Implementation Strategy Report and Community Benefit Plan, FY2024

Dedicated to improving the health and well-being of the people in our community.

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II. ABOUT EL CAMINO HEALTHCARE DISTRICT

El Camino Healthcare District was formed to provide healthcare services that foster good physical and mental health. The District is governed by a five-member publicly elected Board and provides oversight of El Camino Health[1]. The District also administers a Community Benefit Program, which addresses unmet health needs through grants and collaborations with local schools, nonprofits and social and health service providers.

MISSION

It is the purpose of the Healthcare District to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to do any and all other acts and things necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

COMMUNITY BENEFIT PROGRAM

El Camino Healthcare District utilizes El Camino Health's Community Health Needs Assessment (CHNA) as a framework for Community Benefit funding. The CHNA is developed in compliance with IRS requirements. The District invests in programs addressing the identified health needs for community members who live, work or go to school in the District's boundaries. El Camino Healthcare District cities include most of Mountain View, Los Altos and Los Altos Hills; a large portion of Sunnyvale, and small sections of Cupertino, Santa Clara and Palo Alto.

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

Every year, the Community Benefit Annual Report informs the community about Community Benefit Program financials, the grant programs and how these funded services improve the health of vulnerable populations both through direct services and prevention initiatives.[2]

III. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Healthcare District's planned response to the needs identified through the 2022 CHNA process.

This 2024 IS Report and CB Plan is based on the 2022 CHNA and outlines El Camino Healthcare District's funding for fiscal year 2024. It will be updated annually and the update will be based on the most recently conducted CHNA.

Financial Summary

FY24 El Camino Healthcare District Community Benefit Plan:

- 56 Grants: $7,710,000
    - Requested Grant Funding: $9,723,689
- Sponsorships: $85,000
- Placeholder: $125,000
- Plan Total: $7,920,000

IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.

To be considered a health need for the purposes of the 2022 CHNA, the need had to fit a standard definition, be present in at least two data sources, and either prioritized by key informants or focus groups, or suggested by direct statistical indicators that fail benchmarks or exhibit documented inequities by race.[3] A total of 12 health needs were identified in the 2022 CHNA. The health need selection process is described in Section VI of this report.

2022 Community Health Needs List

1. Economic Stability
2. Behavioral Health
3. Housing & Homelessness
4. Health Care Access & Delivery
5. Diabetes & Obesity
6. Cancer
7. Maternal & Infant Health
8. Oral/Dental Health
9. Climate/Natural Environment
10. Unintended Injuries/Accidents
11. Community Safety
12. Sexually Transmitted Infections

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

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

VI. HEALTH NEEDS THAT EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In October 2021, the Hospital Community Benefit Committee met to review the information collected for the 2022 CHNA. The purpose of the meeting was to help select the needs El Camino Health would address, which would form the basis for its community benefit plan and implementation strategies. El Camino Health, by consensus, selected the following needs to address:

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

El Camino Healthcare District utilizes El Camino Health's CHNA and selected health needs as a framework for its Community Benefit funding.

DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

Health Care Access & Delivery (including oral health)

Health care access and delivery, which affects various other community health needs, was identified as a top health need by more than half the CHNA's focus groups and nearly one-third of key informants. Experts and county residents 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. Healthcare access may be especially problematic for youth in the community: In Santa Clara County's schools, the ratio of students to each school nurse (2,992:1) exceeds the state ratio (2,410:1) by nearly 25%.[4] Further, the county's ratio of students to school speech, language, and hearing specialists (1,126:1) is larger than the state's (1,093:1).[4] In addition, Black and Latinx Santa Clara County residents experience significantly worse health compared to county residents of other races; for example, preventable hospital stays (4,942 per 100,000 Black Medicare enrollees [adults aged 65 and over and persons with disabilities] and 3,969 per 100,000 Latinx Medicare enrollees in the county versus 3,358 per 100,000 Medicare enrollees statewide[5]) may be a sign of inequitable access to high-quality care. Certainly in East San José, one of the geographic areas where health disparities are concentrated, there is a higher percentage of individuals enrolled in Medicaid or other public health insurance (42%) compared to the state average (38%).[6] Conversely, in Sunnyvale (zip code 94085), another area of concentrated health disparities, a much lower proportion of individuals are enrolled in Medicaid/public health insurance (21%)[6], but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).[6]

Many key informants and focus group participants connected healthcare access with economic instability. For example, some mentioned that low-income residents may be required to prioritize rent and food over healthcare. Others noted that individuals who are not provided with sick time must choose to go unpaid in order to visit the doctor for themselves and/or family members, stating that expanded service hours on weekends and evenings are still needed. It was stated that low-income and undocumented county residents especially have difficulty accessing insurance. Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern; in our 2019 CHNA report, Latinx county residents were significantly less likely to have health insurance than others. Additionally, CHNA participants identified the lack of information for patients about healthcare costs as a 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 as well as patients' lack of privacy. There was also concern expressed by providers about the lower reimbursement rate for telephone appointments (i.e., without video).

The need for healthcare workforce training in order to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas that were identified included LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients who have mental health issues, are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included education of healthcare workers around public charge issues, and the need for greater language capacity. More than one in ten (11%) Santa Clara County residents speak limited English, compared to less than 10% in California overall.[6] However, there are even more-glaring geographic disparities: in Sunnyvale (zip code 94085) more than one in seven (14%), and in the East San José area more than two in ten (22%) residents speak limited English.[6] Limited English proficiency can restrict healthcare access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility in order to retain coverage were called out as 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 healthcare among these groups.

Behavioral Health (including domestic violence and trauma)

Behavioral health, which includes mental health and trauma as well as consequences such as substance use, ranked high as a health need, being prioritized by all focus groups and more than half of key informants.

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 an increased demand for services; however, children and adolescents

were of particular concern. Statistics from prior to the pandemic's advent suggest that youth mental health is an issue: Students in Santa Clara County have lower access to psychologists at school (1,199:1) compared to students statewide (1,041:1, a 15% difference).[7] Perhaps in part due to these access issues, the county's youth self-harm injury hospitalization rate (32.7 per 100,000 age 0-17) is significantly higher than the state's rate (22.4 per 100,000).[8] Experts noted the lack of mental health providers (348.0 per 100,000 people in the county vs. 352.3 per 100,000 at the state level)[9] and addiction services overall, especially 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 prior to 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.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among Santa Clara County's Black population occur at nearly twice the rate (25.0 per 100,000 people) as for all Californians (14.0 per 100,000).[10] Self-harm injury hospitalizations are much higher for the county's white youth (66.3 per 100,000 age 0-17) and Latinx youth (31.9 per 100,000) than for all California youth (22.4 per 100,000).[11] The county's white suicide rate for all ages (13 per 100,000 people) remains persistently higher than the state rate (11 per 100,000 people).[12] 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."[13] 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 community members who are Black, Indigenous, or other people of color (BIPOC) 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."[14] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) were substantially higher for Black (23.0 per 1,000) and Latinx (9.3) Santa Clara County youth than for California youth overall (4.1 per 1,000).[15]

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 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.[16] It was stated that services for people without health insurance can be expensive and difficult to access.

Diabetes & Obesity

Approximately one-third of key informants and focus groups identified diabetes and obesity as a top health need. Two experts in Santa Clara County specifically called out diabetes as a rising problem in the community, while the trend for adult obesity remains flat. Currently, 8.4% of Santa Clara County community members have diabetes, compared to 9.9% of all Californians.[17] Key informants and focus group participants identified the need for nutrition education, particularly from a young age, and some key informants further noted the cost of healthy food as a barrier to good nutrition. SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%).[18]

The lack of physical activity was cited as a driver of obesity by multiple key informants, mostly in the context of the pandemic's interference with regular activities. Associated with this concern, the county's walkability index (9.9) is worse than the state's (11.2), while the walkability index for East San José (0.8) and the 94040 zip code of Mountain View (1.5), another area of concentrated health disparities, are substantially worse than either.[19] The county's Pacific Islander and Latinx middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide; Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards.

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 Santa Clara County (22.2 per 1,000 people) compared to the state rate (48.1 per 1,000).[20] Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (31%) compared to children statewide (35%).[21] Multiple residents made the connection between unhealthy eating and mental health—what's going on "in their head and their heart."

Our 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates compared to the state, and the 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."[22]

Other Chronic Conditions (other than Diabetes & Obesity)

Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: Mortality rates for heart disease, stroke, cancer, chronic liver disease/cirrhosis, and Alzheimer's disease and other dementias are all better than state benchmarks.

However, health conditions such as cardiovascular disease, cancer, and respiratory problems are among the top 10 causes of death in the county. With regard to cancer, the rate of cancer incidence among children ages 0-19 is slightly higher in the county (19.0 per 100,000) than the state (18.2 per 100,000).[23] Mammography screening levels, an early cancer detection measure, are lower for the county's Black women (33%), Latinas (29%), and Native American women (33%) than California women overall (36%).[24] Our previous (2019) CHNA report indicated that Black county residents have a higher incidence of breast cancer, lung cancer, prostate cancer, and a higher prevalence of cancer of all sites combined, while Latina residents have a substantially higher incidence of cervical cancer. With regard to respiratory problems, the level of asthma prevalence for people of all ages is higher for Santa Clara County (10%) than the state (9%).[25] One key informant noted that asthma rates have been worsening.

An expert in chronic disease mentioned a rise in dementia-related issues. Additionally, two health experts mentioned the issue of hypertension, one in conjunction with poor mental health, and the other as a condition that is often unmanaged among unhoused patients.

There are also racial/ethnic disparities and inequities with respect to chronic conditions: Heart disease and stroke were identified as two of the chronic conditions that are often seen in data on ethnic health disparities. An expert in Black health cautioned about high rates of asthma in areas with poor air quality. There are also persistent disparities in cancer incidence rates and other cancer statistics. The rate of cancer incidence among children ages 0-19 is highest among Santa Clara County's white children (21.2 per 100,000) and Asian/Pacific Islander children (20.2 per 100,000).[23] 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, residents 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."[26]

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

Nearly all focus groups and almost three-quarters of key informants identified economic stability, including education and food insecurity, as a top community priority. According to the U.S. Office of Disease Prevention and Health Promotion, "many people can't afford things like healthy foods, health care, and housing. …People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or [chronic] conditions… may be especially limited in their

ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy."[27]

The cost of living in Santa Clara County is extremely high, and income inequality in Silicon Valley is 1.5 times higher than at the state level.[28] More specifically, the 94040 and 94043 zip code areas of Mountain View have a higher level of income inequality (both 0.5 on the Gini index) than either the county or the state overall (both 0.4 on the Gini index).[29] In addition, the East San José area experiences higher levels of Neighborhood Deprivation[30] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0).[29] Further, while the index that maps geographic access to job opportunities for the county (50, on a scale of 0 to 100) is similar to California overall (48), jobs proximity index metrics for East San Jose (2) and the 94040 zip code in Mountain View (10) are much worse.[31] The median household income in East San José ($79,602) is also lower than even the state median ($82,053), let alone the county median household income ($129,210).[29]

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of Santa Clara County Black (45%), Pacific Islander (38%), and Latinx (46%) 11th-graders met or exceeded grade-level English-language arts standards compared to California 11th-graders overall (57%).[32] Also, a smaller percentage of local Latinx 11th graders met or exceeded math standards (28%) versus California's 11th-graders (32%).[32] Related to these statistics, much smaller proportions of the county's Black (32%), Pacific Islander (34%), and Latinx (38%) high school graduates completed college-preparatory courses compared to high school graduates statewide (47%).[33] In our 2019 CHNA report, we described similar inequities in educational attainment. In some county sub-geographies in particular, the proportion of adults who do not have at least a high school diploma is much higher (East San José, 31%; 94040 in Mountain View, approximately 28%) than the state average (18%).[29] Educational inequities, often related to neighborhood segregation[34], lead to educational disparities that begin at an early age: the elementary school proficiency index, which measures the academic performance of 4th-graders, is significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4).[35]

Data available on economically precarious households shows that while 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion rises to 58% among Santa Clara County households.[36] Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards.[36] Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty).[28] In our 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 healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

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 county residents

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.[37] Prior to the pandemic, the cost of childcare may also have been a limiting factor; infant child care (age 0-2) cost $20,746 per year in Santa Clara County, compared to $17,384 on average statewide. Similarly, pre-K child care (age 3-5) cost $15,315 in Santa Clara County versus $12,168 on average in California overall.[38] Economic insecurity affects single-parent households more than dual-parent households[39]; in East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).[29]

VII. EL CAMINO HEALTHCARE DISTRICT'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Healthcare District's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, our community health investment for FY24 will be directed to improve health care access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

This plan represents the revamping of a multi-year strategic investment in community health. El Camino Healthcare District believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2022 CHNA process.

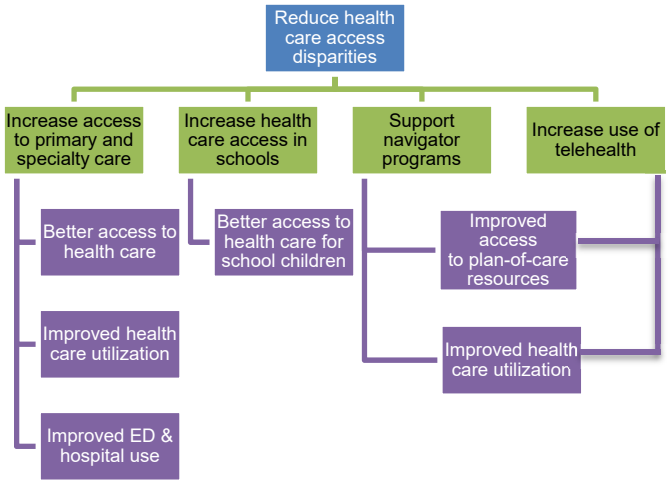
HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

El Camino Healthcare District views efforts to ensure equitable access to high-quality health care and respectful, compassionate, culturally competent delivery of health care services as a top priority for its community benefit investments. Given the community's strong focus on issues of health care access and delivery during the 2022 CHNA, El Camino Healthcare District chose goals that support initiatives to reduce disparities in access to and delivery of primary and specialty care for community members in its service area. The goals also include improvements in access to and delivery of oral health care and maternal/infant health care, based on statistical data and information provided by experts interviewed during the CHNA. The hospital expects to make a positive impact by improving health care access and utilization, reducing unnecessary emergency department visits and hospitalizations, and reducing disparities in health outcomes.

GOAL

INITIATIVES

ANTICIPATED IMPACTS

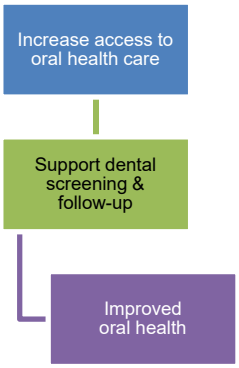


Goal	Initiative	Anticipated Impact
1. Reduce disparities in access to high-quality care	A. Support increased access to primary care and specialty care services for vulnerable individuals[40, 41, 42, 43, 44, 45, 46, 47, 48, 49]	(i) Individuals experience better access to health care (ii) Improved health care utilization (iii) Reduced unnecessary ED visits and hospitalizations
	B. Support greater access to healthcare in schools[50]	(i) Improved access to health care for school-aged children and youth
	C. Support clinical and community health navigator programs[51, 52, 53]	(i) Community members access clinical and community resources that support their plan of care
	D. Support increased use of telehealth and other technology solutions[54, 55, 56]	

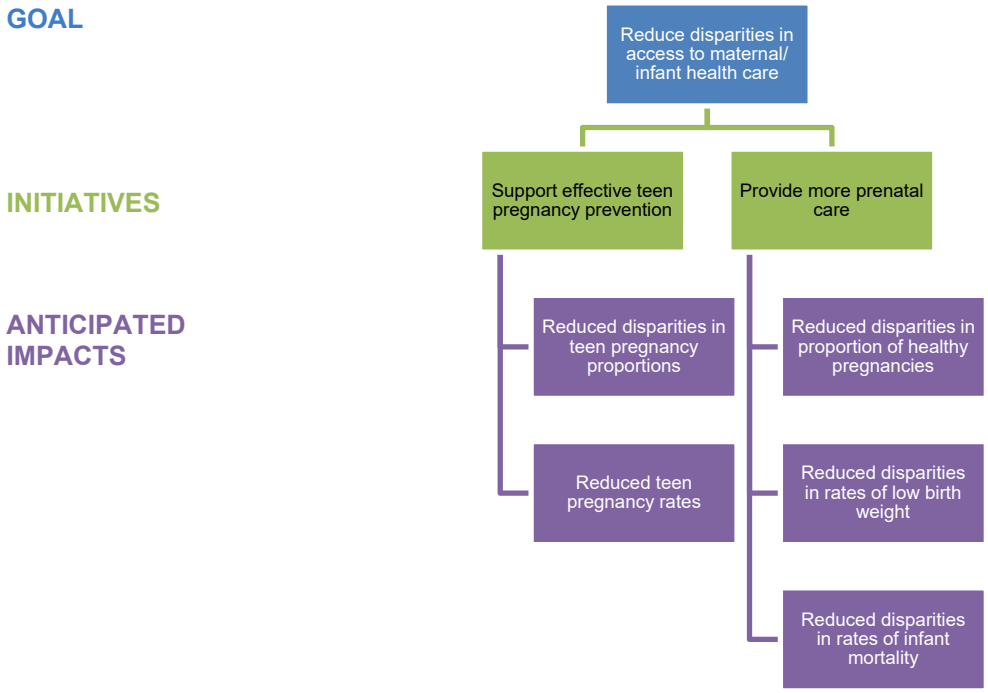
GOAL

INITIATIVE

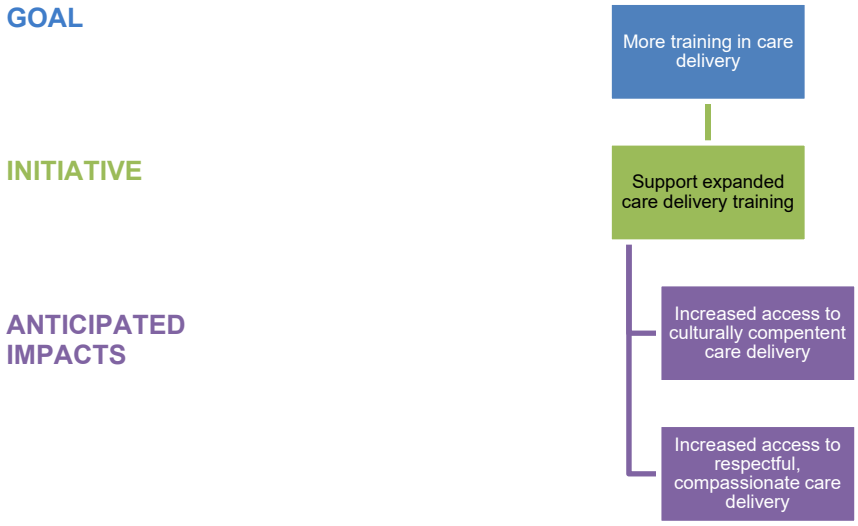
ANTICIPATED IMPACT



Goal	Initiative	Anticipated Impact
2. Increase access to oral health care for underserved community members	A. Support school- and community-based programs that offer dental screenings and care, including tele-dentistry[57, 58, 59, 60]	(i) Improved oral health among community members



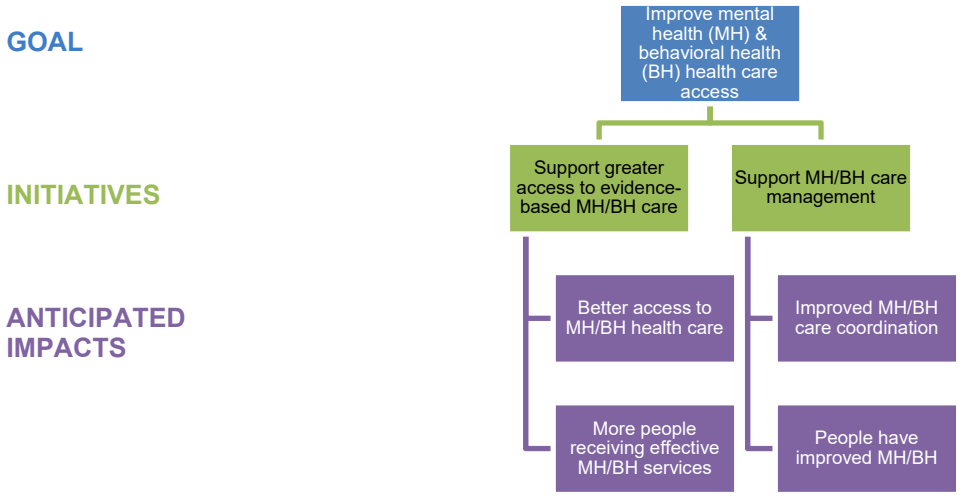
Goal	Initiative	Anticipated Impact
3. Reduce disparities and inequitable access to maternal/ infant health care for community members	A. Support effective teen pregnancy prevention programs[61, 62, 63]	(i) Reduced disparities in the proportion of teens who are pregnant (ii) Reduced proportions of teens who are pregnant
	B. Increase access to and utilization of adequate prenatal care[64, 65, 66, 67, 68]	Reduced disparities in: (i) Proportions of women with healthy pregnancies (ii) Rates of low birth weight (iii) Rates of infant mortality



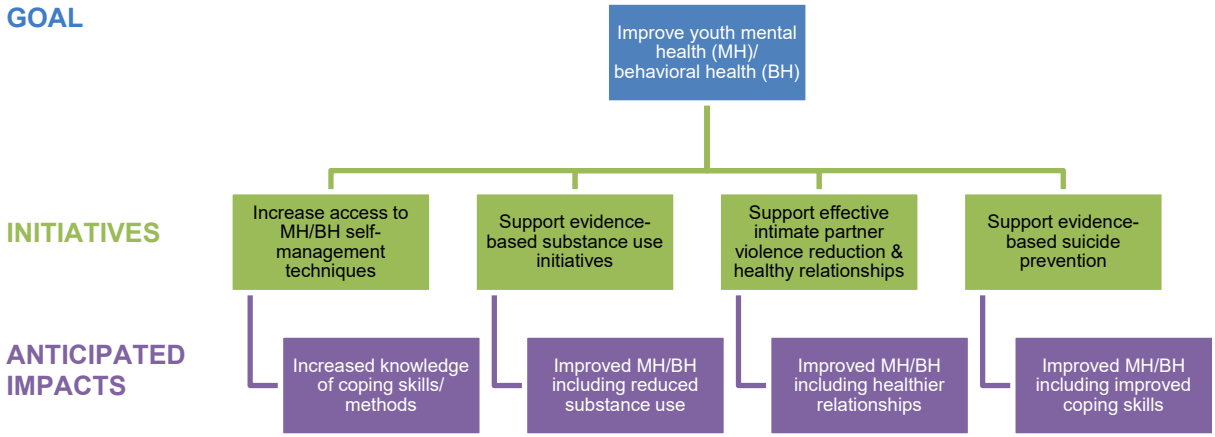
Goal	Initiative	Anticipated Impact
4. Provide/ expand workforce training in cultural competence, and compassionate and respectful care delivery	A. Support workforce training in cultural competence, and compassionate and respectful care delivery[69, 70, 71, 72]	(i) Increased access to culturally competent health care services among underserved community members, including LGBTQ+ and community members with limited English proficiency (ii) Increased access to compassionate and respectful health care among underserved community members, including LGBTQ+ and community members with limited English proficiency

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

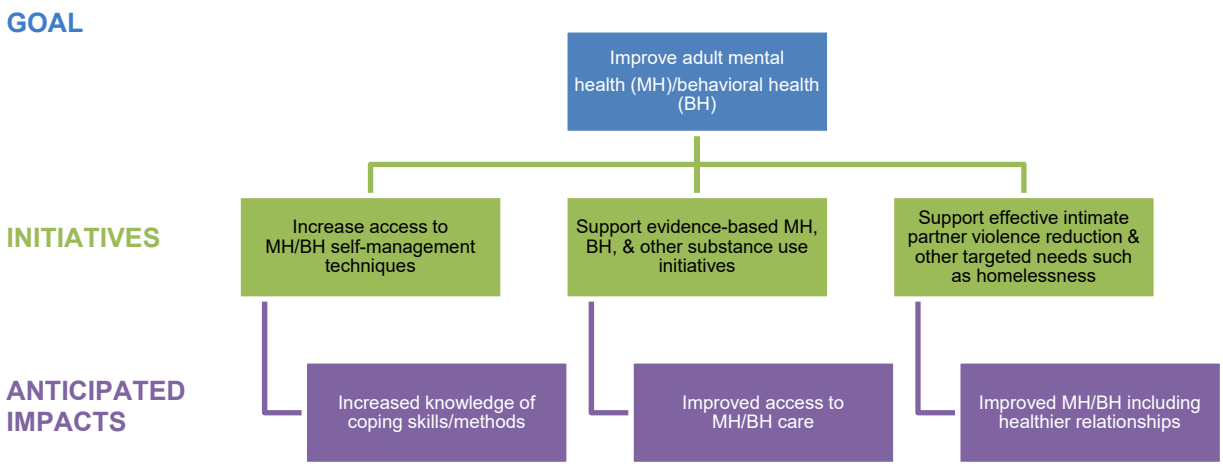
Even prior to the pandemic, data indicated that behavioral health (including mental health, trauma, and substance use) was a significant health need, especially with respect to the supply of providers. Community input during the 2022 CHNA emphasized how much worse and more widespread behavioral health issues have become due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral health care, El Camino Healthcare District chose goals that support more direct approaches to improving the mental and behavioral health of both youth and adult community members. By using a two-pronged approach, addressing access to care and care itself, El Camino Healthcare District expects to be able to make a positive impact by improving community members' mental and behavioral health, including contributing to improved coping skills, healthier relationships, and reduced substance use.



Goal	Initiative	Anticipated Impact
1. Improve mental/ behavioral health care access for community members	A. Support in-person and virtual expanded access to evidence-based counseling, addiction treatment, behavioral health case management, etc. [73, 74, 75, 76, 77]	(i) Improved access to mental/behavioral health programs and services (ii) More community members receiving effective mental/ behavioral health services
	B. Care management to support community members' self-management and mental health[78, 79]	(i) Improved coordination of mental/behavioral services (ii) Improved mental/behavioral health among those served



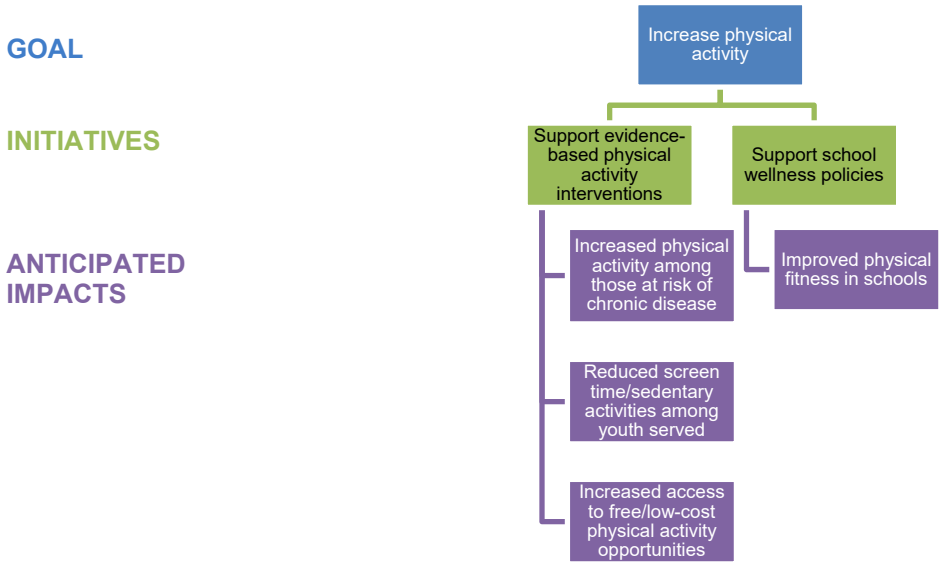
Goal	Initiative	Anticipated Impact
2. Improve mental/ behavioral health of youth in the community	A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[80 , 81]	(i) Increased knowledge among youth served about methods of coping with stress and depression
	B. Support for substance abuse initiatives with evidence of effectiveness[82, 83, 84]	(i) Improved mental health among those served, including reduced substance use
	C. Programs that prevent or reduce youth and young adult intimate partner and sexual violence and promote healthier relationships[85, 86]	(i) Improved mental health among those served, including healthier relationships
	D. Programs that reduce or prevent suicide with evidence of effectiveness[87, 88]	(i) Improved mental health among those served, including improved coping skills



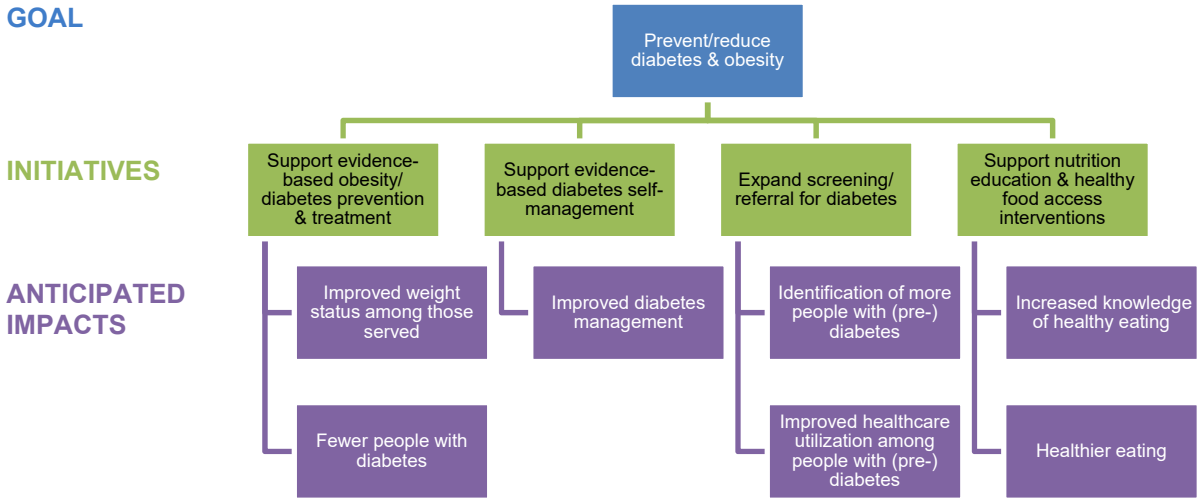
Goal	Initiative	Anticipated Impact
3. Improve mental/ behavioral health of adults in the community	A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[89, 90, 91]	(i) Increased knowledge among those served about methods of coping with depression, anxiety, and stress
	B. Support for screening, accurate diagnosis, effective treatment, and follow-up for mental/ behavioral health and substance use/ addiction treatment services[92, 93, 94]	(i) Improved access to mental and behavioral health services among those served
	C. Programs that support targeted unmet needs such as supporting individuals experiencing or at risk of homelessness or intimate partner violence[95, 96]	(i) Improved mental health among those served (ii) Improved utilization of clinical and community resources among those served

DIABETES & OBESITY

During the 2022 CHNA, community members provided input on poor food access and the lack of physical activity, both of which are drivers of diabetes and obesity. Additionally, CHNA data indicated issues with the food environment, geographic disparities in walkability, and ethnic disparities in youth fitness, among other things. Experts also indicated that diabetes rates are trending up in Santa Clara County. Therefore, El Camino Healthcare District chose goals that support initiatives that prevent or reduce obesity and diabetes, as well as those that increase physical activity, reduce food insecurity, and increase healthy food access among community members. The hospital expects these efforts will make a positive impact by contributing to improved weight status, improved diabetes management, and reduced rates of obesity & diabetes in the community.



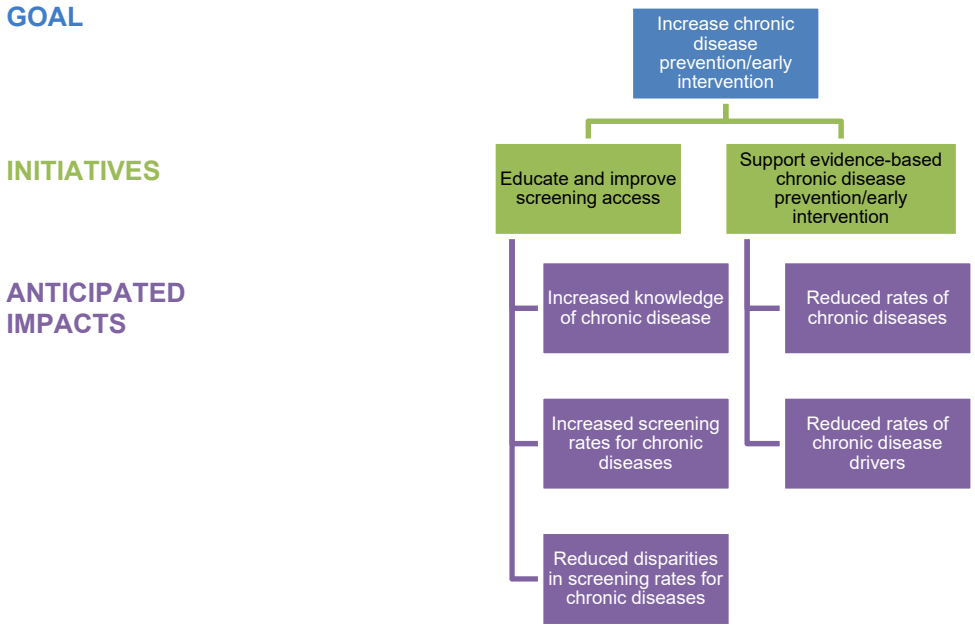
Goal	Initiative	Anticipated Impact
1. Increase physical activity among community members	A. Support physical activity interventions shown to contribute to weight loss and reduced screen time among youth and adults[97, 98, 99, 100]	(i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions (ii) Reduced screen time & time on sedentary activities among youth served (iii) Increased access to and utilization of free/low-cost opportunities for physical activity
	B. Support implementation of school wellness policies for promoting physical activity[101]	(i) Improved physical fitness among students in schools served



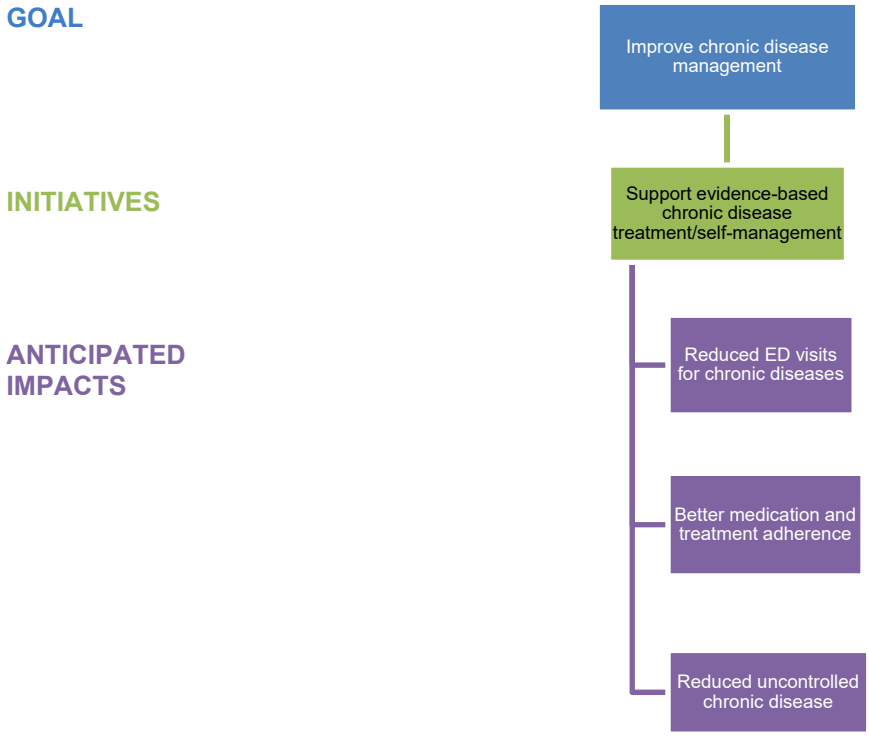
Goal	Initiative	Anticipated Impact
2. Prevent/ reduce obesity & diabetes among community members	A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[102, 103, 104, 105, 106, 107, 108, 109, 110]	(i) Improved weight status in youth and adults served (ii) Long-term reduction in the number of community members with diabetes
	B. Support diabetes treatment/self-management programs with evidence of effectiveness[111, 112, 113, 114, 115]	(i) Improved diabetes management in participants served
	C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[116, 117]	(i) Identification of more individuals with diabetes and pre-diabetes (ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes
	D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[118, 119, 120, 121]	(i) Increased knowledge and understanding about healthy eating among people served (ii) Healthier eating among community members receiving interventions

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

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



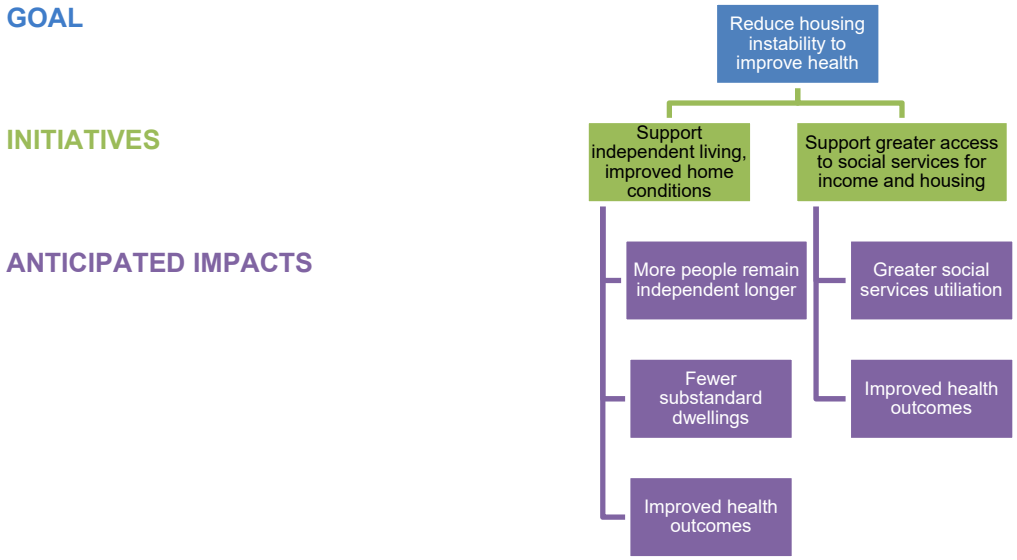
Goal	Initiative	Anticipated Impact
1. Increase prevention and early intervention of chronic diseases in the community	A. Provide education and improve access to screenings[122, 123, 124, 125, 126, 127, 128]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening for chronic disease (iii) Reduced disparities in chronic disease screening rates
	B. Support evidence-based chronic disease prevention and early intervention programs[129, 130, 131]	(i) Reduced rates of chronic diseases (ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc.



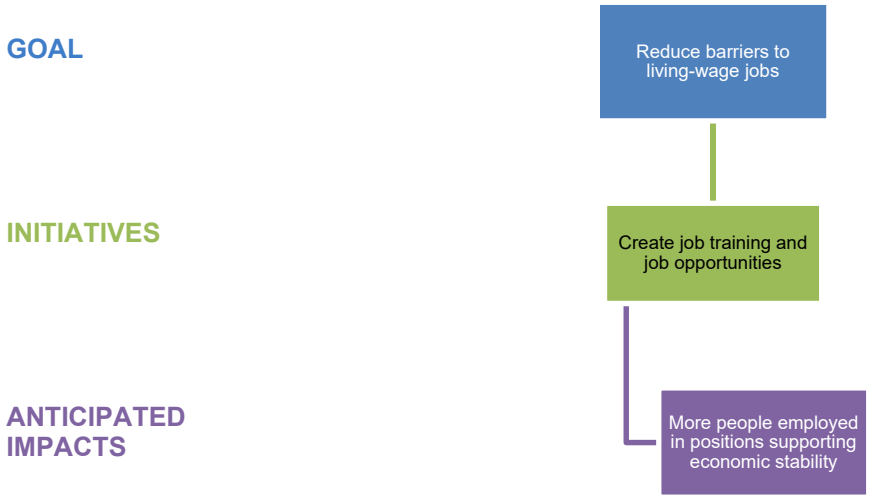
Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[132, 133, 134]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication and treatment adherence (iii) Reduced rates of uncontrolled chronic disease

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

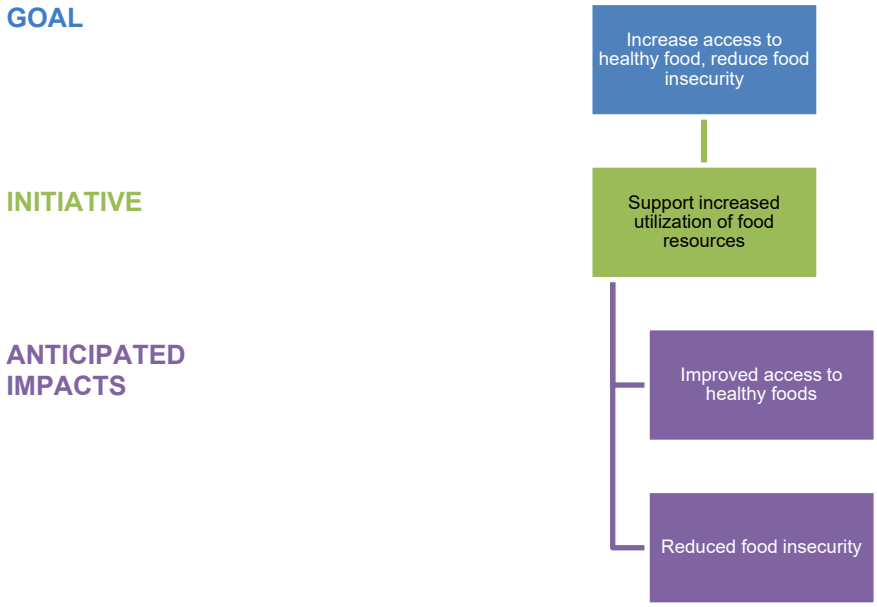
Economic stability was a top priority for the community in the 2022 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and health care are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Healthcare District chose goals that support initiatives to reduce housing instability, food insecurity, and barriers to living-wage employment. Through efforts to address community members' basic needs, El Camino Healthcare District believes it will make a positive impact via increased utilization of social services and improved well-being and health outcomes among community members.



Goal	Initiative	Anticipated Impact
1. Reduce housing instability among community members	A. Support independent living and efforts to improve substandard living conditions[135, 136, 137]	(i) More community members remain independent longer (ii) Reduced number of sub-standard dwellings (iii) Improved health outcomes for those at-risk of and/or experiencing homelessness
	B. Support efforts to improve access to social services that address income and housing insecurity[138, 139, 140]	(i) Increase in social services utilization (ii) Improved health outcomes for those at-risk of and/or experiencing homelessness



Goal	Initiative	Anticipated Impact
2. Reduce barriers to employment/ careers that provide community members with a living wage	A. Create workforce training and employment opportunities for underrepresented populations[141, 142, 143, 144]	(i) More community members employed in positions that support economic stability



Goal	Initiative	Anticipated Impact
3. Reduce food insecurity and increase healthy food access for low-income community members	A. Support increased utilization of healthy/ culturally appropriate food through CalFresh/SNAP enrollment, existing food banks, and other sites[145, 146]	(i) Improved access to healthy food options (ii) Reduced food insecurity

FISCAL YEAR 2024

Community Benefit Grant Funding

$7.7 Million invested to address unmet health needs and improve the health of the people in our community.

Healthcare Access & Delivery
(Including Oral Health)

Behavioral Health
(Including Domestic Violence & Trauma)

Diabetes & Obesity

Chronic Conditions
(Other than Diabetes & Obesity)

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Healthcare Access & Delivery

County of Santa Clara Health System — Routine, preventative dental services for underserved individuals in Mountain View and Sunnyvale

Cupertino Union School District — K-8 school nurse program

El Camino Health: Post Discharge Care Navigator — Supporting vulnerable and underserved patients in their transition from an inpatient stay to the outpatient setting

El Camino Health: Population Health Program Manager — Program manager to develop foundation for identifying and intervening to improve the health of "rising-risk" patients within healthcare district

Health Library & Resource Center Mountain View — Services to improve health literacy and knowledge of care options for patients, families, and caregivers

LifeMoves — Mental health counseling and nursing at Mountain View interim housing community

Lucile Packard Foundation for Children's Health: Teen Health Van — Mobile primary care and psychosocial services for at-risk youth at Mountain View Los Altos Union High School District

Mountain View Whisman School District — Pre-K-8 school nurse program

On-Site Dental Care Foundation — Mobile dental services and education for low-income and homeless community members in Mountain View and Sunnyvale

Pathways Home Health & Hospice — Home health and hospice services for un/under-insured individuals

Peninsula Healthcare Connection: New Directions — Intensive, community-based case management services to individuals with complex medical and psychosocial needs

Planned Parenthood Mar Monte: Mountain View Health Center — Increasing access to primary care and family medicine services for the underserved

Ravenswood Family Health Network — Multilingual, culturally competent primary healthcare, dental, and lab services for low- income residents at the Mountain View and Sunnyvale MayView clinics

RoadRunners — Healthcare transportation service for senior, disabled, and other community members

Sunnyvale School District — Pre-K-8 school nurse program

Behavioral Health

Acknowledge Alliance — Resilience and social-emotional learning lessons for students, teachers, and administrators at Sunnyvale and Mountain View Whisman school districts

Avenidas: Rose Kleiner Adult Day Health Program — Integrated daily support services for older adults with chronic conditions and mental impairments

Caminar: Domestic Violence Survivor Services Program — Bilingual, culturally competent, and trauma-informed services for local survivors of domestic violence

Caminar: LGBTQ+ Youth Space Awareness and Outreach Program — Increasing understanding and support for LGBTQ+ identities and experiences in workplace and community settings through LGBTQ+ cultural awareness presentations

Community Health Awareness Council (CHAC) — Comprehensive school based mental health service program at Sunnyvale School District

Cupertino Union School District — K-8 mental health counseling program

Eating Disorders Resource Center — Support groups and resources for individuals struggling with eating disorders

Friends for Youth — Recruiting, screening, and training mentors for at-risk youth

Kara — Bilingual comprehensive bereavement support, death-related crisis response, and grief education for low-income and monolingual Spanish or limited English speaking Latinx

Behavioral Health *(Continued)*

Law Foundation of Silicon Valley: Removing Barriers to Mental Health Access — Legal and education services for people with mental health disabilities to improve access to mental health care and safety-net benefits

Lighthouse of Hope Counseling Center — Community-based counseling services for low-income residents in Mountain View and Sunnyvale

Los Altos School District — K-8 mental health counseling program

Maitri — Comprehensive, culturally appropriate services for South Asian and immigrant survivors of domestic violence

Mission Be — Mindfulness training to students, teachers, and parents at Mountain View Los Altos High School District, Mountain View Whisman School District, and Los Altos School District

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

Mountain View Los Altos Union High School District — Mental health counseling program

My Digital TAT2 — Digital media literacy and online safety education for 3rd-5th grade students, teachers, staff, and parents in English and Spanish at Mountain View Whisman School District

National Alliance on Mental Illness (NAMI) Santa Clara County — Peer mentor support for mental illness

WomenSV — Case management, support groups and advocacy for victims of domestic violence

YWCA Golden Gate Silicon Valley: ARISE — Trauma-informed counseling services for low-income and LGBTQ+ victims of domestic violence and sexual assault

Diabetes & Obesity

American Diabetes Association: Project Power — Diabetes prevention program for youth ages 5-12 focusing on healthy eating and physical activity at school sites in Mountain View and Sunnyvale

Bay Area Women's Sports Initiative (BAWSI): BAWSI Girls in Sunnyvale — Physical activity and self-esteem program for students in Sunnyvale School District

Bay Area Women's Sports Initiative (BAWSI): BAWSI Rollers in Sunnyvale — Adaptive physical activities for girls and boys with physical, cognitive, and hearing disabilities

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

City of Sunnyvale: Columbia Neighborhood Center – ShapeUp Sunnyvale — Fitness and nutrition education program for low-income families and youth

Fresh Approach — Farmers market voucher program, nutrition education, and resources for low-income community members

Living Classroom — Garden-based education to enhance food literacy in youth at Mountain View Whisman School District

Playworks — Physical activity and positive school climate program at Sunnyvale School District

Silicon Valley Bicycle Coalition: Bike to Health — Promoting physical activity in underprivileged youth and adults through instructor-led bike rides

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

Via Services: Healthy Living at Via West — Healthy living curriculum in a camp-like setting for children and adults with special needs

YMCA of Silicon Valley — Summer camp programs for low-income youth focusing on physical activity and healthy eating

Chronic Conditions

American Heart Association: Healthy Hearts Initiative — Hypertension and pre-diabetes management classes in Mountain View and Sunnyvale

Breathe California of the Bay Area: Seniors Breathe Easy — Education, screening and training for older adults with respiratory conditions

Community Services Agency of Mountain View and Los Altos — Post-discharge intensive case management for seniors with chronic conditions

Economic Stability

Day Worker Center of Mountain View — Healthy meal distribution and health education classes for day workers and their families

Hope's Corner: Healthy Food for Hope — Nutritious meals for homeless and the food insecure

Mountain View Police Department, Youth Services Unit: Dreams and Futures Camp for At-risk Youth — Summer enrichment program for under-served 4th-8th grade students at high risk for violence and/or involvement with gangs, drugs, and/or alcohol use

Second Harvest of Silicon Valley: Food Bank — Nutritious no-cost food for low-income food insecure clients

Sunnyvale Community Services: Comprehensive Safety-Net Services — Emergency financial assistance with medically related bills for low-income residents in danger of eviction and financial assistance for medical equipment for homebound clients

Sunnyvale Community Services: Social Work & Homebound Client Case Management — Emergency assistance, case management, and services for homebound community members

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VIII. EVALUATION PLANS

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

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

The Board of Directors' support of this Implementation Strategy Report and Community Benefit Plan will allow El Camino Healthcare District to continue responding to the most pressing needs faced by vulnerable residents in our communities.

The premise — and the promise — of community benefit investments is the chance to extend the reach of resources beyond the patient community, and address the suffering of underserved, at-risk community members. These annual community grants provide direct and preventive services throughout the service area. Community Benefit support addresses gaps by funding critical, innovative services that would otherwise not likely be supported. The Implementation Strategy Report and Community Benefit Plan aims to improve the health and wellness of the El Camino Healthcare District.

ENDNOTES

[1] El Camino Hospital is the legal and funding entity for El Camino Health's community benefit program. The community benefit requirement applies to 501(c)(3) tax-exempt hospitals.

[2] https://www.elcaminohealthcaredistrict.org/community-benefit

[3] The definition of a health need is a poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need. Further definitions of terms and specific criteria for health needs identification may be found in El Camino Health's 2022 CHNA report.

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