5%
Math Scores (3rd graders)	2.7	2.8	3.8	2.6	--	--	--	--	3.6
Median Household Income	$80,400	$76,200	$148,900	$79,900	--	$78,200	--	--	$133,400
Meeting or Exceeding Grade-Level CAASPP Standard in English Language Arts, 11th Graders	57.0%	45%	84%	38%	78%	45%	Filipino 68%	46%	76%
Meeting or Exceeding Grade-Level CAASPP Standard in Math, 11th Graders	32%	33%	84%	28%	72%	37%	Filipino 55%	35%	70%
Reading Scores (3rd graders)	2.9	2.8	3.8	2.6	--	--	--	--	3.6
Students Not Completing High School	9.6%	13.5%	9.3%	18.1%	15.5%	--	Filipino 19.7%	--	9.7%

Economic Security Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- In San Mateo County, a minimum-wage earner in a two-parent, two-child family must work 158 hours per week in order to make ends meet; in Santa Clara County, they must work 131 hours per week to make ends meet.[9]
- One third of households in San Mateo County and 28% of households in Santa Clara County do not earn enough to make ends meet.[9]
- In San Mateo County, the minimum annual household income necessary to afford basic needs (based on household composition) is $68,454; in Santa Clara County, it is $57,034.[9]

HEALTH CARE ACCESS & DELIVERY

Table 24, Health Care Access & Delivery

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Children with Health Insurance Coverage (ages 0-18)[2]	98.0%	98.0%	96.9%	↑
Medicaid/Public Insurance Enrollment[1]	27.7%	27.0%	37.9%	↑
Other Primary Care Providers (not PCPs) (N people per provider)[4]	**2,130♦**	1,310	1,480	↓
Percent Uninsured[1]	4.2%	4.3%	7.5%	↓
Preventable Hospital Stays (Medicare enrollees)[4]	1,880	2,829	3,358	↓
Primary Care Physicians Rate[1]	105.0	104.5	79.8	↑
Ratio of Students to School Nurses[2]	**4,464♦**	**2,992♦**	2,410	↓
Uninsured Children[1]	1.9%	1.9%	3.2%	↓
Children Living in Limited English-Speaking Households (ages 0-17)[2]	7.2%	8.0%	8.7%	↓
High Speed Internet[1]	90.6%	91.7%	86.0%	↑
Life Expectancy (years)[4]	85.0	84.9	81.7	↑
Limited English Proficiency[1]	8.7%	**11.1%♦**	9.6%	↓
Population with Any Disability[1]	8.2%	8.0%	10.6%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Percent Over Age 75 with a Disability[1]	46.1%	48.2%	51.1%	↓
Premature Death (years of potential life lost before age 75)[4]	3,300	3,500	5,300	↓
Premature Mortality Rate (under age 75, age-adjusted)[4]	180.0	190.0	270.0	↓
Ratio of Students to School Speech/Language/Hearing Specialists[2]	1,072	1,126	1,093	↓

Table 25, Heart Disease & Stroke

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Deaths Due to Cerebrovascular Disease (Stroke)[3 †]	25.5	29.3	35.9	↓
Deaths Due to Coronary Heart Disease[3 †]	47.6	49.9	80.6	↓
Heart Disease Deaths[1]	109.5	99.7	143.6	↓
Heart Disease Prevalence[1]	10.6%	11.3%	14.5%	↓
Hypertension/High Blood Pressure Prevalence[6 †]	24.3%	--	29.8%	↓
Stroke Prevalence[1]	2.6%	3.3%	3.6%	↓

Table 26, Infectious Diseases (other than COVID-19)

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Deaths Due to Influenza/ Pneumonia[3 †]	8.9	9.5	13.7	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Pertussis[13 †]	--	0.8	8.5	↓
Tuberculosis[3]	**8.5♦**	**7.8♦**	5.3	↓
Flu vaccinations (Medicare enrollees)[4]	49.0%	51.0%	43.0%	↑
Kindergarteners with All Required Immunizations[2]	96.6%	97.3%	94.8%	↑

Table 27, Oral Health

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Adults with tooth decay/ removed teeth (ages 45-64)[15]	--	45%	50%	↓
Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.[15]	--	59%	62%	↑
Dentists Rate[1]	104.2	118.4	87.0	↑
ED Visits for Non-Traumatic Dental Conditions[15]	--	257	353	↓
Never Had Dental Exam (ages 2-11)[2]	2.3%	3.1%	6.4%	↓

Health Care Access & Delivery Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- The number of dentists per 100,000 people is improving in both counties.[4]
- Deaths due to coronary heart disease are trending down in both counties, and deaths due to stroke are also falling in Santa Clara County, but have not improved in San Mateo County.[3]
- Hypertension/high blood pressure prevalence is falling in San Mateo County.[6]

- Deaths due to influenza/pneumonia are falling in both counties.[3]
- The proportion of kindergarten children with all required immunizations is rising in Silicon Valley.[7]
- Rates of pertussis are falling in Santa Clara County.[13]
- Rates of tuberculosis are falling in both counties, according to their public health departments.[6, 13]

Health Care Access & Delivery Race & Ethnicity Indicators

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

Table 28, Health Care Access & Delivery, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Children with Health Insurance Coverage (ages 0-18)	96.9%	--	98.3%	96.4%	98.9%	--	--	--	98.9%
Flu Vaccinations (Medicare enrollees)	43%	35%	46%	39%	--	36%	--	--	53%
Life Expectancy (years)	81.7	79.0	89.5	87.8	--	--	--	--	83.4
Premature Death (years of potential life lost before age 75)	5,300	6,800	2,500	3,300	--	--	--	--	3,600
Premature Mortality (under 75, age-adjusted)	270	380	130	160	--	--	--	--	200
Preventable Hospital Stays	3,358	3,686	1,520	2,083	--	27,270	--	--	1,811

Table 29, Health Care Access & Delivery, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Children with Health Insurance (ages 0-18)	96.9%	98.8%	98.0%	98.0%	98.9%	--	--	--	97.4%
Child Welfare-Involved Youth (ages 1-20) Receiving a Dental Exam in the Past 12 Mo.	62%	58%	55%*	61%	--	--	--	--	51%
ED Visits for Non-Traumatic Dental Conditions	353	811	62	404	--	--	--	--	258

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Flu Vaccinations (Medicare enrollees)	43%	35%	54%	38%	--	50%	--	--	53%
Life Expectancy (years)	81.7	79.7	90	84.3	--	83.9	--	--	83.1
Premature Death (years of potential life lost before age 75)	5,300	6,600	2,400	4,300	--	6,700	--	--	3,800
Premature Mortality (under 75, age-adjusted)	270	350	120	220	--	310	--	--	210.0
Preventable Hospital Stays	3,358	4,942	2,132	3,969	--	6,703	--	--	2,721.0

* Datapoint is for Asian/Pacific Islanders combined.

Health Care Access & Delivery Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- In San Mateo County, there are 0.3 primary care clinics per 10,000 people and in Santa Clara County there are 0.4 per 10,000.[3]
- Of children in Santa Clara County's DentalFirst program, the proportions with urgent and emergency dental needs by age are:[15]
    - Ages 0-2: 10%
    - Ages 3-5: 34%
    - Ages 6-8: 35%
    - Ages 9-13: 28%
    - Ages 14-18: 23%
- Among all deaths in both counties, 6.7% are due to cerebrovascular diseases.[3]
- Among all deaths in both counties, 24.0% in San Mateo County and 19.3% in Santa Clara County are due to heart diseases.[3]
- Among all deaths in both counties, 2.1% in San Mateo County and 3.8% in Santa Clara County are due to hypertension.[3]
- Among all deaths in both counties, 1.9% in San Mateo County and 1.8% in Santa Clara County are due to influenza and pneumonia.[3]

HOUSING & HOMELESSNESS

Table 30, Housing & Homelessness

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Homeownership Rate[1]	60.2%	56.4%	54.8%	↑
Housing Affordability Index[1]	**67.2♦**	**73.0♦**	88.1	↑
Median Rental Cost[1]	**$2,451♦**	**$2,374♦**	$1,689	↓
Moderate Housing Cost Burden[1]	19.2%	19.4%	21.4%	↓
Overcrowded Housing[1]	7.9%	8.2%	8.2%	↓
Percent of Income for Mortgage[1]	**39.2%♦**	**36.1%♦**	30.8%	↓
Residential Segregation - Black/White[4]	55	45	55	↓
Residential Segregation - Non-White/White[4]	36	36	38	↓
Severe Housing Cost Burden[1]	17.1%	15.8%	19.2%	↓
Severe Housing Problems (one or more of: overcrowding, high costs, lack of kitchen, lack of plumbing)[4]	23.0%	23.0%	26.0%	↓
Students Recorded as Homeless at Some Point during the School Year[2]	2.0%	1.6%	4.5%	↓
Children Ages 0-17 Living in Crowded Households[2]	23.1%	25.1%	27.9%	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 0-5)[2]	**1.7%♦**	1.1%	1.2%	↓
Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 0-5)[2]	0.3%	**0.4%♦**	0.3%	↓
Children with Blood Lead Levels of 4.5-9.49 mcg/dL, among Those Tested (ages 6-20)[2]	0.6%	2.0%	2.1%	↓
Children with Blood Lead Levels of at least 9.5 mcg/dL, among Those Tested (ages 6-20)[2]	0.2%	**1.1%♦**	0.5%	↓
Neighborhood Deprivation Index[1]	-0.8	-0.8	0.0	↓
Population Density (people per square mile)[1]	9,206.4	9,115.0	8,485.7	

Housing & Homelessness Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- The number of people experiencing homelessness has been rising in San Mateo[11] and Santa Clara[12] counties.
- The proportion of people who are experiencing homelessness and who are unsheltered has been rising in San Mateo County.[11]

Housing & Homelessness Race & Ethnicity Indicators

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

Table 31, Housing & Homelessness, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
People Experiencing Homelessness	N/A	12.3%	1.3%	35.1%	7.1%	1.8%	--	1.8%	70.5%*

* Includes people identifying as white Hispanics.

Table 32, Housing & Homelessness, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
People Experiencing Homelessness	N/A	19%	--	43%	--	8%	24%	--	44%

Housing & Homelessness Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- In San Mateo County, 1,512 people were experiencing homelessness in 2019.† Of these, 60% were unsheltered.[11†]
- San Mateo County had 31 young people (ages 0-24) experiencing homelessness in 2020, almost all of whom were young adults (ages 18-24).[2]
- In Santa Clara County, 9,706 people were experiencing homelessness in 2019.† Of these, 82% were unsheltered.[12]
- Santa Clara County had 1,848 young people (ages 0-24) experiencing homelessness in 2020, 15% of whom were children (ages 0-17). Of the latter, 96% were unsheltered.[2]

MATERNAL & INFANT HEALTH

Table 33, Maternal & Infant Health

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Babies Born to Mothers Who Received Prenatal Care in the First Trimester[2]	90.6%	86.6%	83.6%	↑
Infant Deaths (per 1,000 live births)[1]	3.1	3.2	4.0	↓
Low Birthweight[4]	7.0%	7.0%	7.0%	↓
Preterm Births[1]	7.7%	8.2%	8.8%	↓
Teen Births (per 1,000 females ages 15-19)[4]	9	10	17	↓
Babies Breastfed Exclusively in Hospital[2]	80.8%	80.9%	70.4%	↑

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Babies Breastfed in Hospital (at Any Time)[2]	97.7%	97.1%	93.8%	↑
Population Under Age 18[1]	20.7%	22.2%	22.9%	

Maternal & Infant Health Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- Low birthweight births are rising in Santa Clara County.[2]
- Infant mortality is decreasing in Silicon Valley.[7]

Maternal & Infant Health Race & Ethnicity Indicators

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

Table 34, Maternal & Infant Health, San Mateo County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Babies Born to Mothers Who Received Prenatal Care in 1st Trimester	83.6%	88.3%	89.8%*	88.3%	88.0%	--	--	--	94.2%
Babies Breastfed Exclusively in Hospital	70.4%	73.5%	80.5%	75.2%	80.3%	--	68.7%	--	88.0%
Babies Breastfed in Hospital (at Any Time)	93.8%	95.1%	98.4%	97.4%	96.0%	--	93.9%	95.7%	98.1%
Birth Cohort Infant Death Rate (per 1,000 live births)	3.9	--	2.9*	3.4	--	--	--	--	--
Low Birthweight	7%	9%	8%	6%	--	--	--	--	5%
Teen Births (per 1,000 females ages 15-19)	17	10	2	19	--	--	--	--	1

* Datapoint is for Asian/Pacific Islanders combined.

Table 35, Maternal & Infant Health, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
Babies Born to Mothers Who Received Prenatal Care in 1st Trimester	83.6%	78.5%	89.4%*	78.4%	87.1%	81.3%	--	--	92.1%
Babies Breastfed in Hospital (at Any Time)	93.8%	94.5%	97.9%	95.7%	96.4%	--	--	93.3%	97.8%
Birth Cohort Infant Death Rate (per 1,000 live births)	3.9	--	2.7*	3.5	--	--	--	--	2.3
Exclusive Breastfeeding (in Hospital)	70.4%	78.4%	79%	78.0%	83.6%	--	85.3%	83.3%	88.4%
Low Birthweight	7.0%	9%	8%	6.0%	--	8.0%	--	--	6%
Teen Births (per 1,000 females ages 15-19)	17	7	1	23	--	--	--	--	2

* Datapoint is for Asian/Pacific Islanders combined.

SEXUALLY TRANSMITTED INFECTIONS

Table 36, Sexually Transmitted Infections

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
Chlamydia Incidence[1]	401.3	429.0	585.2	↓
Chlamydia Incidence among Youth (ages 10-19)[2]	476.3	580.0	788.6	↓
Early Syphilis[13]	--	29.6	38.6	↓
Gonorrhea Incidence among Youth (ages 10-19)[2]	47.7	63.7	133.0	↓
HIV/AIDS Deaths[1]	--	11.0	73.5	↓
HIV/AIDS Prevalence[1]	256.0	200.2	389.6	↓

Indicators	San Mateo County	Santa Clara County	California Benchmark	Desired ↑↓
HIV Prevalence (not including AIDS), Age 13 and Over[4]	256.0	200.0	396.0	↓
Syphilis[14 †]	10.1%	--	19.1%	↓

Sexually Transmitted Infections Trends (†)

Certain indicators have been measured longitudinally. Below are the trend directions for indicators with trend data available.

- In Santa Clara County, HIV diagnoses among males are rising for ages 13-24 and 25-44. However, the county's rate of people of all ages and genders living with HIV is decreasing, and it's HIV mortality rate is decreasing as well.[13]
- In San Mateo County, the proportion of the population with syphilis is rising.[14]

Sexually Transmitted Infections Race & Ethnicity Indicators

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

Table 37, Sexually Transmitted Infections, Santa Clara County

Indicators	Bench-mark	Black	Asian	Latinx	Multi-Ethnic	Native Am	Other	Pac Isl	White
HIV Diagnoses (males ages 13+)	18.1*	39.9	9.3**	37.1	--	--	--	--	10.8
Living with HIV (all ages, all genders)	174.7‡	817.6	63.0**	264.6	--	--	--	--	173.5

* Benchmark not available for grouped grades. For conservative comparison purposes, the benchmark used is the highest among those available by grade.

** Datapoint is for Asian/Pacific Islanders combined.

‡ Benchmark is Santa Clara County; no comparable data available for California.

Sexually Transmitted Infections Data Without Benchmarks

Certain indicators were available that had no statewide comparison. These data are described below.

- In Santa Clara County:[13 †]
    - 18.1 per 100,000 males aged 13+ were diagnosed with HIV; specifically among males aged 13-24, 14.1 per 100,000 were diagnosed with HIV.
    - Among adult males, 35.0 per 100,000 aged 25-44 and 10.4 per 100,000 aged 45-64 were diagnosed with HIV.
    - Among people of all ages and genders, 174.7 per 100,000 people are living with HIV.

SUMMARY LIST OF SOURCES

Health needs data found in this document were collected primarily from two publicly available data platforms, the Community Health Needs Dashboard supported by Kaiser Permanente (https://public.tableau.com/app/profile/kp.chna.data.platform/viz/CommunityHealthNeedsDashboard/) and KidsData.org supported by the Population Reference Bureau (https://www.kidsdata.org/). Other data were obtained from the California Department of Public Health and the U.S. Census Bureau, as well as the two county public health departments. Pertinent data points on health needs from these sources are included in data tables with superscript notation:

1 Community Health Needs Dashboard
2 KidsData.org
3 California Department of Public Health
4 County Health Rankings & Roadmaps, Robert Wood Johnson Foundation
5 California Department of Public Health, EpiCenter
6 San Mateo County All Together
7 Joint Venture Silicon Valley, 2020 Index
8 Santa Clara County Department of Probation
9 Center for Women's Welfare, University of Washington. Self-Sufficiency Standard Tool.
10 California Department of Education
11 County of San Mateo, Human Services
12 County of Santa Clara, Office of Supportive Housing
13 County of Santa Clara, Department of Public Health
14 Centers for Medicare and Medicaid Services
15 Santa Clara County Oral Health Report 2018
16 The New York Times COVID-19 Tracker
17 San Mateo County Health

For an index that lists full original sources and years as well as indicator descriptions, see Attachment 1, Secondary Data Indicators List.

ATTACHMENT 3: COMMUNITY LEADERS, REPRESENTATIVES, AND MEMBERS CONSULTED

The list below contains the names of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups including vulnerable populations such as low-income individuals, minorities, and the medically underserved. Interviewees and focus group participants discussed health needs in both San Mateo and Santa Clara counties unless otherwise noted (i.e., designated "SCC" or "SMC").

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Organizations						
Interview	Kristina Lugo, Vice President, Individual and Family Services, Avenidas	Senior health needs	1	Low-income, medically underserved	Leader	3/9/2021
Interview	Yogita Thakur, Chief Dental Officer, Ravenswood Family Health Network	SMC: Oral health	1	Low-income, medically underserved	Leader	3/11/2021
Interview	Arlae Alston, Program Director, Puente de la Costa Sur & unnamed team member	SMC: Coast-side health needs	2	Low-income, medically underserved, minority	Leader	3/15/2021
Interview	Bonnie Broderick, Program Manager, County of Santa Clara, Department of Public Health	SCC: Chronic diseases	1	Low-income, medically underserved	Leader	3/22/2021

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Interview	Alex Golding, Lead Case Manager & Clinical Data Coordinator, San Mateo County Pride Center	SMC: LGBTQ+ health needs	1	Medically underserved, minority	Leader, representative	3/24/2021
Interview	Ken Cole, Agency Director, County of San Mateo Human Services Agency	SMC: Basic needs	1	Low-income	Leader	3/25/2021
Interview	San Mateo County Health	SMC: Public health	1	Low-income, medically underserved	Leader	3/25/2021
Interview	Rhonda McClinton-Brown, Branch Director, Healthy Communities, County of Santa Clara Public Health Department	SCC: Public health	1	Low-income, medically underserved	Leader	4/5/2021
Interview	Dana Bunnett, Executive Director, Kids in Common	SCC: Child & youth wellness	1	Low-income	Leader	4/5/2021
Interview	Anand Chabra, MD, Medical Director, Family Health Services, San Mateo County Health	SMC: Maternal/ teen health	1	Low-income, medically underserved	Leader	4/5/2021
Interview	Michelle de Blank, Supervising Attorney, Family Advocacy	SMC: Social determinants of health	1	Low-income	Leader	4/8/2021

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Program, Legal Aid Society of San Mateo County					
Interview	Charisse Feldman, Public Health Nurse Manager II/MCAH Director, Santa Clara County Public Health Department	SCC: Maternal/ teen health	1	Low-income, medically underserved	Leader	4/14/2021
Interview	Maribel Martinez, Director, County of Santa Clara, Office of LGBTQ Affairs	SCC: LGBTQ+ health needs	1	Medically underserved, minority	Leader, representative	4/15/2021
Interview	Shakalpi Pendurkar DDS, MPH, Director, San Mateo County Oral Public Health Program (formerly Supervising Dentist of Gardner Family Health Network, Santa Clara County)	SCC: Oral health	1	Low-income, medically underserved	Leader	4/29/2021
Focus Group	Hosts: El Camino Health & Sutter Health	Adult mental/ behavioral health	13	Medically underserved	(see below)	4/12/2021
	Attendees:					

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Zena Andreani, Program Manager-Crisis Intervention and Suicide Prevention Center, StarVista				Leader	
	Mark Cloutier, CEO, Caminar				Leader	
	Scott Gilman, Director of Behavioral Health and Recovery Services, San Mateo County Health				Leader	
	Ashley Hartoch, Complex Care Manager, Stanford Health Care				Leader	
	Tiffany Ho, MD DFAPA, Behavioral Health Medical Director, County of Santa Clara Health System				Leader	
	Susan Houston, Vice President of Older Adult Services, Peninsula Family Service				Leader	
	Lauren Johnson, Manager, Community Engagement, Scrivner Center For Mental Health & Addiction Services, El Camino Health				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Teresa Johnson, Teresa Johnson, Director Food & Nutrition Services, The Health Trust				Leader	
	Mego Lien, Prevention Services Division Manager, County of Santa Clara Behavioral Health Services Department				Leader	
	Lan Nguyen, Program Manager, Santa Clara County Behavioral Health Services Department - Suicide and Crisis Services				Leader	
	Dr. Munisha Vohra, MA, LCSW, Director of Clinical Services, Community Overcoming Relationship Abuse				Leader	
	Program Manager , LMFT, Momentum for Health				Leader	
	Next Door Solutions to Domestic Violence				Leader	
Focus Group	Host: Stanford Health Care	Health equity	10	Medically underserved, minority	(see below)	4/14/2021

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Attendees:					
	Steven Adelsheim, Director, Stanford Psychiatry Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry and Behavioral Sciences				Leader	
	David Chang, Clinical Assistant Professor, Department of Medicine, Division of Primary Care and Population Health; also Assistant Health Officer, San Mateo County Health, Division of Public Health, Policy, & Planning				Leader	
	Sang-ick Chang, M.D., MPH, Associate Dean and Division Chief, Primary Care & Population Health, Stanford Medical School				Leader	
	Meenadchi Chelvakumar, Clinical Assistant Professor, Primary Care Provider, Stanford/Ravenswood Family Health Network				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Ryan Padrez, Assistant Clinical Professor of Pediatrics; Medical Director, Stanford University School of Medicine; The Primary School				Leader	
	Loto Reed, Program Specialist, Wellness and Community Engagement, Stanford University				Leader	
	Stephen Richmond, Clinical Assistant Professor, Stanford University				Leader, representative	
	Baldeep Singh, Clinical Chief, Stanford Internal Medicine, Co-Director, Pacific Free Clinic				Leader	
	Clinical Associate Professor, Stanford Healthcare				Leader	
	Stanford University Division of Primary Care and Population Health				Leader	
Focus Group	Host: El Camino Health	SCC: Social services	12	Low-income	(see below)	4/19/2021

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Attendees:					
	Ray Bramson, Chief Operating Officer, Destination: Home				Leader	
	Kelly Chau, Ph.D., Senior Vice President of Programs, The Health Trust				Leader	
	Nicole Fargo, Associate Director, Community Services Agency				Leader	
	Mike Gonzalez, Manager, Community Resource Center, Santa Clara Family Health Plan				Leader	
	Brian Greenberg, VP/Programs and Services, LifeMoves				Leader	
	Nereyda Hurtado, Associate Director, Grail Family Services				Leader	
	Josh Selo, Executive Director, West Valley Community Services				Leader	
	Director of Programs and Services, Sunnyvale Community Services				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Executive Director, Midtown Family Services				Leader	
	African American Community Service Agency				Leader	
	El Camino Health				Leader	
	Peninsula Healthcare Connection				Leader	
Focus Group	Host: Stanford Health Care & Sutter Health	Safety Net Clinics	12	Low-income, medically underserved	(see below)	4/26/2021
	Attendees:					
	Anupama Balakrishnan, Chief Medical Officer, Indian Health Center of Santa Clara Valley				Leader	
	Alma Burrell, Associate Director, Roots Community Health Center				Leader	
	Will Cerrato, Clinics Manager, San Mateo Medical Center / RotaCare Free Clinics				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Parneet Dhindsa, MPH, Planned Parenthood Mar Monte				Leader	
	Poorva Kamath, Medical Director, AACI				Leader	
	Stephanie Kleinheinz, CEO, School Health Clinics of Santa Clara County				Leader	
	Haleh Sheikholeslami, Medical Director/MD, Peninsula Healthcare Connection				Leader	
	Chief Executive Officer, Ravenswood Family Health Network				Leader	
	Medical Director of Healthcare Services, Samaritan House				Leader	
	Gardner Health Services				Leader	
	North East Medical Services				Leader	
	San Mateo Medical Center				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
Focus Group	Host: Lucile S. Packard Children's Hospital-Stanford	Youth Mental Health	12	Medically underserved	(see below)	4/29/2021
	Attendees:					
	Arash Anoshiravani, Medical Director, Teen Van, Stanford School of Medicine				Leader	
	Vinney Arora, Executive Director, My Digital TAT2				Leader	
	William Blair, MVLA Wellness Coordinator, MVLA School District				Leader	
	Judith Gable, LCSW, Director of Collaborative Counseling Program, Acknowledge Alliance				Leader	
	Melissa Guariglia, PsyD, School-Based & Clinical Services Department Director, StarVista				Leader	
	Vicki Harrison, MSW, Program Director, Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry &				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Behavioral Sciences, Stanford University School of Medicine					
	Jamila McCallum, Regional Director, Edgewood San Mateo, Edgewood Center for Children and Families				Leader	
	Ron Pilato, Chief Psychologist and Training Director, Community Health Awareness Council (CHAC)				Leader	
	Nkia Richardson, Executive Director, CASA of San Mateo County				Leader	
	Marico Sayoc, Executive Director, Counseling and Support Services for Youth				Leader	
	Executive Director, Adolescent Counseling Services				Leader	
	Uplift Family Services				Leader	
Focus Group	Host: Samaritan House	SMC: Social Services	10	Low-income	(see below)	5/12/2021

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Attendees:					
	Jenifer Clark, Research & Evaluation Specialist, First 5 San Mateo County				Leader	
	Judith Guerrero, Executive Director, Coastside Hope				Leader	
	Raymond Hodges, Director, County of San Mateo Department of Housing				Leader	
	Jill Jacobson, Executive Director, Boys & Girls Club of the Coastside				Leader	
	Marya Ouro-Gbeleou, Program Director, Daly City Partnership; Daly City Community Service Center				Leader	
	Jen Overholt, Director of Impact, JobTrain				Leader	
	LaTrice Taylor, Associate Director, Programs & Services, Samaritan House				Leader	

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Ophélie Vico, Community Health Manager, Puente de la Costa Sur				Leader	
	Director of Nutrition, Second Harvest of Silicon Valley				Leader	
	YMCA Community Resource Center				Leader	
Focus Group	Host: Bay Area Community Health Advisory Council (BACHAC)	Black Health	7[52]	Minority, medically underserved	(see below)	6/14/2021
	Attendees:					
	Dieter Bruno, Chief Medical Officer, Dignity Health-Sequoia Hospital				Leader, representative	
	Davina Hurt, Councilwoman & Boardmember of CARB/BAAQMD, City Of Belmont and California Air Resources Board/Bay Area Air Quality Management District				Leader, representative	

[52] One attendee did not give permission to be listed in this appendix.

Data Collection Method	Name, Title, Agency	Topic	# of People	Target Group(s) Represented	Role in Target Group	Date Input Was Gathered
	Lisa Tealer, Executive Director, Bay Area Community Health Advisory Council (BACHAC)				Leader, representative	
	Bay Area Community Health Advisory Council				Leader, representative	
	Bay Area Community Health Advisory Council				Leader, representative	
	Unity Care Group				Leader, representative	
Community Members						
Focus Group	Host: Gardner Health Services	Health clinic patients	4	Low-income, medically underserved	Members	6/7/21

ATTACHMENT 4: QUALITATIVE RESEARCH PROTOCOLS

CHNA KII Protocol - Professionals (60 min.)

PREP

- Schedule call, send survey and main questions [*minimum: 1 week ahead of time*].
- 48 hours before:
    - Review the individual's background on LinkedIn and/or their organization's website; review their survey response (health needs they identified).
    - Send reminder email; remind them of their survey response (most pressing needs among those they serve) and the main questions.
        - If they didn't respond to the survey, include the link and ask them to respond ASAP before the interview.

INTRODUCTION (5 MIN.)

[Start recording from the beginning of the session.]

- Welcome and thanks
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA).
    - A CHNA is required of all non-profit hospitals in the U.S. every three years. The report based on this assessment will be a snapshot in time; this report will be published next year (in 2022) and consulted through 2025.
    - Will inform investments that hospitals make to address community needs.
- Our interview is scheduled for sixty minutes -- does that still work for you?
- Today's questions:
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs
    - How things may have changed in the past few years (trends)
    - Any models or best practices you know of for addressing the needs
    - Areas of concern

    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
    - Will record so that we can get the most accurate record possible
    - Will not share the audio itself; transcript will go to hospitals
    - Hospitals will make decisions about which needs they can best address
    - We can keep anything confidential, even the whole interview. Let me know any time.
    - *[First half depends on their survey response:]* Plan to name *you/your organization* in the report where we list all the experts we consulted, but will not attach your name to any quotes we might use.
- Any questions before I begin? *[If we don't have the answer, commit to finding it and sending later via email.]*

Kick on Zoom recording!

HEALTH NEEDS DISCUSSION (35 MIN.)

You identified [*read list*] as the most pressing needs for the people you serve. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. Please describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. *Probe:* Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources,

geographic location (DUAL COUNTY -- between counties?), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
[*Prompts for populations if they are having trouble thinking of any*: DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lag what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you've heard about, or practices you've read about in literature.]

OK, let's get started. For *[name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]*

Only if their expertise was not related to one or more of the needs chosen:

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 min.)

I know you didn't identify the coronavirus as a specific need; would you mind…

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed since COVID began?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this interview, please feel free to send me an email.

Thank you so much for contributing your expertise and experience to the CHNA.

CHNA FG Protocol - Professionals (90 min.)

PREP

- Schedule group of 8-10 participants. If needed, create recruitment email/flyer for hospital rep. Ahead of time, send participants:
    - Pre-focus group survey and main questions [*minimum: 1 week ahead of time*].
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- 48 hours before, prepare:
    - Review the individuals' backgrounds on LinkedIn and/or their organizations' websites; review their survey responses (health needs they identified).
    - Send reminder email; if any didn't respond to the survey, include the link and ask them to respond ASAP before the focus group.
    - Ensure you have PDF of agenda/questions ready.

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is ____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- What the project is about:
    - Identifying health needs in our community, including social determinants of health (called the Community Health Needs Assessment or CHNA)
    - The report based on this assessment will be a snapshot in time, required of all non-profit hospitals in the U.S. every three years; this report will be published next year (in 2022) and consulted through 2025
    - Will inform investments that hospitals make to address community needs
- Today's questions: *show slide*
    - Better understand the needs you identified as most pressing in [San Mateo and/or Santa Clara] [County/counties]
    - Which populations are experiencing inequities related to the needs

    - How things may have changed recently (trends)
    - Any models or best practices you know of for addressing the needs
    - Areas of concern
    - *[If not one of the needs identified:]* Your expertise as it relates to the community's needs
    - *[If not one of the needs identified:]* Your comments on how the pandemic has affected the people you serve
- What we'll do with the information you tell us today:
    - We are recording this group so that we can make sure to get your words right.
    - Will not share the video itself; transcript or notes will go to hospital
    - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
    - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!

- Guidelines:
    - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
    - We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
    - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.
- Any questions before I begin? *[If we don't have the answer, commit to finding it and sending later via email.]*

HEALTH NEEDS DISCUSSION (45 MIN.)

As a group, you identified [*read list*] as the most pressing needs for the people you serve -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only* ***bold text*** *to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **how you see the need playing out**, including how well the need is being addressed right now and what barriers might exist to seeing better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."
   Probe: Who is addressing the need? [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location (DUAL COUNTY -- between counties), transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **which populations are experiencing inequities** with respect to the need (that is, who are better or worse off than others) and explain their situation.
   [*Prompts for populations if they are having trouble thinking of any*: DUAL COUNTY -- between counties?, income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Third, to say **how things may have changed** in the last few years (since we know that the data always lags what is happening now). What emerging trends or areas of concern do you see? Think about how things were going prior to the emergence of COVID-19, and also how they are now, with the impact of the pandemic.

4. Finally, I'll ask you to explain **what you feel is needed to better address this need**, including **any models or best practices for addressing the need.** *Probe*: Who should be doing that (addressing this need)? [*Prompts if needed:* Practices you have observed within your health system or organization, in our county agencies, national practices you have heard about, or practices you have read about in literature.]

OK, let's get started. For *[name first need], [start at Q1; address all four questions, then go back to Q1-4 with second need, again with third need, then go on to the questions below.]*

***Only if* their expertise was not related to one or more of the needs chosen:**

FURTHER DISCUSSION: THEIR EXPERTISE (5-10 min.)

You were invited to share your expertise/experience about [*e.g., substance use disorder, senior health, or homelessness*]. Let's talk a little about that; how does it relate to the community's health needs?

Only if COVID was not chosen as a need/was not discussed in the context of other needs:

FURTHER DISCUSSION: CORONAVIRUS PANDEMIC (5-10 min.)

I know you didn't identify the coronavirus as a specific need; would you mind…

- Telling me about the effects of the pandemic you may be seeing among the people you serve (not just among those who were ill with COVID)?
- What inequities are you seeing?
- How have things changed in the last few years (both prior to COVID, and since COVID began)?

ADDITIONAL COMMENTS (time permitting)

We have a few minutes left; is there anything else you would like to add regarding community health needs? Anything else we can convey to the hospitals?

REQUEST FOR ASSISTANCE WITH ASSETS LIST (2 min.)

The IRS requires that we get feedback from the community on potential resources available to address these health needs. We are compiling a list of resources by health need later this spring, which will be based on 2-1-1's list. **Would you be willing to review a list at that time, related to your area of expertise, and give us feedback?** For example, we may ask whether the resources seem sufficient or if there are resources available that we have missed. *[Make a note as to whether they agree or not.]*

CLOSING (1 min.)

Thank you for contributing your expertise and experience to the CHNA.

You can look for the hospitals' CHNA reports to be made publicly available on their individual websites in the second half of 2022.

If anything occurs to you later that you would like to add to this discussion, please feel free to send me an email.

CHNA Zoom[53] FG Protocol - Community Members (90 min.)

PREP

- Work with host to schedule group of 8-10 participants. If needed, create recruitment email/flyer for host. Ahead of time, have host send participants:
    - Pre-focus group health needs survey [depending on group]
    - FG date, time, and Zoom login information
    - Advise that the session will be recorded
- Prepare:
    - PDF of agenda/questions
    - Review pre-survey responses
    - PDF of health needs list (including definition of health care access) [if no pre-survey]
    - Zoom poll of health needs [if no pre-survey]

INTRODUCTION (10 MIN.)

[Start recording from the beginning of the session.]

- Hello everyone. Today we are hosting a focus group about health here in our county. This session will run until [*time*].
- My name is ____ and I'm with Actionable Insights, a local consulting firm. When we start our discussion in a few minutes, we will call on you and ask you to say your name before speaking.
- Purpose:
    - You are here today to let nonprofit hospitals know what the biggest health needs are in our county.
    - This is called the Community Health Needs Assessment (CHNA), which is required every three years by the IRS, so it is an official, public report.
    - Hospitals will use this to plan how they will use their resources to improve health and wellness in our county.
- Today's questions: *show slide*
    - What are the needs?

[53] If planning to do a What'sApp FG, can revise this protocol.

        - Which groups of people are doing better or worse when it comes to the needs?
        - What can hospitals/health systems do to improve health in the community?
    - We will also talk about your pandemic experience and what you think the long-term effects will be (not just on health, but overall).
    - Lastly, we will get your perspective about equity and cultural competence when it comes to health care.

- Confidentiality:
    - We are recording this group so that we can make sure to get your words right.
    - We will only use first names here -- you will be anonymous. (If you want to use a fake name that's OK, too!)
    - Will not share the video itself; transcript will go to hospital.
    - When we are finished with all of the focus groups, we will read all of the transcripts and summarize the things we learn. We will also use some quotes so that the hospital can read your own words. We will not use your name when we give them those quotes.
    - If for any reason you are deciding that you do not want to participate, it is OK to leave the meeting now. No hard feelings!

- Guidelines:
    - We know you have other commitments and we really appreciate you taking the time out of your day to be here. It is my job to move us along to keep us on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions so we can finish on time.
    - We understand that you may have distractions on your end; we ask that you do the best you can to remain present, and let us know through the chat if you absolutely need to step away.
    - If no pre-survey: You have a choice of a $25 credit to Amazon or Target. Please chat your email address to my colleague [*name*] now, along with your choice. If you don't tell her which one you prefer, we'll send you an Amazon credit.
    - It's OK to disagree, but please be respectful. We want to hear from everyone. Really want your personal opinions and perspectives, even – especially! – if they aren't the same as everyone else's.

- Any questions before we begin? *[If we don't have the answer, commit to finding it and sending later via email.]*

HEALTH NEEDS DISCUSSION (45 MIN.)

If no pre-survey: We are going to show you a list of health needs in our county from 2019. [*show slide*] You'll see that there are regular physical health conditions, like cancer (we added COVID), and other kinds of needs, like food insecurity and housing. We're going to read the needs, then put up a poll for you to choose the three you think are the most urgent and important in your community.

[Read off needs, then launch zoom poll. Give people 2 minutes to complete.]

If collected by pre-survey, start here: As a group, you identified [*read list*] as the most important needs in your community -- these are the needs that got the most votes in the pre-survey. For each of these needs, I'll ask you four things [*read only **bold text** to introduce this section*]:

1. *[Facilitators call on participants one by one.]* "Please say your first name, and then describe **what the need looks like in your community**, including what barriers might exist to people having better outcomes. You can choose to pass if you didn't vote for the need and don't have anything to say about it."
   [*Prompts for barriers if they are having trouble thinking of any:* Income/economic issues, language, culture/stigma, lack of awareness/education, policies/laws, budget cuts, lack of community resources, geographic location, transportation, housing, addiction, stress, being victims of abuse/bullying/crime]

2. This may overlap the previous question, but I'll ask you to identify **what groups of people are better or worse off than others** for that need and explain how or why.
   [*Prompts for populations if they are having trouble thinking of any*:
   income/education level, housing status, language, immigration status, age, ethnicity, sexual orientation, gender identity, disability status, geographic location]

3. Finally, I'll ask you to describe, for that need, **what you think the people in charge should do to support, enhance, facilitate, or fund** to help communities become healthier / improve everyone's lives.

OK, let's get started. For *[name first need], [start at Q1; address all three questions, then go back to Q1-3 with second need, then again with third, then go on to the questions below.]*

YOUR PANDEMIC EXPERIENCE (15 min.)

We all know that the coronavirus has been really disruptive to our normal lives since March of 2020. Specifically, we want to hear about your experience with getting health care since then. First, we'll review the answers to the poll questions, then we'll talk more.

- Poll question results:
    a. What is your health insurance status? *[Describe results].*
    b. Do you have a doctor you see regularly? *[Describe results].*
    c. Has the pandemic made it more or less difficult to access the health care you need? *[Describe results].*
    Tell us more about how the pandemic affected your ability to access health care.

    [Potential probes] Tell us more about your reasons for putting off a regular appointment or not seeing a provider for something that went wrong. Tell us your opinion of virtual appointments. How did you like them? What was good about them (maybe even better than an in-person appointment)? What about them could be improved?

- **Not only thinking about healthcare, but more generally:** What do you think the long-term impact of the pandemic will be on you, your family, and your friends and neighbors?

YOUR PERCEPTION OF EQUITY ISSUES (20 min.)

As you probably know, people have been talking about issues of equity much more than ever before. "Equity" means fairness and unbiased treatment. When it comes to health care, what's your perspective about equity and cultural competence? For example:

- What do you think are the barriers to everyone having the same access to health care?
- What do you think are the barriers to everyone getting the same quality of health care?

- We've heard that not all providers know how to care for people in a respectful and culturally competent way. What do you think those providers are missing? What do you think they need to learn?
- What can hospitals and health systems do to best address equity for you and the people in your community?

CLOSING (1 min.)

Thank you for contributing your opinions and experience to the CHNA.

You can contact us if you want any more information about the assessment. If anything occurs to you later that you would like to add, please feel free to send me an email.

ATTACHMENT 5: COMMUNITY ASSETS AND RESOURCES, SAN MATEO COUNTY

Programs and resources available to meet identified community health needs are listed on the following pages.

ACCESS TO HEALTH CARE RESOURCES

HEALTH CARE FACILITIES AND AGENCIES

In addition to assets and resources available to address specific health needs, the following health care facilities are available in the county. Many hospitals provide charity care and cover Medi-Cal shortfalls.

Hospitals and Health Systems	City/Region
Kaiser Foundation Hospital Redwood City	Redwood City
Kaiser Foundation Hospital South San Francisco	South San Francisco
Lucile S. Packard Children's Hospital Stanford	Palo Alto
Menlo Park Surgical Hospital	Menlo Park
Mills Health Center	San Mateo
Mills-Peninsula Medical Center	Burlingame
Peninsula Healthcare District	
San Mateo County Medical Center	San Mateo
Sequoia Healthcare District	
Sequoia Hospital	Redwood City
Seton Medical Center/Seton Coastside	Daly City/Moss Beach
Stanford Health Care	Palo Alto

Clinics*	City/Region
Arbor Free Clinic, Cardinal Free Clinics	Menlo Park
Belle Air School Health Clinic	San Bruno
Clinic by the Bay	San Francisco
Daly City Youth Health Center	Daly City
Lucile S. Packard Children's Hospital Stanford	Mobile Health Services
Planned Parenthood	Multiple locations; see URL.
Ravenswood Family Health Center	East Palo Alto
RotaCare Bay Area	Half Moon Bay and Daly City
Samaritan House Free Clinic	San Mateo and Redwood City
San Mateo Medical Center Clinics	Multiple locations; see URL.
Sequoia Teen Health Center/Sequoia High School	Redwood City
Student Health Clinic	Belle Air School (San Bruno Park School District)

*Does not include private health care services. Please utilize 2-1-1 for lists of those clinics.

ORAL HEALTH RESOURCES

- Ravenswood Family Dentistry
- Samaritan House Dental clinic
- San Mateo County Health: Dental Services
- San Mateo County Dental Society
- San Mateo County Oral Health Coalition
- Sonrisas Dental Health Half Moon Bay and San Mateo

OTHER GENERAL HEALTH CARE RESOURCES

- CareSolace
- Community Gatepath
- Community Health Education Programs
    - See Hospitals and Health Systems
- Daly City Partnership Social Services
- Daly City Peninsula Partnership Collaborative, Health Aging Response Team
- Edgewood Center for Children and Families
- Family Caregiver Alliance (FCA)
- Get Healthy San Mateo County
- Get Up & Go, Escorted senior transportation
- Health Benefits Resource Center
- The Latino Commission
- Kaiser Permanente Education Theater Program
- Mental Health Association of San Mateo County
- Mid-Peninsula Boys & Girls Club
- Mission Hospice & Home Care
- Northeast Medical Services (NEMS)
- Ombudsman Services of San Mateo County
- Pacifica Collaborative
- Pathways & Home Health & Hospice
- Peninsula Library System
- Puente de la Costa Sur
- Redi-wheels program
- San Mateo County Paratransit Coordinating Council
- San Mateo County Access and Care for Everyone (ACE) health plan
- San Mateo County Access to Care for Everyone Program Supports
- San Mateo Medical Association Community Service Foundation
- SCAN Foundation
- STEPS dues subsidy program

RESOURCES BY IDENTIFIED HEALTH NEED (LIST A)

AGENCY OR ORGANIZATION	CANCER	CLIMATE/ NATURAL ENVIRONMENT	MATERNAL & INFANT HEALTH	SEXUALLY TRANSMITTED INFECTIONS
American Cancer Society	X			
Bay Area Cancer Connections (incl. Gabriella Patser Program)	X			
Colon Cancer Community Awareness campaign	X			
Joy Luck Club	X			
Relay For Life	X			
Samaritan House, Breast Care Clinic	X			
"Look Good, Feel Better"	X			
County of San Mateo Office of Sustainability		X		
The Watershed Project		X		
First 5 San Mateo County			X	

AGENCY OR ORGANIZATION	CANCER	CLIMATE/ NATURAL ENVIRONMENT	MATERNAL & INFANT HEALTH	SEXUALLY TRANSMITTED INFECTIONS
La Leche League			X	
March of Dimes			X	
Mid-Coastal CA Prenatal Outreach Program			X	
Nursing Mothers Counsel			X	
Preeclampsia Foundation			X	
San Mateo County Health Department Black Infant Health Project			X	
San Mateo County Health Department Nurse-Family Partnership program			X	
San Mateo County Health Department Pre-to-3 Program			X	
San Mateo County Health Department WIC			X	
Sequoia Hospital Lactation Center			X	

AGENCY OR ORGANIZATION	CANCER	CLIMATE/ NATURAL ENVIRONMENT	MATERNAL & INFANT HEALTH	SEXUALLY TRANSMITTED INFECTIONS
American Lung Association				
Breathe California Smoking Cessation Classes				
Health Connected				X
Peer Health Exchange				X
San Mateo County Fall Prevention Coalition				
San Mateo County Poison Control				

RESOURCES THAT ADDRESS MULTIPLE HEALTH NEEDS (LIST B)

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
12-step recovery programs	X		X		

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
Acknowledge Alliance	X				
Adolescent Counseling Services	X				
ALICE: Filipino organization		X			
American Board for Child Diabetics			X		
Asian American Recovery Services	X	X			
Bay Area Community Health Advisory Council			X		
Boys & Girls Clubs of North San Mateo County	X				
Caminar	X				
Catholic Charities	X				
Cleo Eulau Center	X				
Coastside Adult Day Health Center	X				

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
Coastside Hope				X	X
Community Overcoming Relationship Abuse (CORA)	X	X			X
Daly City Community Services Center	X	X	X	X	X
Daly City Peninsula Partnership Collaborative	X	X	X	X	X
Daly City Youth Health Center	X	X	X		
Edgewood Center for Children & Families	X	X		X	
El Centro de Libertad	X	X			
Elder Abuse Prevention Task Force		X			
Fair Oaks Community Center				X	X
Freedom House	X				
Fresh Lifelines for Youth	X	X		X	

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
Friends for Youth	X				
Health Right 360 San Mateo	X				
HIP Housing					X
Home & Hope					X
Job Train				X	
Latino Commission	X				
LifeMoves	X	X		X	X
Mental Health Association of San Mateo County	X				
National Alliance on Mental Illness/San Mateo County	X				
Niroga Institute	X				
North Peninsula Food Pantry & Dining Center of Daly City				X	
One Life Counseling Center	X				

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
Pacific Stroke Association			X		
Pacifica Resource Center				X	X
Peace Development Fund		X			
Peninsula Bridge				X	
Peninsula Conflict Resolution Center		X	X		
Peninsula Family Service	X		X	X	
Peninsula Kidpower, Teenpower, Fullpower		X			
Pre-to-3 Program			X		
Puente de la Costa Sur	X		X	X	X
Rape Trauma Services	X	X			
Ravenswood Family Health Center	X		X		
Rebuilding Together Peninsula					X

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
SafeKids Coalition of Santa Clara and San Mateo Counties		X	X		
Samaritan House			X	X	X
San Mateo County Behavioral Health and Recovery Services Clinics	X				
San Mateo County Human Trafficking Initiative		X			
San Mateo County Pride Center	X	X			
San Mateo Police Activities League			X		
Second Careers Employment Program				X	
Second Harvest Food Bank				X	
Sequoia Strong	X		X		
Sitike Counseling Center	X				

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
StarVista	X				
Streets Alive! Parks Alive!			X		
Strong for Life			X		
Via Heart Project					
Women's Recovery Association	X				
YMCA	X		X	X	X
Youth Mental Health First Aid Training	X				
Community/Senior Centers					
Adaptive Physical Education Center (Redwood City)			X		
Fair Oaks Adult Activity Center (Redwood City)			X	X	
Little House Activity Center (Menlo Park)			X	X	

AGENCY OR ORGANIZATION	BEHAVIORAL HEALTH	COMMUNITY SAFETY	DIABETES & OBESITY	ECONOMIC SECURITY	HOUSING/ HOMELESSNESS
San Carlos Adult Community Center			X		
Twin Pines Senior & Community Center (Belmont)			X	X	
Veterans Memorial Senior Center (Redwood City)			X		

ATTACHMENT 6: COMMUNITY ASSETS AND RESOURCES, SANTA CLARA COUNTY

Programs and resources available to meet identified community health needs are listed on the following pages, organized in two categories:

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

GENERAL RESOURCES

- 211 (United Way). A free, confidential referral and information service that helps people find local health and human services by web, phone, and text.
- Aunt Bertha aka FindHelp.org
- Community Health Partnership
- Ethiopian Community Services
- FIRST 5 Santa Clara County (children 0-5)
- The Health Trust
- Listing of Santa Clara County programs and services
- Santa Clara County Public Health Department
- Vietnamese-American Service Center

COMMUNITY HEALTH NEEDS

BEHAVIORAL HEALTH

Assets

- ASPIRE youth mental health program
- CareSolace
- Corporation/El Centro de Bienestar
- Depression and Bipolar Support Alliance (DBSA)
- Gardner Family Care
- Gilroy Behavioral Health
- HEARD (Health Care Alliance for Response to Adolescent Depression)
- Hope Counseling Center Services
- NAMI
- Project Safety Net (Palo Alto) youth suicide prevention coalition
- South Bay Project Resource

- Tobacco Free Coalition Santa Clara
- UJIMA Adult & Family Services
- Young Adult Transition Team same as La Plumas Mental Health

Resources

- Adolescent Counseling Services
- allcove
- Alum Rock Counseling Center
- Asian Americans for Community Involvement (AACI) support services for survivors of domestic violence
- Bay Area Children's Association (BACA)
- Bill Wilson Center
- Billy DeFrank LGBT Community Center
- CA Dept of Rehabilitation, San Jose District
- Caminar
- Casa de Clara
- Catholic Charities
- Chamberlain's Mental Health (Gilroy)
- Child Advocates of Silicon Valley
- Community Health Awareness Council (CHAC)
- Community Solutions
- Counseling and Support Services for Youth (CASSY)
- Crestwood Behavioral Health
- County of Santa Clara Behavioral Health Services, including Mental Health Crisis Services and The Q Corner (LGBTQ+ support)
- Discovery Counseling Center (Morgan Hill)
- Eastern European Services Agency
- Eating Disorder Resource Center of Silicon Valley
- Ethnic Cultural Community Advisory Committees (ECCAC)
- Grace Community Center
- In-Home Supportive Services (IHSS)
- Jewish Family Services of Silicon Valley
- Josefa Chaboya de Narvaez Mental Health
- Law Foundation of Silicon Valley Mental Health Advocacy Project
- LGBT Youth Space Drop-In Center
- LifeMoves counseling
- Maitri support services for survivors of domestic violence
- MayView Community Health Centers, members of Ravenswood Family Health Network (Mountain View, Palo Alto, Sunnyvale)
- Mekong Community Center
- Mental Health Urgent Care

- Momentum for Mental Health
- Momentum-Alliance for Community Care
- NAMI (National Alliance on Mental Illness)
- Next Door Solutions support services for survivors of domestic violence and gender-based violence, therapy, counseling, support groups
- Parents Helping Parents
- Ravenswood Family Health Center
- Rebekah's Children's Services (Gilroy)
- Recovery Café
- San José Behavioral Health Hospital
- San José Vet Center
- Santa Clara Valley Medical Center Sunnyvale Behavioral Health Center
- Services for Brain Injury
- Silicon Valley Independent Living Center (SVILC)
- Sourcewise
- Supporting Mamas
- Uplift Family Services
- YMCA Silicon Valley Project Cornerstone and support services for survivors of domestic violence

CANCER

Assets

- American Cancer Society
- Bonnie J. Addario Lung Cancer Foundation
- Cancer Support Community
- Leukemia & Lymphoma Society
- Vietnamese Reach for Health Initiative

Resources

- Asian American Cancer Support Network
- Bay Area Cancer Connections
- Cancer CAREpoint
- Latinas Contra Cancer
- Real Options - mammograms

CLIMATE/NATURAL ENVIRONMENT

Assets

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

COMMUNITY SAFETY

Assets

- County of Santa Clara East San José Prevention Efforts Advance Community Equity Partnership - PEACE Partnership
- Promoting Healthy Relationships Campaign in South San José/South County
- SafeCare Home Visiting Services
- Safe Kids Santa Clara/San Mateo coalition
- Santa Clara County Child Abuse Prevention Council
- Santa Clara County Human Relations Commission
- Santa Clara County Office of Gender-Based Violence Prevention
- Santa Clara County Office of Women's Policy: Santa Clara County Domestic Violence Council
- Santa Clara County Public Health Department, including "We All Play a Role" in Violence Free Communities Campaign, Safe and Healthy Communities Division (violence and injury prevention) including anti-bullying resources for parents
- South County United for Health collaborative
- South County Youth Task Force

Resources

- Alum Rock Counseling Center
- Asian Americans for Community Involvement – Asian Women's Home, Center for Survivors of Torture
- Bill Wilson Center: Safe Place
- CHAC (Community Health Awareness Counseling)

- Community Solutions
- Family & Children Services of Silicon Valley: Domestic Violence Survivor Support Services
- GoNoodle online lessons on bullying awareness
- ICAN (Vietnamese parenting classes)
- Maitri: Anjali Transitional Housing Program
- Next Door Solutions to Domestic Violence: The Shelter Next Door
- Peace Builders Program (elementary schools)
- PlayWorks
- Rebekah Children's Services
- San José Mayor's Gang Prevention Task Force
- San José Police Department Family Violence Center
- Santa Clara County Juvenile Probation Department programs
- StrongHearts Native Helpline: domestic and sexual violence helpline
- Sunday Friends violence prevention classes
- Uplift Family Services counseling for all high schools in the Campbell Union High School District; Crisis Intervention Programs
- YMCA Silicon Valley / Project Cornerstone, Support Services, Emergency Shelter

DIABETES & OBESITY

See Economic Stability for free food resources.

Assets

- Bay Area Nutrition and Physical Activity Collaborative (BANPAC)
- California WALKS Program
- Community Alliance with Family Farmers (CAFF) Foundation:
- Green Belt Alliance
- Pacific Institute
- Santa Clara County Diabetes Prevention Initiative
- Santa Clara County Office of Education's Coordinated School Health Advisory Council
- Sunnyvale Collaborative
- YMCA National Diabetes Prevention Program

Resources

- African American Community Services Agency
- Asian Americans for Community Involvement Clinic
- Boys and Girls Clubs of Silicon Valley
- Breathe CA

- Challenge Diabetes Program
- Children's Discovery Museum
- Choices for Children: 5 Keys for Child Care
- Community Service Agency Mountain View
- County of Santa Clara Parks and Recreation Department (incl. community centers)
- Eritrean Community Center
- Ethiopian Community Center
- FIRST 5 Family Resource Centers
- Fit Kids Foundation
- Gardner Clinic
- Healthier Kids Foundation
- Kaiser Permanente Farmer's Markets (open to the community)
- Lucile Packard Children's Hospital Pediatric Weight Control Program
- Playworks
- Project Access
- San Francisco Planning & Urban Research (SPUR) Double Up Food Bucks
- Santa Clara County Public Health Department Breastfeeding Program
- Silicon Valley HealthCorps
- Second Harvest Food Bank
- Somos Mayfair
- Sunnyvale Community Services
- THINK Together
- Veggielution: Healthy Food Access and Engagement for Low-Income Families
- West Valley Community Services

ECONOMIC STABILITY

Education, employment, and poverty. See also Housing and Homelessness.

Assets

- California Budget & Policy Center
- Silicon Valley Leadership Group

Resources

- African American Community Services Agency
- allcove
- Bay Area Legal Aid

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

Food Resources

- The Food Connection
- Fresh Approach –mobile food pantry
- Hope's Corner
- Loaves and Fishes
- Meals on Wheels (The Health Trust and Sourcewise)
- Santa Maria Urban Ministries
- St. Joseph's Cathedral
- St. Joseph's Family Center—food bank and hot meals (Gilroy)
- St. Vincent De Paul
- Salvation Army
- Second Harvest Food Bank
- Valley Verde
- Vietnamese-American Service Center

HEALTH CARE ACCESS AND DELIVERY

Health Care Facilities and Systems

- El Camino Hospital – Los Gatos
- El Camino Hospital – Mountain View
- Good Samaritan Hospital

- Kaiser Foundation Hospital – San Jose
- Kaiser Foundation Hospital – Santa Clara
- Lucile Packard Children's Hospital Stanford
- O'Connor Hospital
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara Valley Health & Hospital System
- Stanford Health Care
- VA Hospital Menlo Park (U.S. Department of Veterans Affairs)
- VA Palo Alto Health (U.S. Department of Veterans Affairs)

Community Clinics

- Asian Americans for Community Involvement
- allcove (physical health consultation for youth 12-25)
- Bay Area Community Health (formerly Foothill Community Health Center; multiple clinics)
- Cardinal Free Clinics (incl. Pacific Free Clinic)
- Gardner Health Services
- Indian Health Center
- Mar Monte Community Clinic
- MayView Community Health Centers, members of Ravenswood Family Health Network (Mountain View, Palo Alto, Sunnyvale)
- Medical Respite Program
- Planned Parenthood Mar Monte
- Peninsula Healthcare Connection
- Ravenswood Family Health Center
- Roots Community Health Center
- RotaCare Bay Area
- School Health Clinics of Santa Clara County

Mobile Health Services

- County of Santa Clara Public Health Department Needle Exchange Program sites
- Gardner Mobile Health Center
- Health Mobile (Dental)
- Lucile Packard Children's Hospital Teen Van
- Santa Clara Valley Homeless Health Care Program Van

Oral/Dental Health Assets

- County of Santa Clara Public Health Department Oral Health Program
- First 5 – oral health education and referral services
- Santa Clara County Dental Society
- Women, Infants, and Children (WIC)

Oral/Dental Health Resources

- Children's Dental Center
- Foothill Community Health Center
- Head Start
- Health Mobile
- Healthier Kids Foundation
- Onsite Dental Care Foundation
- Santa Clara Valley Medical Center Dental Clinics

Other Access-Related Assets

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

Other Access-Related Resources

- Avenidas
- City Team Ministries
- College health centers (public and private universities [4], community colleges [7])
- Community Services Agency
- El Camino Hospital Roadrunners
- Heart of the Valley Escorted Transportation (nonprofit)
- Love Inc.
- Mountain View Community Shuttle
- Outreach & Escort, Inc.
- Peninsula Family Services – Ways to Work
- School health clinics (San José High, Overfelt, Washington, Franklin-McKinley Neighborhoods)

HOUSING & HOMELESSNESS

Assets

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

Resources

- Asian Americans for Community Involvement (AACI) domestic violence shelter
- American Vets Career Center
- Bill Wilson Center emergency shelter for youth
- Casa de Clara (Catholic volunteer group—services to women and children in downtown San José including shelter, food, clothing, emotional support, and referrals for housing, employment, and counseling)
- Catholic Charities Housing—affordable housing units
- Chinese Community Center of the Peninsula
- CityTeam
- Community Services Agency emergency shelter
- Community Service Agency Homeless Prevention Services
- Community Solutions domestic violence shelter
- Destination Home
- Downtown Streets Team
- Dress for Success—interview suits and job development
- EHC Life Builders Emergency Housing Consortium
- Foster youth group home providers
- Gilroy Compassion Center

- Goodwill Silicon Valley
- The Health Trust Housing for Health
- HomeFirst
- Hope Services—employment for adults with developmental disabilities
- Housing Opportunities for Persons with AIDS
- InnVision the Way Home
- Life Moves (Homeless Housing)
- Love Inc.
- Maitri transitional housing for domestic violence survivors
- New Directions
- New Hope House
- Next Door Solutions domestic violence shelter
- NOVA Workforce development
- Rebuilding Together (repairs to keep people in homes)
- Sacred Heart Community Services
- Sacred Heart Community Services emergency assistance
- St. Joseph emergency assistance
- Salvation Army
- Senior Housing Solutions
- Sunnyvale Community Services—housing and emergency assistance
- Unity Care—Foster youth housing
- Unity Care—foster youth employment assistance Community-Based Organizations - Employment
- West Valley Community Services emergency assistance
- YWCA Silicon Valley domestic violence shelter

MATERNAL/INFANT HEALTH

Assets

- Healthier Kids Foundation
- March of Dimes

Resources

- Birthright of San José
- Casa Natal Birth and Wellness Center
- Continuation schools (parenting classes)
- First 5 Santa Clara County New Parent Kits
- Grail Family Services
- Informed Choices (Gilroy)

- La Leche League (Campbell, San José, Santa Clara)
- Nursing Mothers Counsel
- Real Options — prenatal care
- San Juan Diego Women's Center / Birth and Beyond
- Santa Clara County Department of Public Health: Black Infant Health (BIH) Program, Breastfeeding Support Program, Nurse-Family Partnership Program home visitation model, WIC
- Supporting Mamas

SEXUALLY TRANSMITTED INFECTIONS

Assets

- Santa Clara County HIV Commission

Resources

- Asian Americans for Community Involvement: HOPE Program
- Asian American Recovery Services
- Billy DeFrank LGBT Community Center
- Community Health Partnership—Every Woman Counts, Transgender Health
- The Health Trust AIDS Services
- The LGBTQ Youth Space
- Real Options
- Santa Clara County Needle Exchange Program
- Teen Success

ATTACHMENT 7: IRS CHECKLIST

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

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

Federal Requirements Checklist	Regulation Section Number	Report Reference
CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii) (b)(5)(i) (b)(6)(F)(iii)	Section #5
Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(6)(F)(iii)	Section #5
a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health.	(b)(5)(i)(A)	Section #5 & Attachment 3
b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(5)(i)(B)	Section #5 & Attachment 3
I. Medically underserved populations	(b)(5)(i)(B)	Section #5 & Attachment 3
II. Low-income populations	(b)(5)(i)(B)	Section #5 & Attachment 3
III. Minority populations	(b)(5)(i)(B)	Section #5 & Attachment 3
c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(ii)	Section #5 & Attachment 3
Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(6)(F)(iii)	Section #5 & Attachment 3
Describes over what time period such input was provided and between what approximate dates.	(b)(6)(F)(iii)	Section #5 & Attachment 3
Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	Section #5 & Attachment 3
C. CHNA Needs Description & Prioritization		
Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).	(b)(4)	Section #6
Prioritized description of significant health needs identified.	(b)(6)(i)(D)	Section #6
Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	Section #5

Federal Requirements Checklist	Regulation Section Number	Report Reference
Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	Attachments 5 & 6
D. Finalizing the CHNA		
CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	Section #2
CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	Section #8
Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)-1(b)(29).	(b)(7)(i)(A)	By 8/31/2022
a. May not be a copy marked "Draft".	(b)(7)(ii)	By 8/31/2022
b. Posted conspicuously on website (either the hospital facility's website or a conspicuously-located link to a web site established by another entity).	(b)(7)(i)(A)	By 8/31/2022
c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	By 8/31/2022
d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	By 8/31/2022
e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	By 8/31/2022
f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	By 8/31/2022

Further IRS requirements available:

- §1.501(r)-3(b)(iv) and (v): separate and joint CHNA reports
- §1.501(r)-3(d): requirements that apply to new hospital facilities, transferred or terminated hospital facilities, and newly acquired hospital facilities
- §1.501(r)-3(a)(2) and (c): implementation strategy requirements