Implementation Strategy Report and Community Benefit Plan, FY 2026

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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. 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

The mission of the El Camino Healthcare District shall be 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 undertake any and all other acts 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 utilized 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.[a]

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

III. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Healthcare Districts's planned response to the needs identified through the 2025 CHNA process.

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

Financial Summary

FY2026 El Camino Healthcare District Community Benefit Plan:

- 59 Grants: $8,413,000
  - Requested Grant Funding: $10,455,762
- Sponsorships: $90,000
- Placeholder: $497,000
- Plan Total: $9,000,000

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

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

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

2025 Community Health Needs List

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

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

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

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

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

Healthcare Access and Delivery (including oral health)

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

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

CHNA participants indicated that community-based clinics and programs providing direct healthcare services are beneficial but underfunded. In particular, participants focused on difficulties in accessing dental care, especially for low-income individuals and those on Medi-Cal. They explained that there is a significant lack of providers who actually accept Denti-Cal.

Participants noted that even basic dental care can be prohibitively expensive, leading patients to delay or forego treatment altogether.

Participants said migrant and undocumented communities struggle greatly with access to healthcare due to high costs, lack of insurance, and difficulty navigating the medical system. Many community members have challenges understanding medical terminology and knowing what questions to ask providers. Participants also mentioned access barriers for individuals with disabilities or special needs and those with poor transportation options.

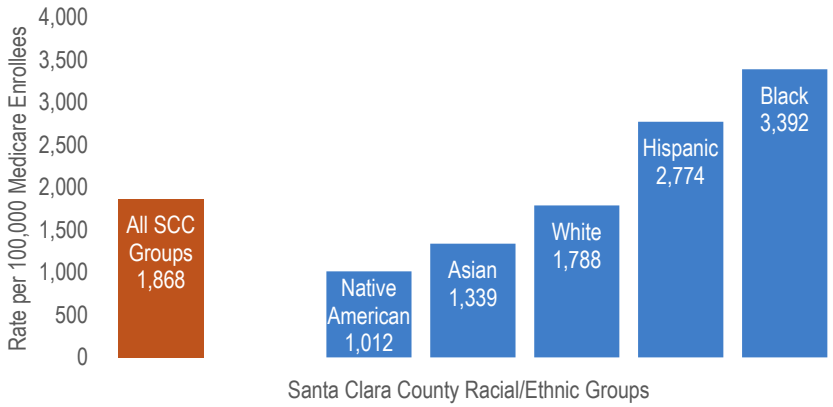
> *“Most nurses or medical practitioners do not know ASL [American Sign Language]... I do not feel good always going with the translator or having to write [things] down or wait longer periods just to be attended to.”*
>
> —Participant, Community Focus Group

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

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

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

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



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

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

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

Behavioral Health (including domestic violence and trauma)

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

CHNA participants frequently noted increases in feelings of loneliness and isolation among community members of all ages, including older adults and youth. Participants emphasized that

[c] Rates are not age-adjusted.

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

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

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

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

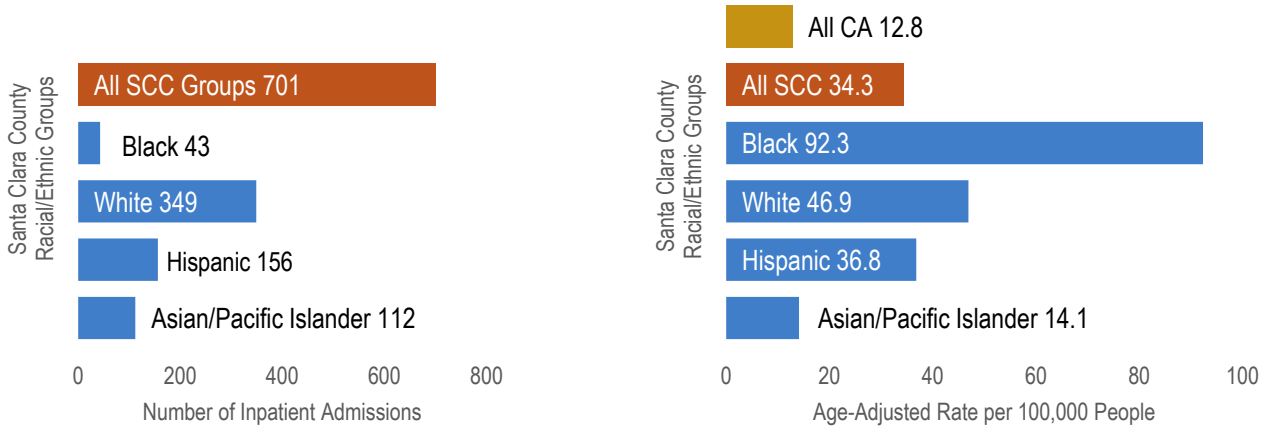
> *"You have individual trauma, you have community trauma, familial, you have generational trauma. … I also think addiction thrives in isolation and loneliness and disconnection. And when I think about this huge spike we saw of overdose deaths being driven by fentanyl and methamphetamines, I think that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

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

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

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

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



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

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

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

Diabetes and Obesity

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

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

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

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

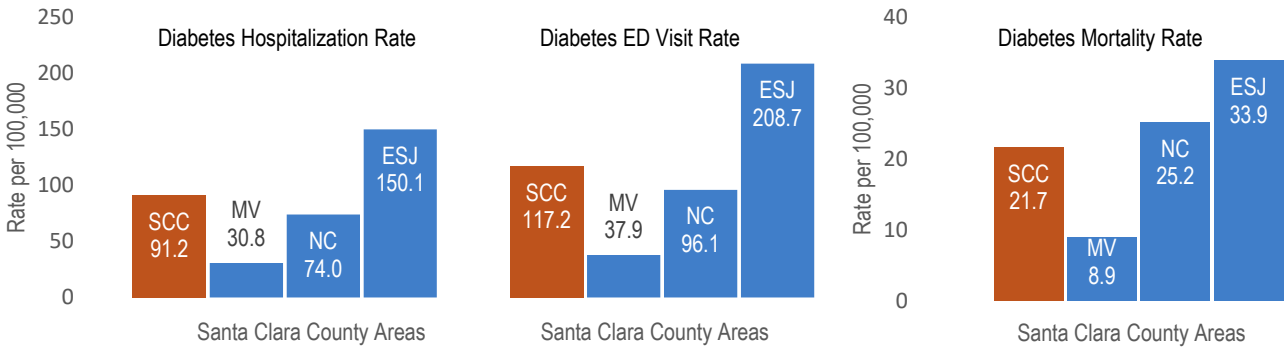
Participants noted that high copays and lack of insurance coverage for effective diabetes medications are significant barriers. They also said that access to nutritionists and proper

[e] Rates are not age-adjusted.

dietary guidance is limited, making it more difficult for patients to manage chronic conditions like diabetes effectively. One participant emphasized the challenge of underdiagnosis of prediabetes among Hispanic community members despite high diabetes rates.

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

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



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

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

None of the other available statistics (e.g., adult physical activity, child diet, food environment, exercise opportunities) are worse for the county overall compared to either neighboring San Mateo County or the state as a whole. However, these state and local benchmarks are not considered particularly healthy. For example, over 20% of Santa Clara County adults are obese, compared to 21% of San Mateo County adults and 30% of CA adults. Similar proportions

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

among adults who are physically inactive can also be found in each geography. One CHNA participant noted that physical activity is hindered by safety concerns in certain neighborhoods, making it difficult for residents to exercise freely outdoors, while others mentioned the lack of access to exercise facilities in certain areas.

Chronic Conditions (other than diabetes and obesity)

Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: overall mortality rates for Alzheimer's disease and other dementias, cancer, chronic liver disease/cirrhosis, heart disease, and stroke are all better than state benchmarks. For that reason, most of these chronic conditions were not identified as health needs in the 2025 Community Health Needs Assessment (CHNA). However, health conditions such as cancer, cardiovascular disease, and respiratory problems are among the top 10 causes of death in Santa Clara County.[g] In addition, there are some concerning statistics and data that show significant racial/ethnic disparities for cancer and respiratory conditions. Finally, El Camino Healthcare District has a commitment to continuing to address chronic conditions as a health need, given its specific expertise and long-standing work on this issue.

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

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

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

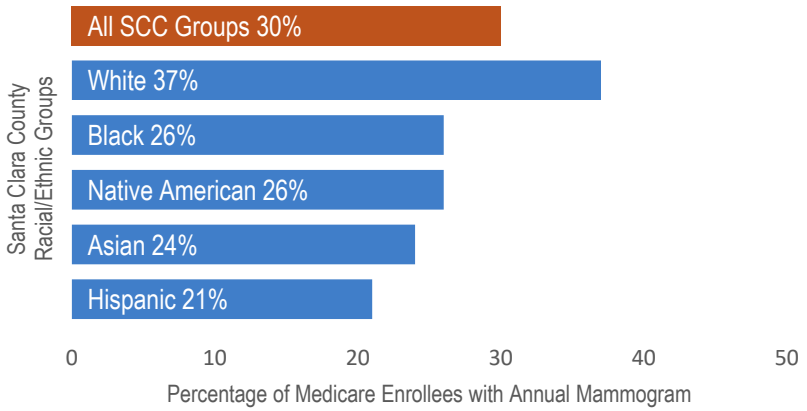
challenges accessing in-home care, made more problematic by the general absence of family support that is often due to the economic migration of younger generations.

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

— Service Provider

Although Santa Clara County's overall cancer mortality (112.0 per 100,000) is on par or better than the state (119.8), mortality by race/ethnicity indicates substantial disparities. For example, overall cancer mortality among Santa Clara County's Black population is much higher (143.5) compared to other ethnic groups. Similarly, the county's Black population has higher rates of mortality for female breast, colorectal, and prostate cancers. While the county's White population also has cancer incidence and mortality rates that exceed benchmarks, these rates are generally lower than those of the county's Black population. Mammography screening among older adults in the county is highest for White women, and lowest for Latinas.

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



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

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

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

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

Given these quantitative and qualitative data, El Camino Healthcare District has grouped cancer, cardiovascular disease, respiratory problems, Alzheimer's and dementia, and other chronic conditions into an overall category that it will address called "Chronic Conditions (other than Diabetes and Obesity)," as indicated above.

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

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

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

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

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

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

  — Service Providers' Focus Group

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

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

  — Spanish-speaking Community Member

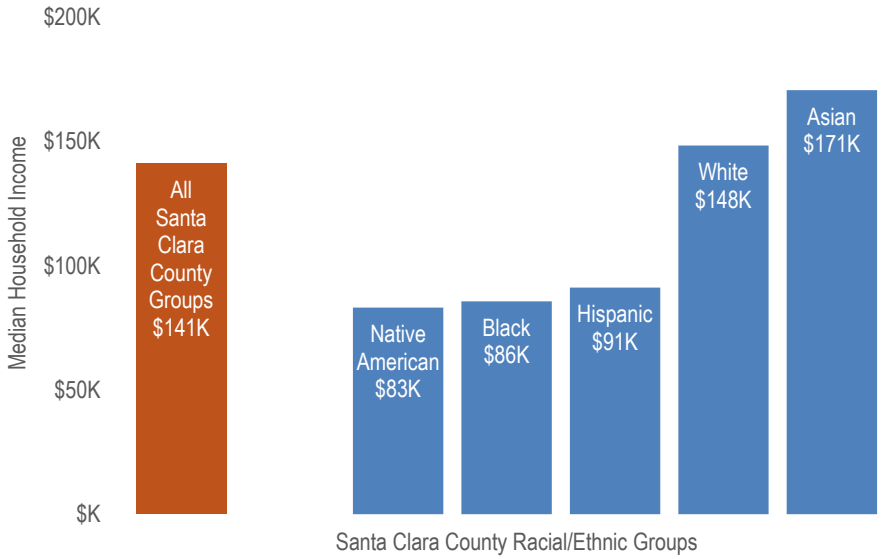
Santa Clara County's percentage of households with children below the Federal Poverty Level is higher than neighboring San Mateo County's, and is rising. In Santa Clara County, Black, Hispanic, and Native American families with children are disproportionately more likely to be in poverty than their Asian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

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

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

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

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



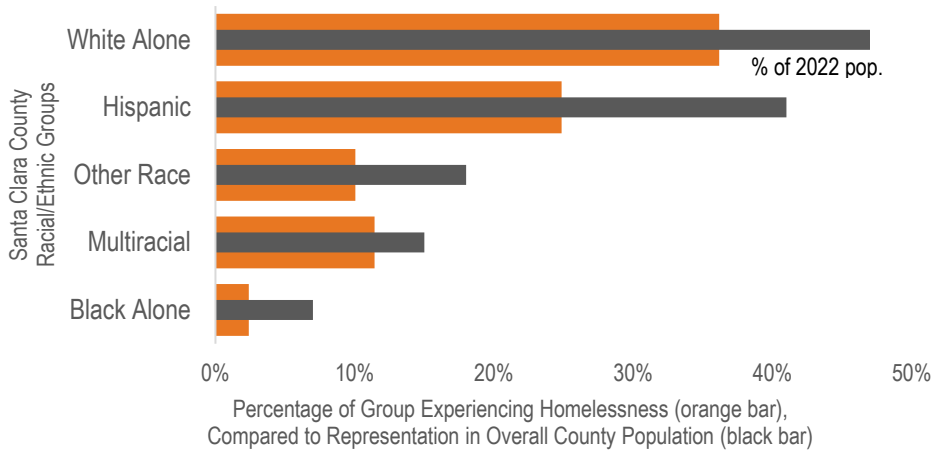
Source: US Census Bureau Small Area Income and Poverty Estimates. Retrieved from County Health Rankings, June 2024.

Santa Clara County's high school graduation rate was lower (83%) than the state rate (88%) in 2022, with the county's Hispanic students more likely than students of other ethnic groups to drop out before graduation. Education has generally and historically correlated directly with income, so educational statistics that differ by race/ethnicity are particularly concerning to CHNA participants.

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

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

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



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

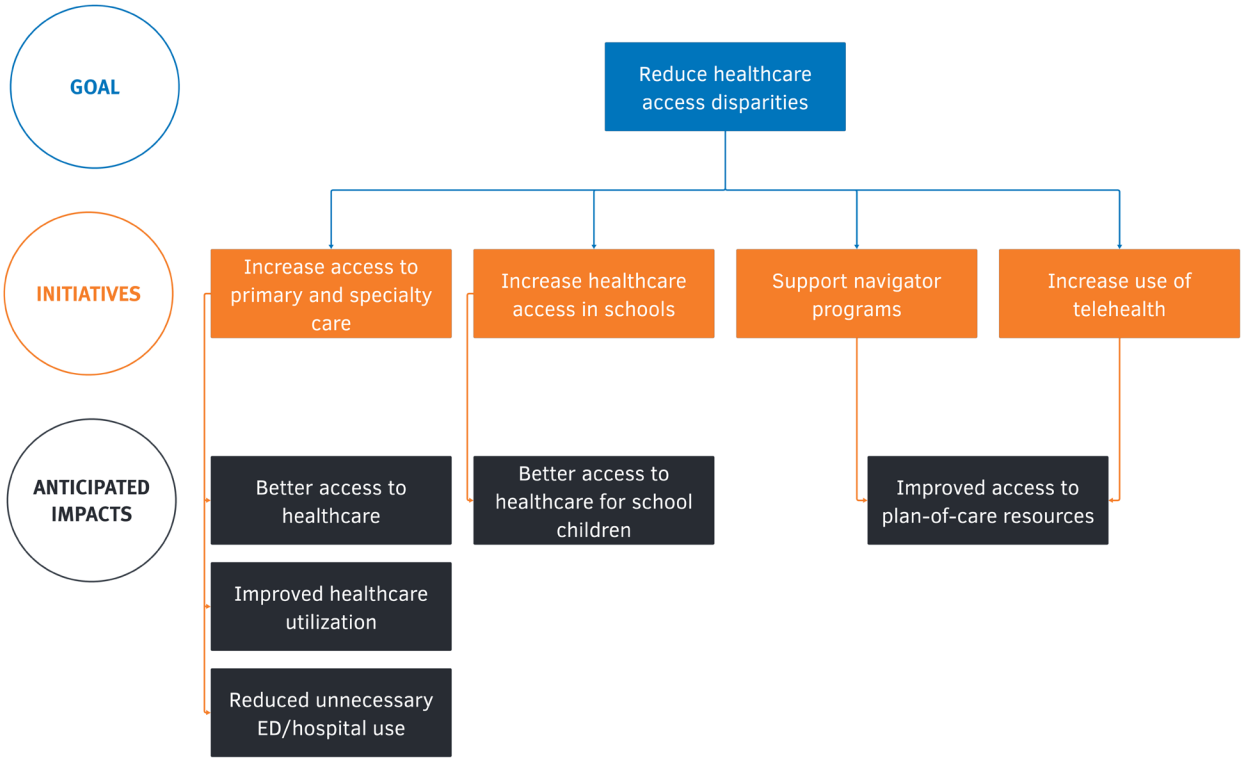
VII. EL CAMINO HEALTHCARE DISTRICT'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

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 FY 2026 will be directed to improve healthcare access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

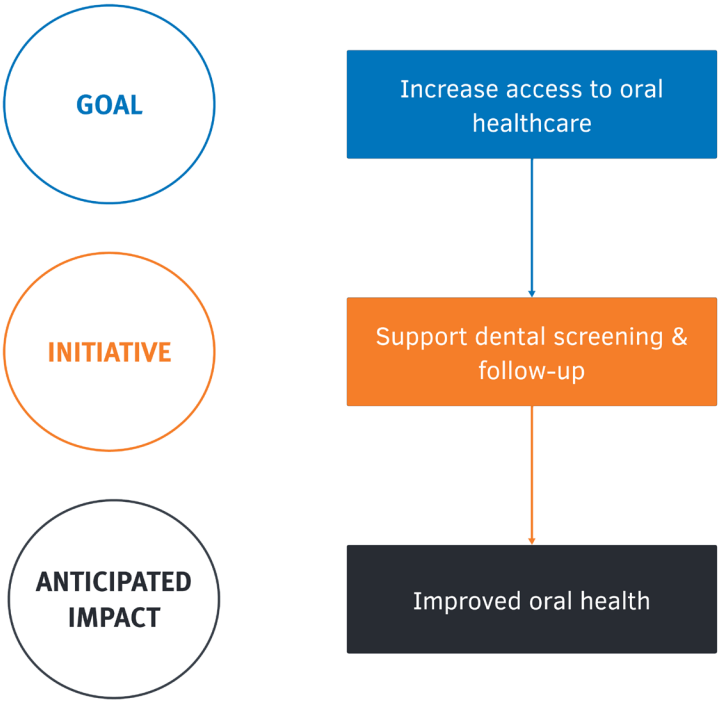
El Camino Healthcare District believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are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

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

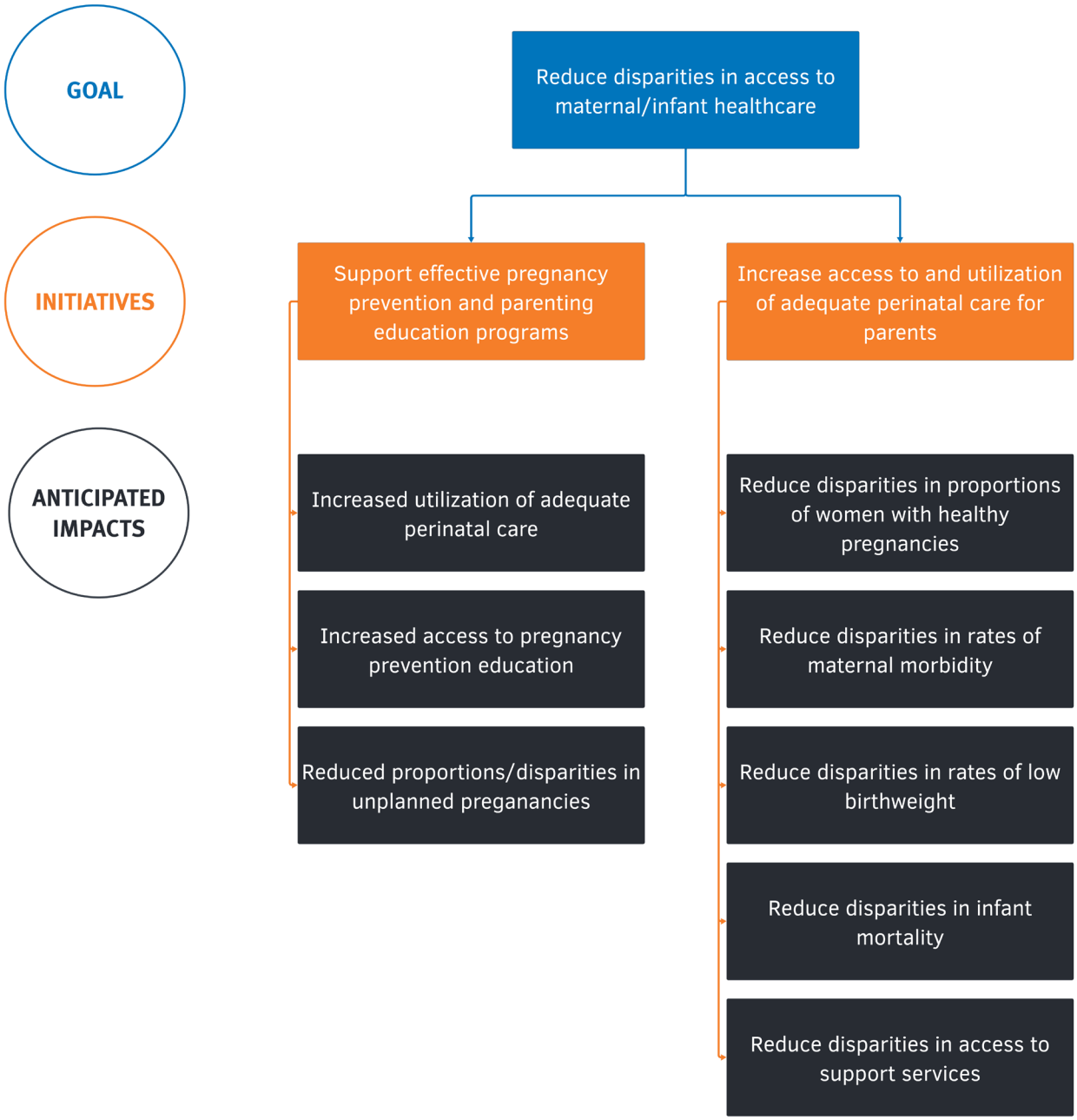
El Camino Healthcare District views efforts to ensure equitable access to high-quality healthcare and respectful, compassionate, culturally competent delivery of healthcare services as a top priority for its community benefit investments. Given the community's identification of issues of healthcare access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



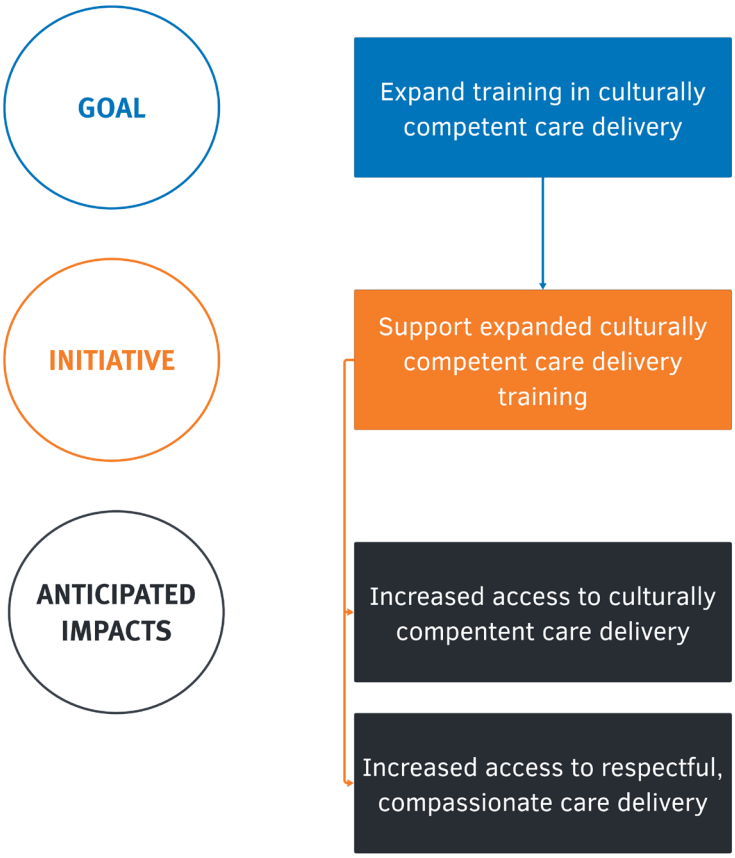
Goal	Initiative	Anticipated Impact
1. Reduce disparities in access to high-quality care	A. Support increased access to primary care and specialty care services for vulnerable individuals[1, 2, 3, 4, 5, 6, 7, 8, 9, 10]	(i) Individuals experience better access to healthcare (ii) Improved healthcare utilization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



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


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

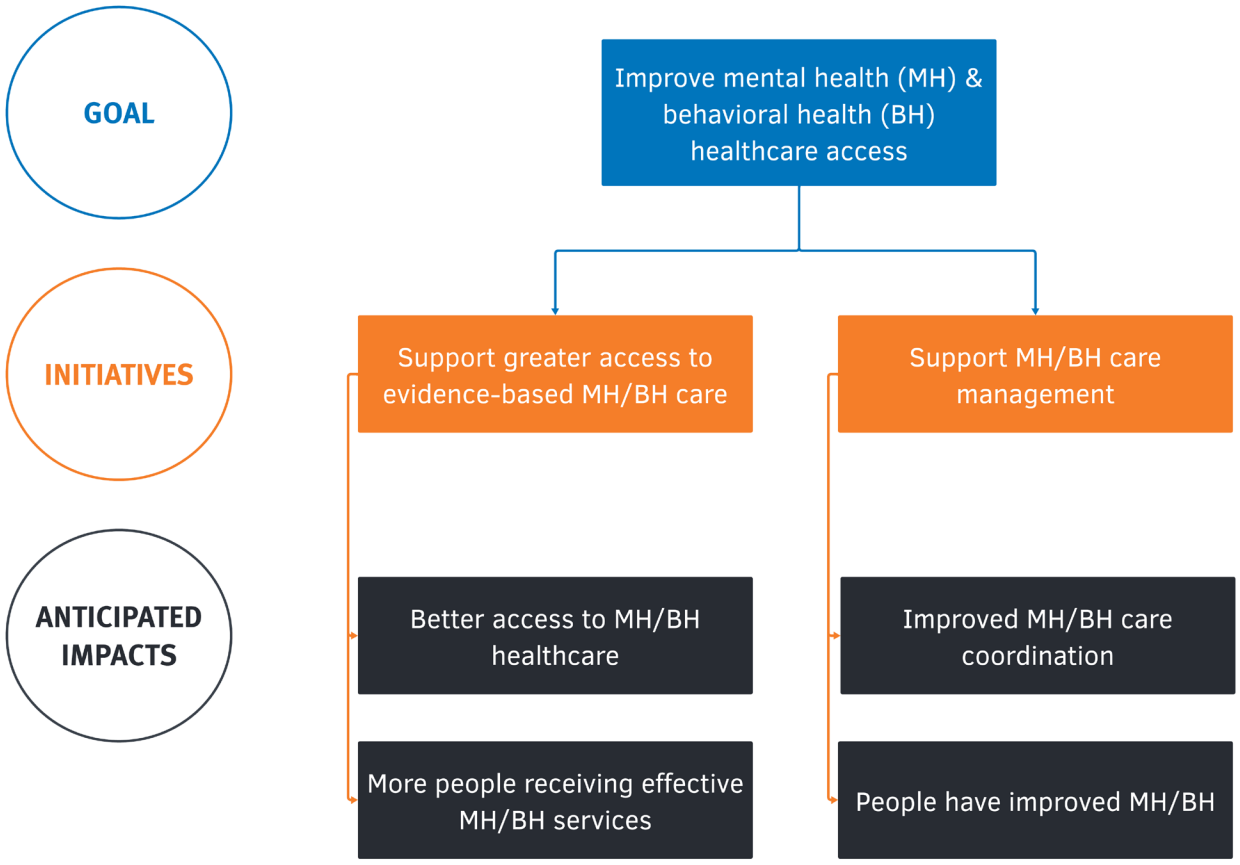
Goal	Initiative	Anticipated Impact
3. Reduce disparities and inequitable access to maternal/infant healthcare for community members	A. Support effective pregnancy prevention and parenting education programs[22, 23, 24]	(i) Increased utilization of adequate perinatal care (ii) Increased access to pregnancy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



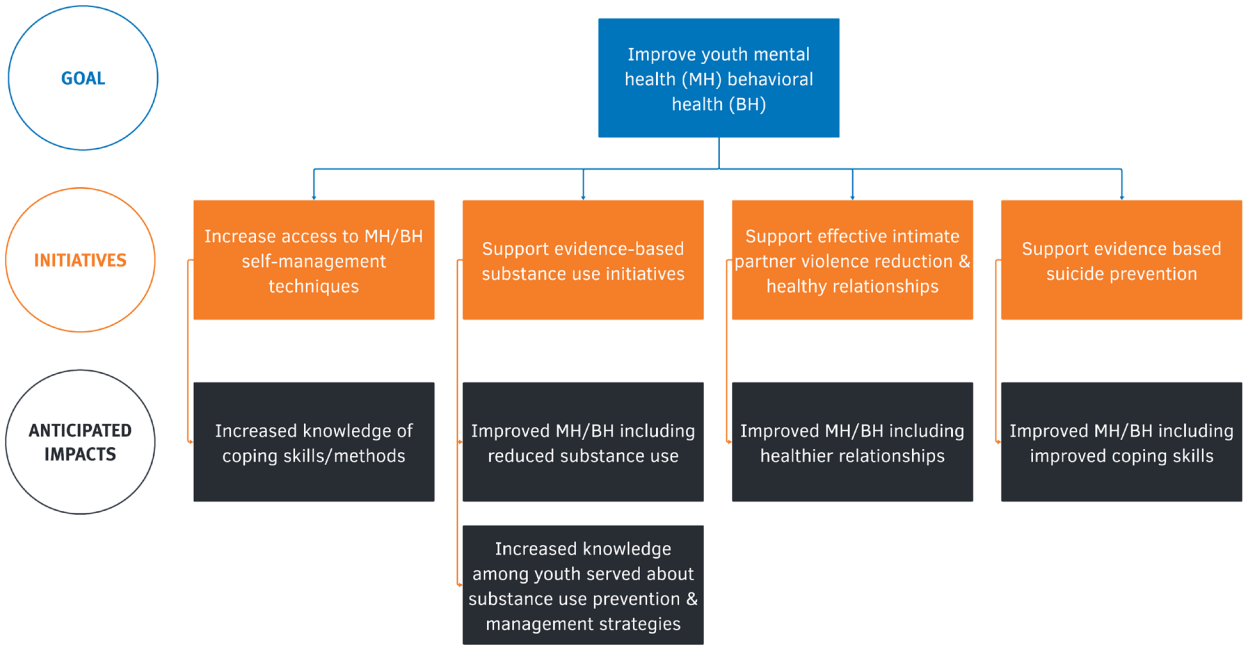
Goal	Initiative	Anticipated Impact
4. Provide/expand workforce training in cultural competence, and compassionate and respectful care delivery	A. Support workforce training in cultural competence, and compassionate and respectful care delivery[31, 32, 33, 34]	(i) Increased access to culturally competent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

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

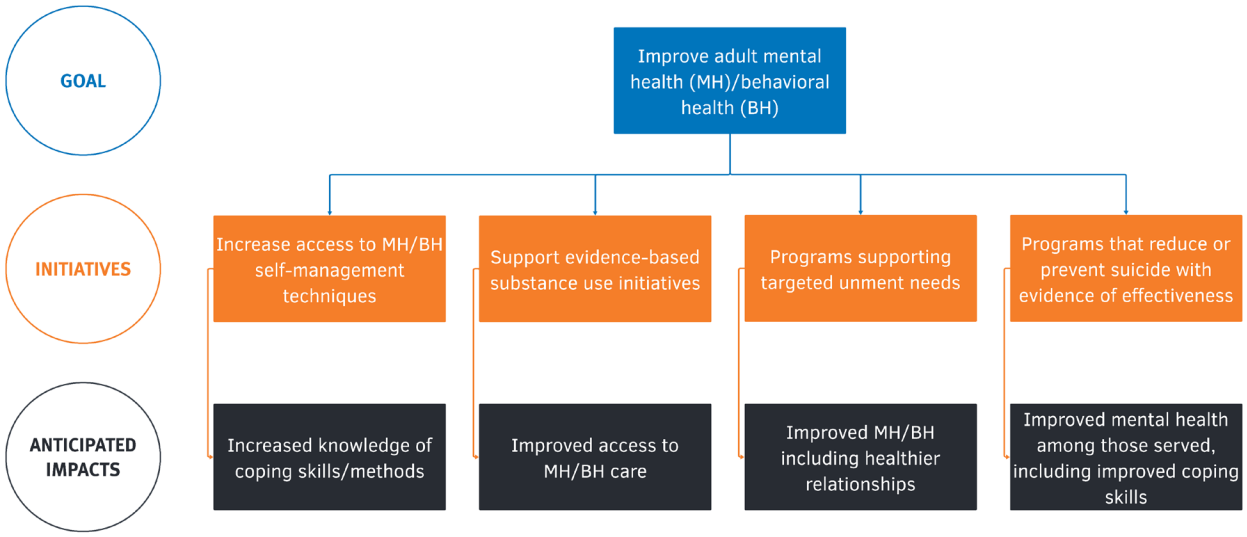
Data indicates that behavioral health (including mental health, trauma, and substance use) continues to be a significant health need, especially with respect to the supply of providers. Community input during the 2025 CHNA emphasized how much worse and more widespread behavioral health issues have become, in part due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral healthcare, El Camino 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 as well as 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. Below and on the following pages, see diagrams for summaries and tables for details.



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



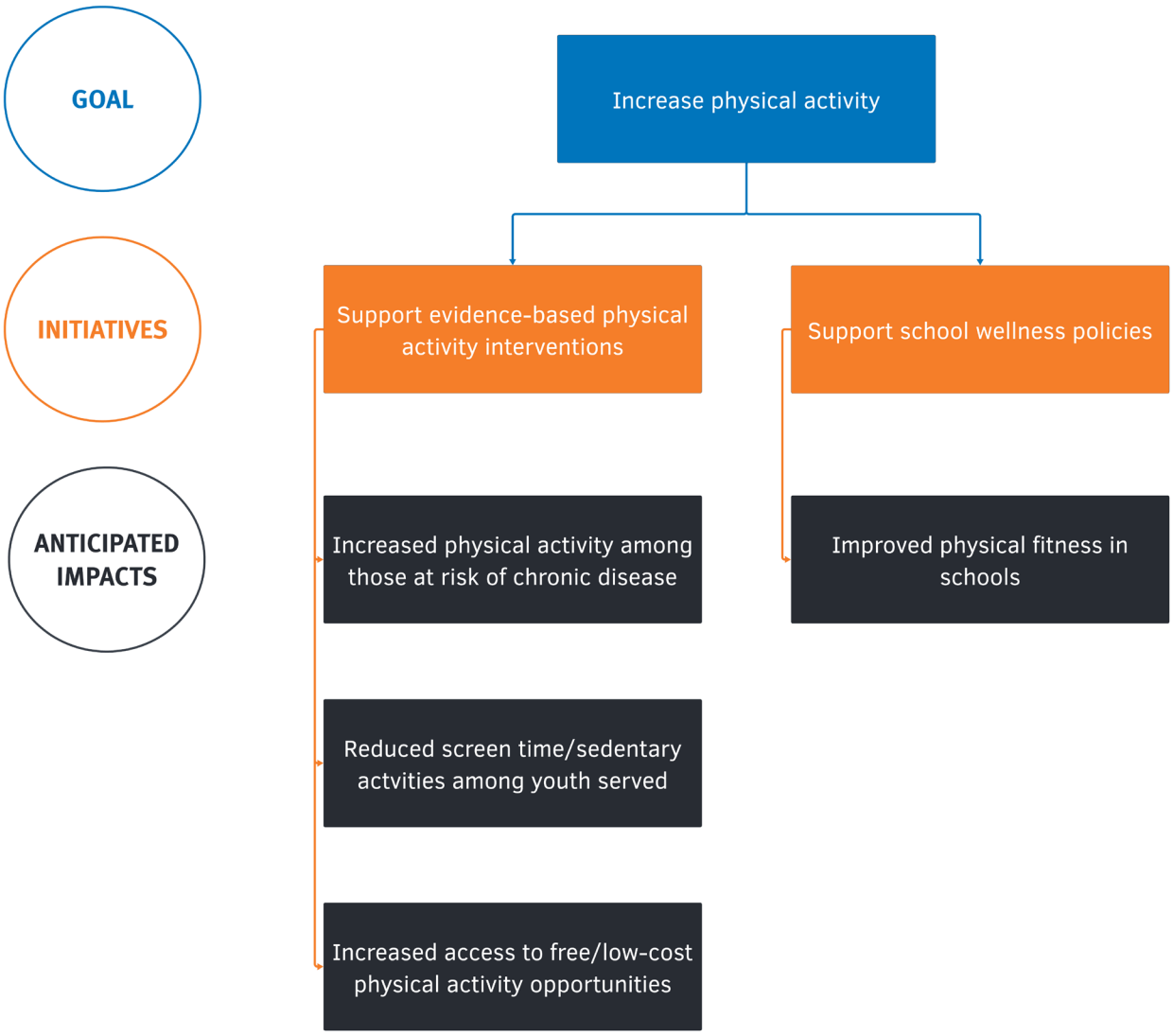
Goal	Initiative	Anticipated Impact
2. Improve behavioral health of youth in the community	A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[42, 43]	(i) Increased knowledge among youth served about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



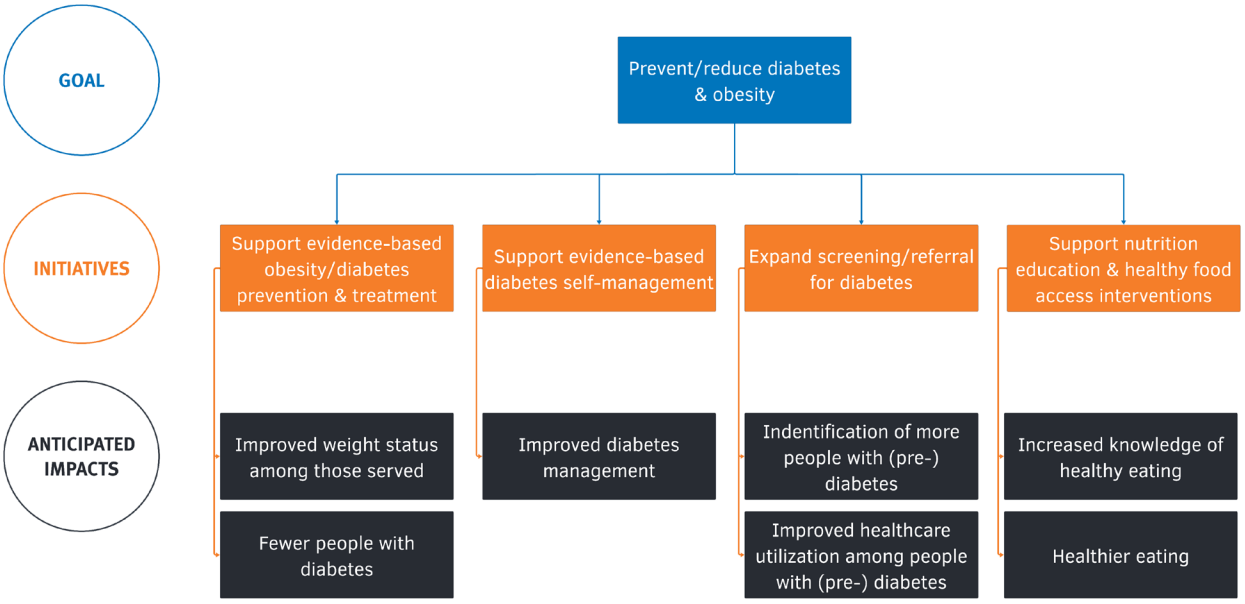
Goal	Initiative	Anticipated Impact
3. Improve behavioral health of adults in the community	A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[51, 52, 53]	(i) Increased knowledge among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

DIABETES & OBESITY

During the 2025 CHNA, community members provided input on prediabetes and the lack of access to safe spaces for physical activity, both of which are related to diabetes and obesity. Additionally, CHNA data indicated issues with diabetes, as well as both ethnic and geographic disparities in diabetes statistics, and youth physical fitness including ethnic disparities, among other factors. To address these issues, El Camino 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. Below and on the following pages, see diagrams for summaries and tables for details.



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

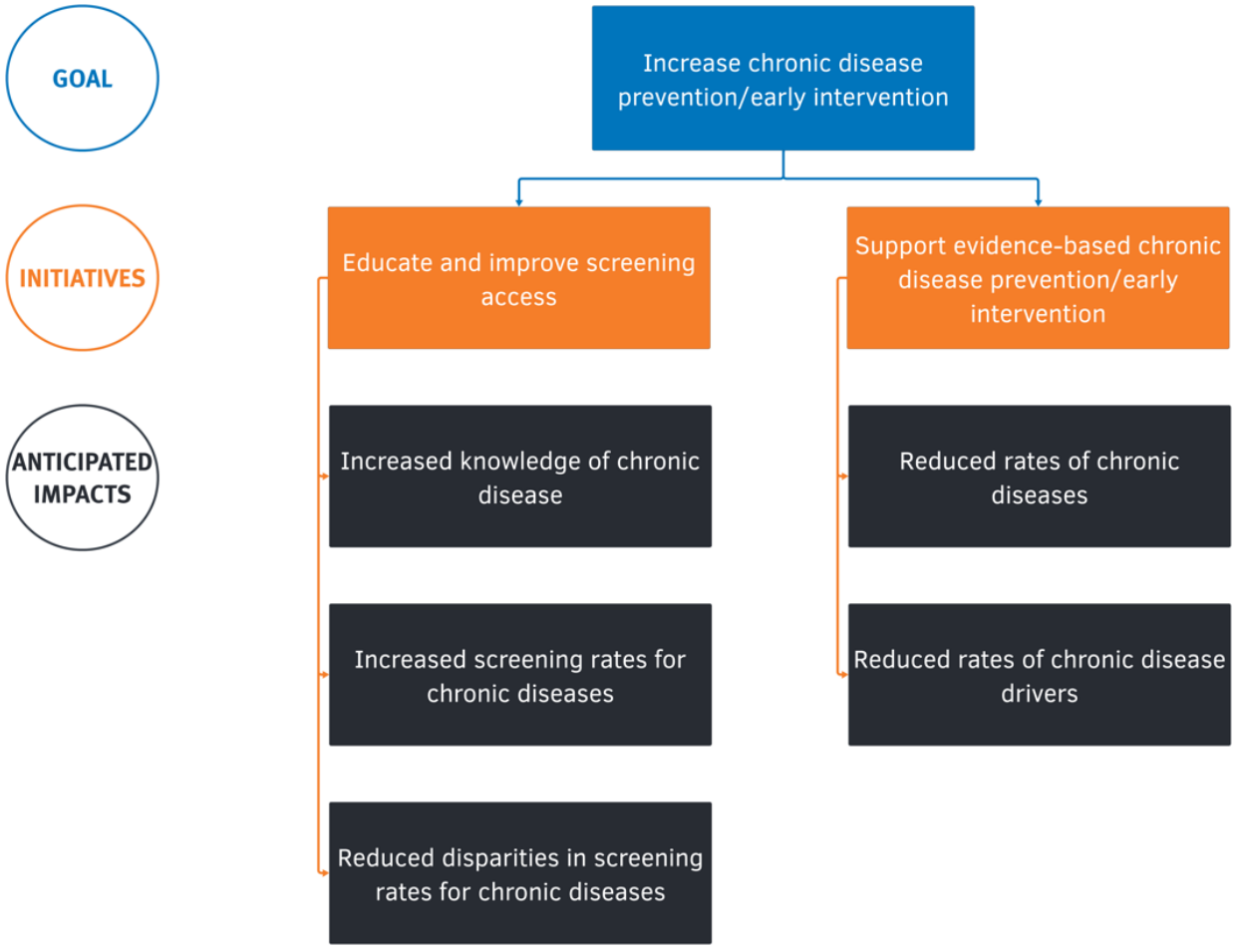


Goal	Initiative	Anticipated Impact
2. Prevent/reduce obesity & diabetes among community members	A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[69, 70, 71, 72, 73, 74, 75, 76, 77]	(i) Improved weight status in youth and adults served (ii) Long-term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

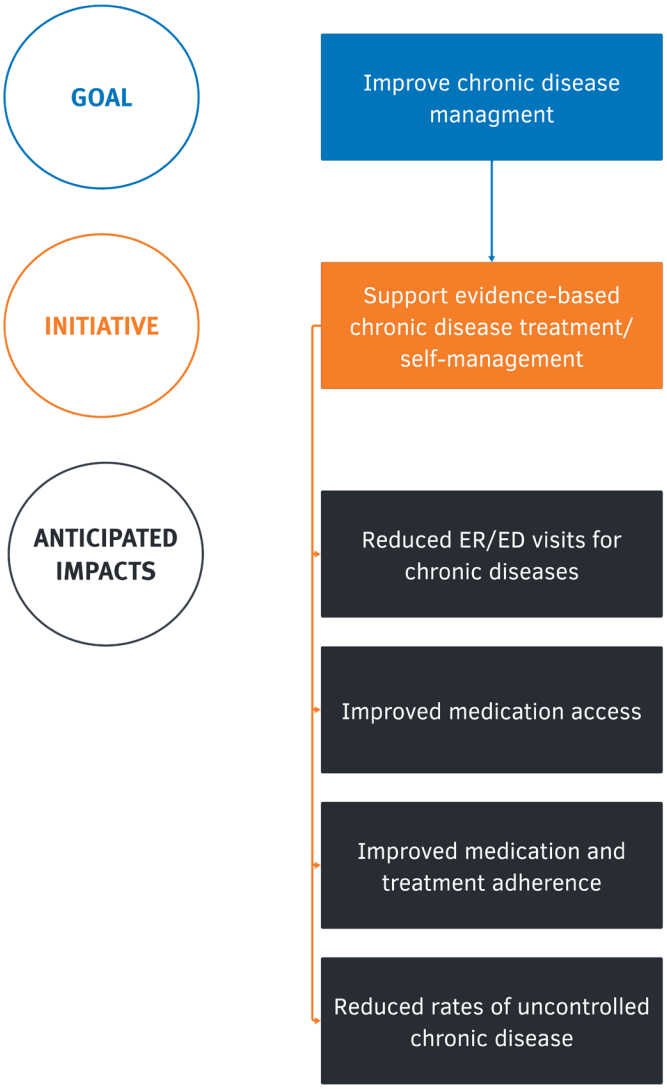
Goal	Initiative	Anticipated Impact
	D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/ community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[85, 86, 87, 88]	(i) Increased knowledge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

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

Many chronic diseases are among the top causes of death in Santa Clara County. CHNA data show there are disparities in chronic conditions such as cancer, asthma, heart disease, and stroke. Therefore, El Camino 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. Below and on the following pages, see diagrams for summaries and tables for details.



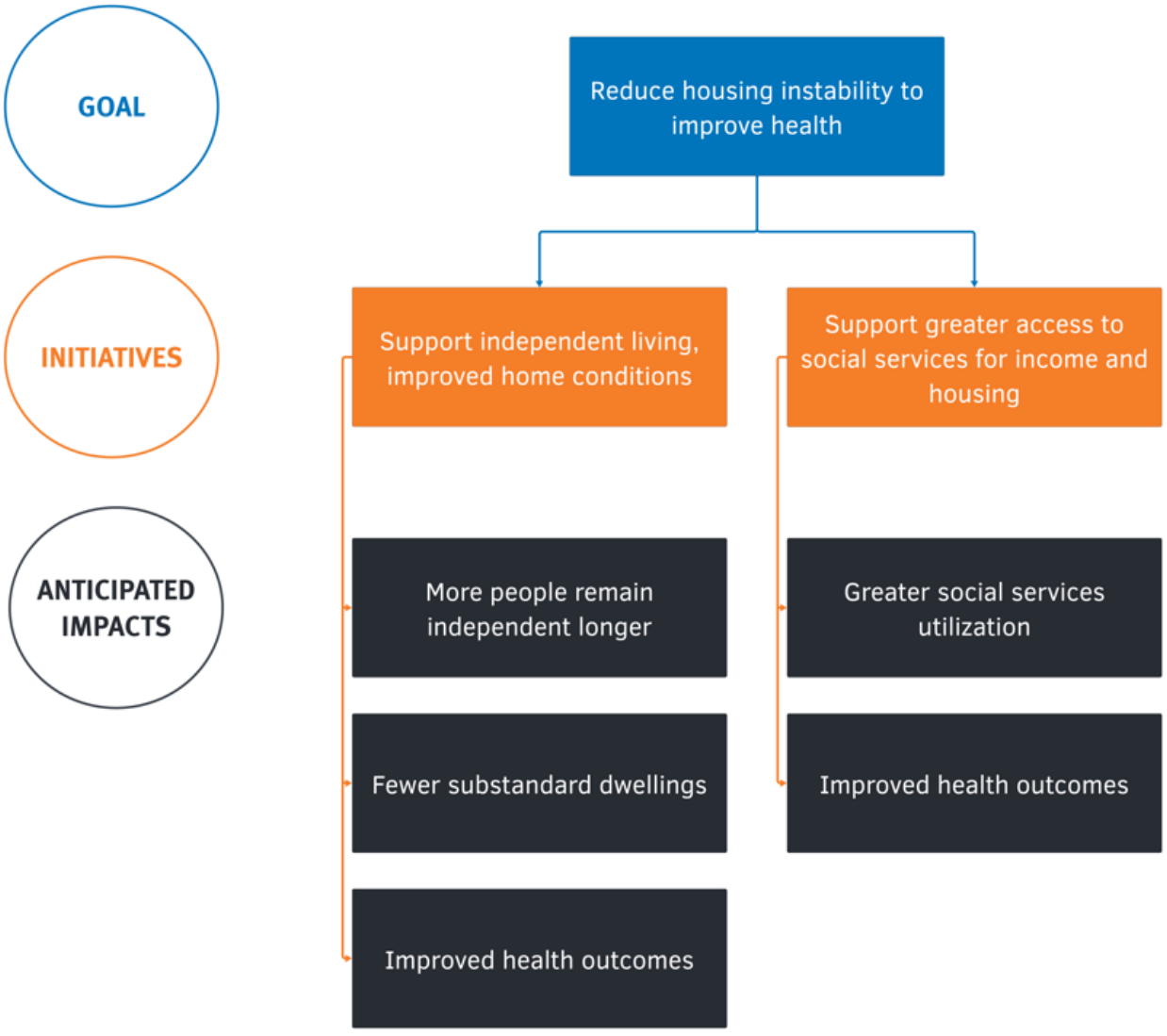
Goal	Initiative	Anticipated Impact
1. Increase prevention and early intervention of chronic diseases in the community	A. Provide education and improve access to screenings[89, 90, 91, 92, 93, 94, 95]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening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



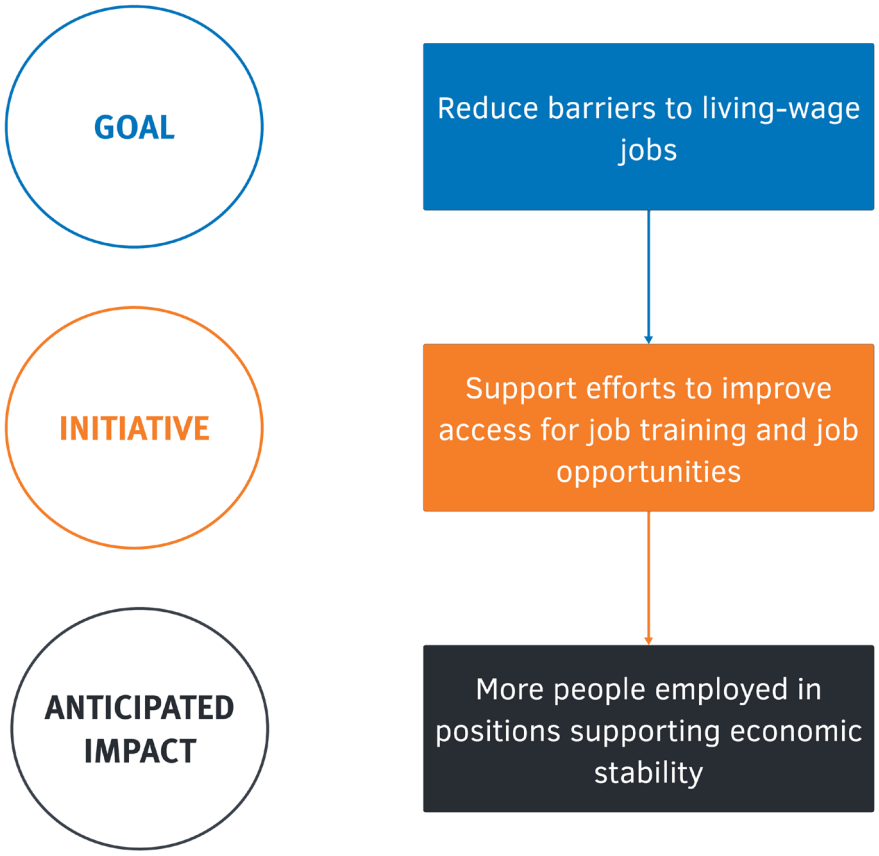
Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[99, 100, 101]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication access (iii) Improved medication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

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

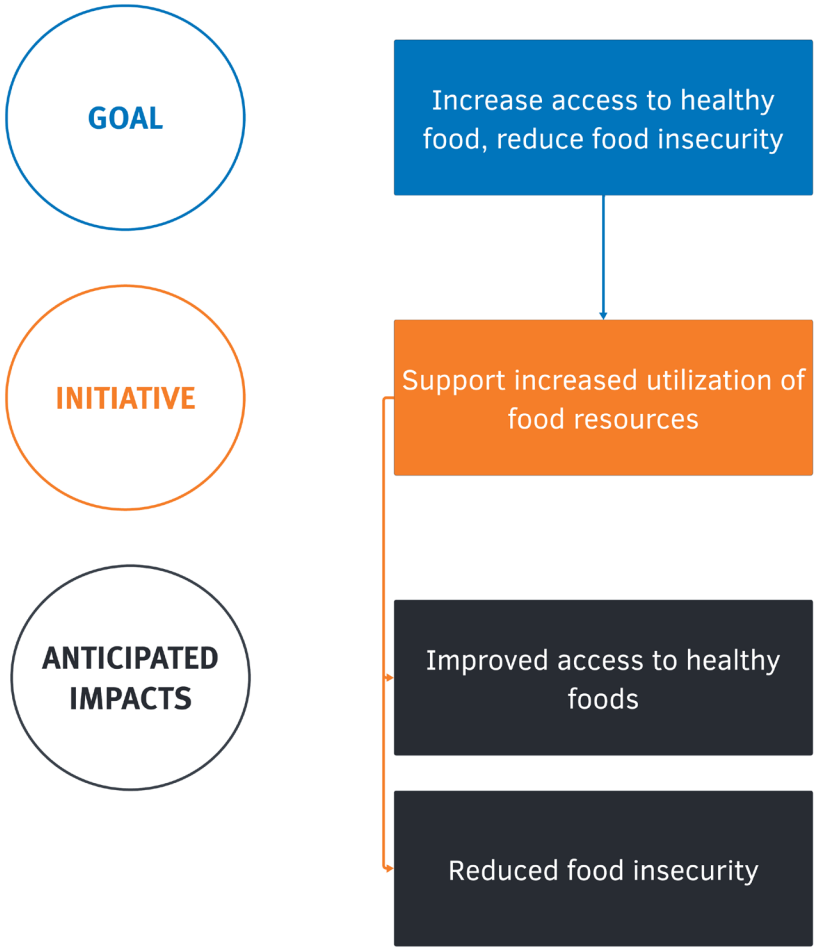
Economic stability was a top priority for the community in the 2025 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and healthcare are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Healthcare 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. Below and on the following pages, see diagrams for summaries and tables for details.



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



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



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

LIST OF APPROVED PROGRAMS

FISCAL YEAR 2026

Community Benefit Grant Funding

$8.4 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

AnewVista Community Services — Assisting seniors in learning how to navigate online health platforms and apps confidently on their own, via in-person and virtual instruction

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

El Camino Health: Health Care Navigation Specialist — Supporting vulnerable and underserved patients with social determinants of health needs in their transition from the hospital to stabilization in the community

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

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

El Camino Health: RoadRunners — Healthcare transportation service for senior, disabled, and other community members

Health Mobile — Mobile comprehensive dental services for low-income and homeless individuals, serving all ages in Mountain View and Sunnyvale

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 School District sites

Mountain View Whisman School District — Transitional Kindergarten through 8th grade student health services

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

Santa Clara Valley Healthcare — Routine, preventative dental services for underserved individuals in Mountain View and Sunnyvale

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

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 — Case management and integrated daily support for older adults experiencing chronic medical conditions, cognitive impairment, mental health issues, and those at risk of social isolation

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

Caminar: LGBTQ+ Speakers Bureau — Increasing understanding and support for LGBTQ+ identities and experiences in workplace and community settings through LGBTQ+ cultural awareness trainings

Cupertino Union School District — Transitional Kindergarten through 5th grade student mental health counseling program

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

Friendly Voices – Phone Buddies for Seniors — Weekly calls and referrals to low income, homebound, and underserved seniors

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

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Community Benefit Grant Funding | El Camino Healthcare District

Behavioral Health *(Continued)*

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

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 — 7th through 8th grade student mental health counseling program

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

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

Mountain View Los Altos Union High School District — 9th through 12th grade student mental health counseling program

Health Connected — Digital media literacy and social emotional health online 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 individuals with severe mental illness

Pacific Clinics — School-based behavioral health interventions for Sunnyvale Elementary School District Transitional Kindergarten through 8th grade students.

YWCA Golden Gate Silicon Valley: ARISE — Bilingual 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 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 2nd through 5th grade girls 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 in Sunnyvale School District

Chinese Health Initiative — Culturally and linguistically competent hypertension, diabetes and cardiovascular disease 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 for Transitional Kindergarten through 5th grade students

Roots Community Health Center — Diabetes and obesity screening, education, and awareness activities targeted to the African American community

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

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 — Training, coaching, and technical expertise for community health workers to deliver blood pressure and nutrition security screenings for underrepresented communities in Mountain View and Sunnyvale partner organization sites

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

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 for day workers and their families

Helping Hands Silicon Valley — Emergency respite and supportive services program to unhoused or those at risk of becoming unhoused

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 — 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

Rebuilding Together Silicon Valley — Home repair and accessibility modifications for low-income older adults in Sunnyvale

Sunnyvale Community Services: Comprehensive Safety-Net Services — Emergency financial assistance with medically related bills for low-income residents in danger of eviction, food/meal delivery 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

The United Effort Organization — Job readiness, housing assistance and other support for unhoused and low-income residents of Mountain View and Sunnyvale

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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 our triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

El Camino 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.

ENDNOTES

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