

2013

COMMUNITY HEALTH NEEDS ASSESSMENT

O'CONNOR HOSPITAL

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 Member of Daughters of Charity Health System

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1. EXECUTIVE SUMMARY

Community Health Needs Assessment (CHNA) Background

The Affordable Care Act (ACA), enacted by Congress on March 23, 2010, stipulates that non-profit hospital organizations complete a community health needs assessment (CHNA) every three years and make it widely available to the public. This assessment includes feedback from the community and experts in public health, clinical care, and others. This CHNA serves as the basis for implementation strategies that are filed with the Internal Revenue Service.

The IRS requires that the hospital conduct a CHNA and adopt an implementation strategy for each of its facilities by the last day of its first taxable year beginning after March 23, 2012. For O'Connor Hospital that tax year is July 1 – June 30. The CHNA may be conducted in that same year, or in the two years immediately preceding the year in which these become effective.

This CHNA report documents how the CHNA was conducted, as well as describes the related findings.

Process & Methods

The Santa Clara County Community Benefit Coalition (“the Coalition”) members, a coalition of eight local non-profit hospitals and other partners, began the CHNA process in 2012. The Coalition’s goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs.

Community input was obtained during the fall of 2012 via key informant interviews with local health experts, focus groups with community leaders and representatives, and resident focus groups. Secondary data were obtained from a variety of sources – see Attachment 1 for a complete list.

In November 2012, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then prioritized by the Coalition, using a second set of criteria. See the results of prioritization included on the next page.

The Coalition met again in December 2012 to identify resources in the community, including hospitals and clinics, and special health and wellness programs.

Prioritized Needs

Based on community input and secondary data, the Coalition generated a list of health needs and then prioritized them via a multiple-criteria scoring system. These needs are listed below in priority order, from highest to lowest. Note that the cross-cutting driver, Access to Health Care, was not included in the prioritization process but is part of the set of health needs.

Santa Clara County Health Needs Identified by CHNA Process, in Order of Priority

1. **Diabetes** is a health need as marked by high rates of diabetes among adults in Santa Clara County. For example, county-wide, diabetes prevalence is at 8% (no better than the state average), but for

the county's African American population diabetes prevalence is 14%. Drivers of diabetes rates include poor nutrition and lack of exercise, and physical environment such as availability of fresh food and fast food.

2. **Obesity** is a health need as indicated by high rates of obese youth (24-31%) and adults (21%) in Santa Clara County, and high rates of overweight youth and adults as well (14% and 36% respectively). Overall rates miss the Healthy People 2020 targets. Latino and Black/African-American residents have the highest rates of overweight and obesity. Drivers of obesity are poor nutrition and lack of exercise, and physical environment such as availability of fresh food and fast food.
3. **Violence** is a health need because the rate of youth homicide (7.4) in Santa Clara County is higher than the Healthy People 2020 target. In addition, the county has seen a large increase in homicides in the years 2011 and 2012. Domestic violence and child abuse rates also miss the benchmark for some ethnic subgroups. Drivers of this health need include mental health and social determinants of health such as poverty and unemployment.
4. **Poor Mental Health** is a health need because of self-reported poor mental health (17%) among Santa Clara County residents, higher than the state average. Also, youth of color are disproportionately depressed and suicidal. Community input indicates high concern about stress and depression specifically.
5. **Poor Oral/Dental Health** is a health need as indicated by the percentage of Santa Clara County youth reporting their teeth were in fair or poor condition (16%), which is worse than the state average (12%). Also, some ethnic subgroups are less likely to have dental insurance, which is a driver of poor oral health.
6. **Cardiovascular Disease, Heart Disease, and Stroke** are a health need, as they are among the top ten causes of death in Santa Clara County and California. The overall rate of high cholesterol in the county (29%) is higher than the Healthy People 2020 target (17%), as are the rates for all ethnic populations. Related to poor cardiovascular health are the health behaviors of smoking, drinking, poor nutrition and lack of exercise.
7. **Substance Abuse (Alcohol, Tobacco, and Other Drugs)** is a health need because Santa Clara County youth and adults have higher rates of binge drinking (12% and 25% respectively) compared with Healthy People 2020 targets. Youth marijuana use is also high. Drivers of substance abuse include poor mental health and lack of treatment/access to care.
8. **Cancer** is a health need; Santa Clara County incidence rates for breast, cervical, liver and prostate cancers are higher than benchmarks/state averages. Certain ethnic subgroups experience different incidence and mortality rates. For instance, the overall county liver cancer mortality rate is 6.8, compared with 5.6 for the state, and even worse for county Latinos (9.0) and Asian/Pacific Islanders (11.9). Contributing factors to cancer are health behaviors such as smoking and drinking, and lack of screening contributes to mortality rates.
9. **Respiratory Conditions** are a health need as indicated by the high asthma hospitalization rate of Santa Clara County children ages 0-4 (24.5 per 10,000). Asthma prevalence among county adults is no better than the Healthy People 2020 target of 13% and should be monitored. The health need is

likely being impacted by smoking among youth/adults as well as poor air-quality levels. Community input demonstrated a concern about the costs of asthma treatment due to lack of medical insurance.

10. **STDs/HIV-AIDS** are a health need in Santa Clara County as indicated by disproportionately high HIV incidence rates among African-Americans (50.4, compared with 10.3 overall). The health need is likely driven by low screening rates and lack of health education.
11. **Birth Outcomes** are a health need because of the percentage of low birth-weight babies in Santa Clara County, which is no better than the state average (approximately 7%). County African Americans are disproportionately affected by low birth-weight (9%), pre-term babies, and infant mortality. A driver of this health need is inadequate early prenatal care.
12. **Alzheimer's** is a health need because of the increasing proportion of Santa Clara County residents living with Alzheimer's disease, and because it is one of the top ten leading causes of death in the county.
13. *(Not included in prioritization process)* **Cross-Cutting Driver: Access to Health Care Services** is a health need in Santa Clara County because socioeconomic conditions (poverty, low levels of education, lack of health insurance) as well as factors such as the size of the health care workforce, linguistic and transportation barriers all affect access to care, which negatively impacts health.

Next Steps

After making this CHNA report publically available in June 2013, O'Connor Hospital will develop an implementation plan based on this data.

2. INTRODUCTION/BACKGROUND

Purpose of CHNA Report and Affordable Care Act Requirements

Enacted on March 23, 2010, federal requirements included in the Affordable Care Act (ACA) stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a community health needs assessment (CHNA) every three years. The CHNA Report must document how the assessment was done, including the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community’s health needs that were identified and prioritized as a result of the assessment. See Attachment 2 – IRS checklist.

As part of the tri-annual CHNA assessment, hospitals must:

- Collect and take into account input from public health experts as well as community leaders and representatives of high need populations including: minority groups, low-income individuals, medically underserved populations and those with chronic conditions
- Identify and prioritize community health needs
- Document a separate CHNA for each individual hospital
- Make the CHNA report widely available to the public
- Adopt an Implementation Strategy to address identified health needs
- Submit the Implementation Strategy with the annual Form 990
- Pay a \$50,000 excise tax for failure to meet CHNA requirements for any taxable year

SB 697 and California’s History with Past Assessments

Compared to SB 697, the California-specific legislation requiring a community health needs assessment, the ACA regulations are more stringent on how to conduct and document the needs assessment. A comparison is shown in the table below.

Comparison of ACA and SB 697 CHNA Requirements

Activity or Requirement	Required by ACA	Required by SB 697
Conduct a community health needs assessment at least once every 3 years	Yes	Yes
CHNA identifies and prioritizes community health needs	Yes (Prioritization of all health needs required before implementation planning)	Yes
Input from specific groups/individuals are gathered	Yes	No
CHNA findings widely available to the public	Yes	No
Implementation strategy is adopted to meet needs identified by CHNA	Yes	Yes
File an Implementation Plan with IRS	Yes	No (CB Plan with OSHPD)
\$50,000 excise tax for failure to meet CHNA requirements for any taxable year	Yes	No

3. ABOUT O'CONNOR HOSPITAL

O'Connor Hospital is a 358-bed acute care, community hospital located in the heart of San Jose, the largest city in Santa Clara County. We provide care for the youth, adults and elderly living in Santa Clara County. Our key services include: Cardiac, Stroke, Emergency, Orthopedic and Joint Replacement, Women & Children, and Wound Care. In an effort to provide services to patients who are less fortunate, O'Connor sponsors programs such as the Health Benefits Resource Center and the Stanford-affiliated Family Medicine Residency Program.

Community Served

Towns, Counties, and/or Zip Codes

O'Connor Hospital serves all of Santa Clara County, which is comprised of the following cities: Campbell, Cupertino, Gilroy, Los Altos, Los Altos Hills, Los Gatos, Milpitas, Monte Sereno, Morgan Hill, Mountain View, Palo Alto, San Jose, Santa Clara, Saratoga and Sunnyvale.

Demographic Profile of Community Served

With 1.78 million residents, Santa Clara County (SCC) is the sixth most populated of California's 58 counties and the most populated of the Bay Area's nine counties. The county's 15 cities contain 95% of the population; more than half of the county's residents (53%) live in the city of San Jose.

Diversity

Santa Clara County is within the top 1% of all U.S. counties in terms of racial and ethnic diversity. According to the 2010 U.S. Census, SCC's racial and ethnic composition is 35% White, 32% Asian, 27% Latino, 2% African American and 3% indicated they were two or more races. No one racial or ethnic classification is a majority within the county. Of those who selected Asian, the predominate subgroups are 27% Chinese, 22% Vietnamese, 21% Asian Indian and 18% Filipino. The vast majority of those who selected Hispanic are Mexican (84%).

Thirty seven percent of the county's population is foreign born, compared to 27% of California's population. Of those foreign born, 61% were born in Asia and 27% were born in Latin America. In SCC, 50% of the population speaks a language other than English at home.

Gender and Age

According to the 2010 U.S. Census, women (49.8%) and men (50.2%) make up equal proportions of the SCC population. The median age of a county resident is 36 years old, which is slightly younger compared to the overall age composition of the U.S.

Young people (ages zero to 19) make up about 26% of the county's population and 38% of households have individuals under 18 living in them. The younger population is more diverse than the overall county population: 37% is Hispanic, 31% is Asian, 24% is White and 5% is Multiracial.

Residents aged 65 and over make up 12% of the county's population. The fastest growing age group in the county is 85 and over; the aging resident trend is expected to continue. In SCC, 23% of households have individuals over 65 living in them.

Poverty

Although the median annual income in Santa Clara County is high at approximately \$89,064, 9.2% of the population lives below the federal poverty level. In 2013, the federal poverty level for a family of two adults and two children was \$23,550.

Looking at the number of individuals living in poverty based on the federal poverty level is an inaccurate representation of economic well-being in SCC. The self-sufficiency standard is a more accurate calculation of income adequacy and takes into consideration county-specific costs for housing, food, and health care, as well as costs associated with work including transportation, child care, and taxes. For SCC the self-sufficiency standard in 2011 for one adult and two children is \$77,973, a stark contrast to the federal poverty level. Working more than four full-time minimum wage jobs is required to meet the most basic expenses for a family of three in Santa Clara County.

According to the federal poverty level, only 6% of seniors are considered poor with an individual annual income below \$10,201. But according to the California Elder Economic Security Standard Index, nearly half of SCC older adults (48.4%) are economically insecure. The Index measures how much income is needed for a retired adult age 65 and older to adequately meet his or her basic need including housing, food, out-of-pocket medical expenses, and transportation in SCC.

Map of Community Served by Hospital Facility

See Attachment 3 – Map of Santa Clara County.

4. ASSESSMENT TEAM

Hospitals and Other Partner Organizations

The Santa Clara County Community Benefit Coalition (“the coalition”), a coalition of eight local non-profit hospitals and other partners, collaborated to complete the CHNA. Coalition participants included:

- Barbara Avery, **El Camino Hospital**
- Jo Coffaro, **Regional Vice President of Hospital Council of Northern & Southern California**
- Colleen Haesloop, **Lucile Packard Children’s Hospital at Stanford**
- Sharon Keating-Beauregard, **Stanford Hospital & Clinics**
- Rocio Luna, **Santa Clara County Public Health Department**
- Candace Roney, **Lucile Packard Children’s Hospital at Stanford**
- Elizabeth Sills, **Kaiser Permanente**
- Joanne Seavey-Hultquist, **Kaiser Permanente**
- Sister Rachela Silvestri, **Saint Louise Regional Hospital**
- Anandi Sujeer, **Santa Clara County Public Health Department**
- Jennifer Thrift, **O’Connor Hospital**
- Patrick Soricone, **United Way Silicon Valley**

This team contracted with Applied Survey Research to conduct the Community Health Needs Assessment in 2012.

Identity and Qualifications of Consultants

The community health needs assessment was completed by **Applied Survey Research (ASR)**, a non-profit social research firm. For this assessment, ASR conducted primary research, synthesized primary and secondary data, facilitated the process of identification and prioritization of community health needs and assets, and documented the process and findings into a report.

ASR was uniquely suited to provide the Coalition with consulting services relevant to conducting the CHNA. The team that participated in the work – Lisa Colvig-Amir, Dr. Jennifer van Stelle, Angie Aguirre, and Melanie Espino – brought together diverse, complementary skill sets and various schools of thought (public health, anthropology and sociology).

In addition to their research and academic credentials, the ASR team has a 32-year history of working with vulnerable and **underserved populations** such as young children, teen mothers, seniors, low-income families, immigrant families, families who have experienced domestic violence and child maltreatment, the homeless, and children and families with disabilities.

ASR’s expertise in **community assessments** is well-recognized. ASR won a first place award in 2007 for having the best community assessment project in the country. They accomplish successful assessments by using mixed research methods to help understand the needs, and by putting the research into action through designing and facilitating strategic planning efforts with stakeholders.

Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Santa Cruz and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties, Marin County, Nevada County, Pajaro Valley, Solano and Napa Counties.

The Coalition contracted with **Resource Development Associates (RDA)** to create a compendium of secondary data. RDA is a 28-year old Bay Area consulting firm supporting government agencies and community-based organizations through assessment, planning, evaluation, data system development and analysis, and grant writing. Located in Oakland, CA, RDA is a privately held, woman-owned consulting firm. It employs a full-time staff of 24 professionals with credentials in public health, clinical services, social welfare, organizational development and planning.

Since its inception, RDA has served some of the largest and most innovative human service initiatives in the nation. It targets its efforts towards the improvement of outcomes for public health and behavioral health agencies, school districts, early childhood programs, adult and juvenile justice organizations, and community-based organizations. RDA consults with a wide array of organizations ranging from federal agencies (e.g., Center for Substance Abuse Prevention (CSAP), Centers for Disease Control and Prevention (CDC), the Department of Housing and Urban Development (HUD), and the Office of Juvenile Justice and Delinquency Prevention (OJJDP)) to smaller, community-based organizations. It conducts comprehensive assessments and evaluations for local cities, public health departments, Maternal, Child and Adolescent Health (MCAH) divisions, and First 5 commissions, as well as alcohol and drug services, juvenile justice initiatives, violence prevention efforts, and educational initiatives. RDA has established and proven competencies in assembling and interpreting large amounts of public data to inform and structure its efforts in community needs profiling.

5. PROCESS AND METHODS

The Santa Clara County Community Benefit Coalition worked in collaboration on the primary and secondary data requirements of the CHNA. The CHNA data collection process took place over six months, and culminated in a report written for the Coalition in January 2013.

Santa Clara County Community Benefit Coalition CHNA Process



Secondary Data Collection

The Coalition contracted with Resource Development Associates (RDA) to create a compendium of secondary data. Working collaboratively on behalf of its member hospitals, the Coalition made available to RDA a selection of the most recent and comprehensive public-health-related reports and documents as well as demographic data. One report in particular, the “Santa Clara County Health Profile, 2012,” served as the “foundational report” for the CHNA due to its comprehensive compilation of recent County-wide public health data. Please see Attachment 1 for a list of data sources utilized.

As a further framework for the assessment, the Coalition requested RDA use the following filters:

- What health areas offer the most current and consistent data?
- What are the most salient/meaningful indicators?
- How do these indicators perform against accepted benchmarks?
- Are there disparate outcomes and conditions for people in the community?
- Are there opportunities for the county’s hospitals to positively impact outcomes to improve the health and quality of life for county residents?

RDA compiled the research and provided comparisons with existing benchmarks (Healthy People 2020, statewide and national averages) in its compendium. The compendium was intended to provide a rich picture of the health of the county. Secondly, it was created with an understanding of how hospitals could make use of these data to plan their community benefit priorities, outreach and education efforts, and to develop strategies for engaging partners to address identified needs.

Primary Data (Community Input)

The Coalition contracted with Applied Survey Research (ASR) to conduct the primary research. They used three strategies for collecting community input: key informant interviews with health experts, focus groups with community leaders and stakeholders, and resident focus groups.

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulate all health conditions that were mentioned, along with health drivers discussed. ASR then made a list of all of the conditions that had been mentioned by a focus group or key informant, counted how many groups or informants listed the condition, and how many times they had been prioritized by a focus group.

Community Leader Input

In all, ASR consulted with more than 54 community representatives of various organizations and sectors. These representatives either work in the health field, or improve health conditions by serving those from the target populations. In the list below, the number in parentheses indicates the number of participants from each sector.

- Santa Clara County Public Health (6)
- Other Santa Clara County Health & Hospital System (3)
- Private hospital systems (3)
- Health Insurance providers (4)
- Mental/Behavioral health or violence prevention providers (4)
- School system representatives (3)
- Community center representatives (10)
- Non-profit agencies providing basic needs (5)
- Other non-profit agencies serving children, seniors and families (15)

See Attachment 4 for the names, titles and expertise of key stakeholders along with the date and mode of consultation (focus group or key informant interview).

Key Informant Interviews

ASR conducted primary research via key informant interviews with nine South Bay experts from various organizations in the health sector. In October and November 2012, experts including public health officers, community clinic managers, and clinicians were consulted. These experts had countywide experience and expertise.

Health experts were interviewed by telephone for approximately one hour. Informants were asked to discuss in detail one of the areas of focus for the CHNA: Health delivery, health access, socio-economic factors, health behaviors, environmental conditions, quality of life (morbidity), and mortality.

Details of Key Informant Interviews

Name	Position	Agency	Conducted
1. René Santiago	Deputy County Executive	Santa Clara Valley Health & Hospital System	Oct 2 nd 1:00 pm
2. Shamima Hasan	CEO	Mayview Community Health Center	Oct 2 nd 2:00 pm
3. Dan Peddycord	Director	Santa Clara County Public Health	Oct 3 rd 11:00 am
4. Dr. Marty Fenstersheib	Health Officer	Santa Clara County Health/Hospital	Oct 3 rd 3:00 pm
5. Reymundo Espinoza	CEO	Gardner Health Center	Oct 4 th 10:00 am
6. Michelle Lew	Executive Director	Asian Americans for Community Involvement	Oct 4 th 1:30 pm
7. Dolores Alvarado	Executive Director	Community Health Partnership	Oct 17 th 1:00 pm
8. Dr. Kent Imai	Medical Director	Community Health Partnership	Nov 6 th 12:00 pm
9. Dr. Thad Padua	Medical Director	Santa Clara Family Health Plan	Nov 9 th 1:00 pm

Stakeholder Focus Groups

Focus groups with stakeholders were conducted in October and November 2012. The discussion centered around four questions, which were modified appropriately for the audience.

1. How healthy is our community (on a scale of 1-5)?
2. What are the health needs (conditions) that you see in the community?
3. What are the most pressing health needs on this list? (three selected)
4. What are the drivers of these prioritized conditions?

Groups were encouraged to discuss drivers from multiple KP domains: health access, health delivery, social-economic factors, environmental factors and health behaviors.

Details of Stakeholder Focus Groups

Focus	Location	Date	Number of Participants
1. Community Health Organizations	Sobrato Center for Non-Profits (San Jose)	10/24/2012	11
2. Community Health Organizations	Sobrato Center for Non-Profits (San Jose)	10/24/2012	13
3. Community Health Organizations	Sobrato Center for Non-Profits (San Jose)	10/24/2012	11
4. South County Organizations	Valley Health Center (Gilroy)	11/1/2012	11
5. Basic Needs Organizations	ASR (San Jose)	11/6/2012	6
6. Chronic Condition Organization	ASR (San Jose)	11/7/2012	7
7. Senior Organizations	ASR (San Jose)	11/7/2012	7
8. Child- Serving Organizations	ASR (San Jose)	11/9/2012	8
9. Youth Organizations	ASR (San Jose)	11/9/2012	4

Please see Attachment 4 for a full list of community leaders/stakeholders and their credentials.

Stakeholder Participant Demographics

Applied Survey Research conducted nine focus groups with 79 stakeholders in the South Bay region. Three groups were held with community-based grantees (35 participants). The remaining six were held with 44 stakeholders from across the county with expertise in various fields and with various populations. Focus group participants were asked to fill out a brief demographic survey. We received 76 surveys total.

- **Professional Experience:** The stakeholders surveyed had a combined 172 years of clinical practice and 348 years of health administration experience. For those who reported experience in these fields, clinicians had an average of 11 years’ experience, and health administrators had an average of 14 years’ experience.
- **Professional Role:** Nearly two-thirds of respondents were from non-profit organizations. Stakeholders also work in public health, clinical care, and administrative positions.
- **Special Population Expertise:** Nearly all of the respondents indicated that they had worked intensely with the low-income population in the last five years. There was good representation of stakeholders from all target populations.

Stakeholder Expertise with Special Populations

Area of Expertise	n	%
Low Income	69	90%
Children	58	75%
Youth	55	71%
Women	45	58%
Uninsured	43	56%
Monolingual	42	55%
Older Adults	31	40%
Chronically Ill	24	31%

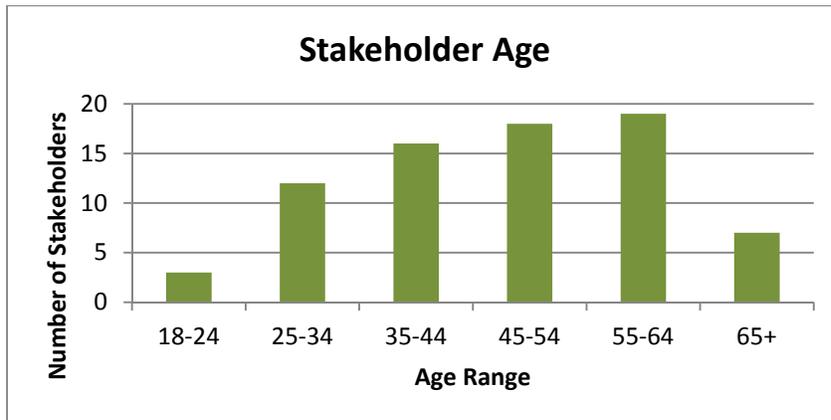
- **Regional Experience:** Stakeholders had worked all across the county, with the most combined number of years' experience in Central and West San Jose.

Stakeholder Expertise in Municipal Regions

Region	Combined Years	Average Years	Number Providers
East San Jose	239	9	26
Central & West San Jose	255	7	35
South San Jose / Los Gatos	74	5	14
South County	204	8	25
Milpitas	54	5	11
Palo Alto/Los Altos/Mountain View	174	8	23
Campbell/Saratoga	100	6	16
Sunnyvale/Cupertino	145	8	18

Other stakeholder demographics:

- **Ethnicity and Language:** Almost two thirds are white (64%) and one quarter (25%) are Latino. Eighteen reported using Spanish at work. Only one respondent reported using a language other than English or Spanish at work.
- **Age Range:** The majority of stakeholders were over the age of 45 but there were representatives of all age groups, including the 18-24 years and over 65 years ranges.



Resident Input

Resident focus groups were conducted in October and November 2012. The discussion centered around four questions which were modified appropriately for the audience.

1. How healthy is our community (on a scale of 1-5)?
2. What are the health needs (conditions) that you see in the community?
3. What are the most pressing health needs on this list? (three selected)
4. What are the drivers of these prioritized conditions?

In order to provide a voice to the community it serves in Santa Clara County, the study team targeted participants who were medically underserved, in poverty, socially or linguistically isolated, or those who had chronic conditions. Eight focus groups were held with community members. The team held two groups with a special population focus: seniors and parents of young children.

These resident groups were planned in various geographic locations around the county. Residents were recruited by non-profit hosts, such as Community Health Partnership, who serves uninsured residents.

Resident Focus Groups

Population Focus	Hospital Area	Location	Date	Number of Participants
1. Uninsured adults	All	Community Health Partnership, San Jose	10/9/12	5
2. Uninsured adults	All	Community Health Partnership, San Jose	10/9/12	6
3. Older adults	All	Indian Health Center, East San Jose	10/10/12	9
4. Youth	All	Fresh Lifelines for Youth (FLY), Milpitas	10/22/12	7
5. North County parents	Santa Clara	Columbia Neighborhood Center, Sunnyvale	10/23/12	6
6. South County residents	San Jose	Kaiser Permanente, Gilroy	10/24/12	7
7. Campbell parents (Spanish)	Santa Clara	Rosemary Elementary School, Campbell	11/13/12	3
8. Milpitas/North San Jose Immigrants	All	Catholic Charities, North San Jose	11/20/12	7

Resident Participant Demographics

Fifty community members participated in the focus group discussions across the county. All participants completed an anonymous demographic survey, the results of which are reflected below.

- 90% of participants were ethnic **minorities**. English was a second language for most participants.
- 44% of residents (22) were under 40 years old, including seven youth under 20 years of age. 36% were middle-aged (40 years to 50 years old) and 16% were older adults (age 60 and over).
- Almost a third of the participants were **uninsured**, while 46% had benefits through Medi-Cal, Medicare or another public health insurance program.
- Almost two-thirds of the community residents lived in medically **underserved** areas of the county: South county cities of Morgan Hill, Gilroy and San Martin, East San Jose, and the Mayview area of Sunnyvale.
- Most households were comprised of multiple adults over age 25 (65%) and a child or youth under age 25. About half (48%) of the participants had **children** under the age of 18 in the house. Among the participants who lived in a household with children, the average number of children was two. A third of respondents reported having at least one **young adult** age 18-24 in their households.
- Of those who responded to the question about annual household income, all but two respondents reported having an annual household income of **under \$45,000 per year**. The vast majority (79%) earned under \$25,000 per year, which is near Federal Poverty Level for a family of four, and below the California Self-Sufficiency Standard for two adults with no children (\$45,609). This demonstrates

a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

Income of Community Members Participating in Focus Groups

Annual household Income	Participants	% of participants including “missing”	% of participants without “missing”
Under \$25,000	37	74%	79%
\$25,000-\$44,000	8	16%	17%
\$45,000-\$64,000	1	2%	2%
\$65,000-\$84,000	1	2%	2%
Missing	3	6%	-
Grand Total	50	100%	100%

Information Gaps & Limitations

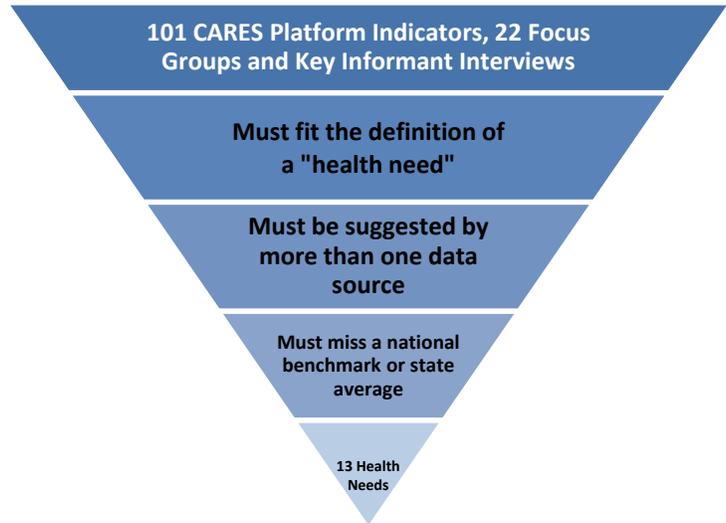
ASR and the Coalition were limited in their ability to assess some of the identified community health needs due to a lack of secondary data. Such limitations included data on oral/dental health, substance abuse (particularly, use of illegal drugs and misuse of prescription medication), dementia, and mental health. More specific limitations included lack of county data on bullying; ethnic subgroups affected by Hepatitis B; suicide among LGBTQ youth; diabetes among children; and lack of extended data on breastfeeding (data cover only the days a mother and child are in the hospital).

There were also limitations on how ASR and the Coalition was able to understand the needs of special populations including LGBTQ, undocumented immigrants, and Blacks/African-Americans. Due to the small numbers of these community members, many data are statistically unstable and do not lend themselves to predictability.

6. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY HEALTH NEEDS

To identify the community's health needs, ASR and the Coalition followed these steps:

1. Gathered data on 80+ health indicators using the University of Missouri's, Center for Applied Research and Environmental System (CARES) Data Platform developed for Kaiser Permanente ("CARES Platform"), Healthy People 2020 objectives, the RDA compendium of secondary data, and qualitative data. See Attachment 5 for a list of indicators on which data were gathered.
2. Narrowed the list to "health needs" by applying criteria
3. Used criteria to prioritize the health needs



These steps are further defined below.

Identification of Community Health Needs

As described in Section 5, a wide variety of experts and community members were consulted about the health of the community. Community members were frank and forthcoming about their personal experiences with health challenges and their perceptions about the needs of their families and community.

Collectively, they identified a diverse set of health conditions (see table below) and demonstrated a clear understanding of the health behaviors and other drivers (environmental and clinical) that affect the health outcomes. They spoke about prevention, access to care, clinical practices that work and don't work, and their overall perception of the community's health. Cross-cutting drivers that frequently arose during primary data collection are listed in Attachment 6.

All Health Conditions Named During Primary Data Gathering

Arose 10 or more times in interviews or focus groups:
Substance abuse (ATOD)/behavioral health (incl. prescription meds)/addiction
Diabetes/poor nutrition
Cardiovascular disease (heart disease, stroke, CHF, HBP, hypertension)
Poor mental health/trauma/suicide/depression/anxiety/stress/cutting
Obesity/overweight/poor nutrition
Violence (incl. abuse/bullying)
Arose 5-9 times in interviews or focus groups:
Respiratory conditions (asthma, allergies, bronchitis, COPD)
Cancers
Poor oral/dental health
Teen pregnancy
Arose at least once but less than 5 times in interviews or focus groups:
Acute/episodic issues (ulcers, skin diseases, etc.)
ADD/ADHD/learning disabilities
Anemia
Arthritis
Autism/Asperger's
Chronic diseases
Deformities - tetarogenic
Dementia/Alzheimer's
Drowning
Emphysema
Falls/injury
Fatigue
Hepatitis B/C
High cholesterol
Infant mortality
Jaundice
Kidney stones
Low birthweight
Parkinson's
Pregnancy-related conditions
Premature births
Sciatica
Sleep apnea/disorders
Social/emotional development
STDs/unhealthy sexual behavior
Stroke
Thyroid
Trauma
Viruses
Vision/Glaucoma/Cataracts

In order to generate a list of health needs, ASR used a spreadsheet (known as the “data culling tool”) to list indicator data and evaluate whether they were “health needs.” The indicator data collected included CARES Platform data, secondary data, and qualitative data from focus groups or key informant interviews.

In order to be categorized as a prioritized Community Health Need, all three of the following criteria needed to be met:

1. The issue must fit the definition of a “health need.”
2. The issue is suggested or confirmed by more than one source of secondary and/or primary data.
3. At least one related indicator performs poorly against the Healthy People 2020 (“HP 2020”) benchmark or, if no HP 2020 benchmark exists, against the state average.

Thirteen health conditions or drivers fit all three criteria and were retained as community health needs. The list of needs, in priority order, is found below.

DEFINITIONS

A health **need** is a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

A health **driver** is a behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health.

A health **indicator** is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

A health **outcome** is a snapshot of diseases in a community that can be described in terms of both morbidity (quality of life) and mortality (death rates).

A health **condition** is a disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

Summarized Descriptions of Prioritized Santa Clara County Community Health Needs

Access to health care is a health need in Santa Clara County as marked by the proportion of the community who are linguistically isolated. In addition, there are areas with low educational attainment, which also impacts health outcomes. The community input indicates that underinsurance and lack of insurance coverage is an issue. Lack of transportation is also an access barrier that affects those in poverty. Stigma and lack of knowledge both impact the seeking of preventative care or treatment. Also, too few general and specialty practitioners, especially in community clinics, results in long wait times for appointments. These issues around lack of access contribute to community members using urgent care and emergency rooms for treatment of conditions that have worsened due to lack of treatment or preventative care.

Alzheimer’s disease is a health need in Santa Clara County as marked by Alzheimer’s disease being the third leading cause of death. It is the fastest growing cause of death in California and the number of people living with Alzheimer’s disease is also growing rapidly. Community input suggests that the impact on caregivers who have few resources (especially for transportation) will affect quality of life for those living with Alzheimer’s. Qualitative research also suggests that there is a lack of gerontologists and those who can help coordinate care.

Birth outcomes are a health need in Santa Clara County, as marked by the percentage of low birth-weight babies, which is no better than the state average (though below the HP2020 benchmark). African Americans are disproportionately affected, with the percentage of African American babies of low birth-weight higher than the state average and HP 2020 benchmark. While infant mortality is not a concern county-wide, it is possible that some subgroups (e.g., African American infants) are disproportionately affected; however, the data are too sparse to rely upon. The health need is likely being impacted by certain social determinants of health, and by the percentage of women receiving early prenatal care. While this is not an issue on the county-wide level, a disproportionately smaller percentage of Native American women receive early prenatal care in comparison to other ethnic groups. Community feedback indicates that the health need is affected by concerns about the cost of care, and poor access to primary care providers and specialists due to lack of insurance, particularly among low-income residents. In addition, community input suggested that limited prenatal visits may be driven by lack of knowledge of the importance of prenatal care, language barriers between patients and specialists, cultural issues such as body modesty, as well as the cost of care.

Cancer is a health need in Santa Clara County as marked by incidence rates of breast, cervical, liver, and prostate cancer that are too high compared to HP 2020 benchmarks/state averages, and a liver cancer mortality rate that is too high compared to the state average. Breast and prostate cancer disproportionately affect Whites; lung and prostate cancer disproportionately affect African Americans. Latinos and Asian/Pacific Islanders have higher incidence rates of cervical and liver cancer than other ethnic groups, and disproportionately high mortality rates due to liver cancer as well. Latinos additionally are unduly burdened by mortality from colorectal cancer. The health need is likely being impacted by health behaviors such as rates of screening that do not meet established benchmarks, and low fruit and vegetable consumption that are no better than average (as diet has been shown to have an impact on many types of cancer). Community input indicates that the health need is also affected by lack of knowledge about cancer prevention and treatment, fear and denial, lack of staff time for follow-up with those who are at risk and should be screened, concerns about the costs of treatment, and poor access to primary care providers and specialists due to lack of insurance, particularly among low-income residents. There was also some concern about youth tobacco use (as smoking has also been shown to have an impact on various types of cancer).

Cardiovascular Disease, Heart Attack, and Stroke are health needs in Santa Clara County as marked by high overall percentages of high cholesterol and hypertension, both of which fail HP 2020 benchmarks. African Americans and those who identify as multiracial have a higher stroke mortality rate than the HP 2020 benchmark. African Americans and Whites disproportionately experience hypertension and high cholesterol. Heart disease deaths are worst in the South County area and in East San Jose. Poor nutrition, which is related to cardiovascular disease, is of concern in the county. Adult and youth consumption of fruits and vegetables, and household expenditures on the same, is no better than the state average, and in some cases is worse. There are also more fast food restaurants, and fewer grocery stores and WIC-authorized stores, than the state average. Community input reflected this, as well as a concern about lack of exercise. The community also indicated that the health need is being affected by stress and lack of knowledge about stroke and heart disease.

Diabetes is a health need in Santa Clara County as marked by relatively high rates of diabetes. The overall adult rate meets the HP 2020 benchmark, but Latino and African American residents are disproportionately diabetic, and worse off in comparison with the county and state averages and benchmark. Of all ethnic groups, African Americans experience the highest percentage of hospitalizations due to diabetes. Community input about diabetes was strong, and expressed the connection between the disease and related health

behaviors such as poor nutrition and lack of physical activity. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, soda consumption, the proximity of fast food establishments, and a lack of grocery stores and WIC-authorized food sources.

Mental health is a health need in Santa Clara County as marked by a percentage of self-reported poor mental health that is higher than the state average. Latino and African-American youth disproportionately exhibit symptoms of depression, and African American youth additionally experience suicidal ideation rates higher than the county-wide average. Community input indicates that the health need is likely being affected by stress (driven by financial/economic concerns) and the lack of education about how to cope with stress, stigma about mental illness leading to fear and denial, lack of knowledge about mental health treatment, and poor access to mental health care providers and specialists due to lack of insurance and/or mental health benefits among those who are insured, and/or due to a lack of providers (i.e., workforce development issues). Related to poor mental health are the health needs around violence and substance abuse.

Obesity is a health need in the Santa Clara County as marked by high rates of overweight and obesity among both youth and adults. Overall rates are just below state averages, but the adult overweight rate misses the HP 2020 benchmark. Latino and African American residents are disproportionately overweight and obese, and worse off in comparison with California (and in some cases, U.S.) averages. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, soda consumption, the proximity of fast food establishments, and a lack of grocery stores and WIC-authorized food sources.

Oral/dental health is a health need Santa Clara County as marked by the percentage of youth reporting their teeth in fair or poor condition, which is higher than the state average. Latino and Asian/Pacific Islander youth are disproportionately affected. While adult dental health is not identified as a concern county-wide, some subgroups (Latinos, Native Americans, Asian/Pacific Islanders) are more likely than others not to have dental insurance, at rates nearing the statewide average. The health need is likely being impacted by certain social determinants of health, and by the cost of dental care. Community feedback indicates that the health need is affected by concerns about poor access to dental care providers and specialists due to lack of insurance, particularly among residents with chronic conditions.

Respiratory conditions are a health need in Santa Clara County as marked by hospitalization rates of children ages 0-4. Asthma hospitalization rates of youth ages 0-17 show geographical disparities, with the worst rates in Saratoga, South San Jose, parts of Los Gatos and Campbell. The health need is likely being impacted by health behaviors such as the percentage of youth smoking, and by issues in the physical environment such as air-quality levels. Community input indicates that the health need is also affected by concerns about the costs of treatment (including prescription medication and equipment) due to underinsurance or lack of insurance, particularly among low-income residents.

STDs including HIV and AIDS are a health need in Santa Clara County as marked by high incidence rates of HIV among African Americans and Latinos, as well as high primary and secondary syphilis incidence rates among males county-wide. The rate of HIV hospitalizations is worst in central San Jose. The health need is likely being impacted by low screening rates for HIV (county-wide, the percentage of teens and adults ever screened for HIV is lower than the state average), as well as certain social determinants of health. Community feedback suggests that the health need is perceived as primarily affecting youth, and is impacted by poor outreach, lack of knowledge/health education about transmission, risk, and screening, the fear of stigmatization by others, access to and costs of prevention (e.g., condoms), and peer pressure.

Substance abuse is a health need in Santa Clara County as marked by levels of binge drinking among youth and adults that are higher than HP 2020 benchmarks. Community feedback indicates that the health need is impacted by stress and poor coping skills across all sub-populations, concerns about the cost of treatment, fear of being stigmatized, and poor access to primary care providers, specialists, and other support options due to lack of insurance or underinsurance, particularly among low-income residents. Medication misuse and mismanagement was also discussed, and was thought to be due to a lack of knowledge about medications and their associated risks. In addition, community input suggested that adolescents are especially vulnerable to this health need, as it was believed they are more affected by peer pressure, curiosity, media portrayals, accessibility of alcohol, tobacco, and other drugs, and parental permissiveness.

Violence is a health need in Santa Clara County as marked by rates of youth homicide that are higher than the HP 2020 benchmark for homicide overall. Rates of bullying are also high, though no statewide data are available for comparison. In addition, while county-wide levels of child abuse and domestic violence do not fail against state averages, the percentage of child abuse among African Americans is much higher than the state average. The health need is likely being impacted by health behaviors such as binge drinking (where the county adult rate is higher than the state average) and gang membership (percentages of gang identification among African American, Native American, and Latino youth are higher than the county-wide levels). Community input indicates that the health need is also affected by the cost of and/or lack of activity options for youth, financial/economic stress, lack of policy enforcement, poor family models, unaddressed mental and/or behavioral health issues among perpetrators, cultural/societal acceptance of violence, lack of awareness of support and services for victims, and linguistic isolation. Community members also suggested that violence is underreported by victims, possibly due to stigma and/or cultural norms.

For further details, please consult the Health Needs Profiles appended to this report as Attachment 7.

Prioritization of Health Needs

Before beginning the prioritization process, the Coalition chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

1. Clear disparities/inequities exist among subpopulations in the community.
2. An opportunity to intervene at the prevention or early intervention level.
3. A successful solution has the potential to solve multiple problems.
4. The community prioritizes the issue over other issues.

Scoring Criteria 1-3: The score levels for the prioritization criteria were:

- 3:** Strongly meets criteria, or is of great concern
- 2:** Meets criteria, or is of some concern
- 1:** Does not meet criteria, or is not of concern

A survey was then created, listing each of the health needs in alphabetical order and offering the first three prioritization criteria for rating. Coalition members rated each of the health needs on each of the first three prioritization criteria during an in-person meeting in November 2012.

Scoring Criteria 4 (Community prioritization): ASR gave community prioritization scores based on the results of the primary data gathering process. (See Section 5 for primary data collection methodology.) The score levels for the fourth prioritization criterion were:

- 3:** Health need was prioritized by more than half of the key informants and focus groups
- 2:** Health need was prioritized, but by half or fewer of the key informants and focus groups
- 1:** Health need was mentioned by at least one key informant or focus group, but not prioritized by any

Combining the Scores: For the first three criteria, Coalition members’ ratings were combined and averaged to obtain a combined coalition score. Then, the mean was calculated based on the four criterion scores for an overall prioritization score for each health need.

List of Prioritized Needs

The need scores ranged between 1.4 and 3.0, with 3 being the highest score possible and 1 being the lowest score possible. The needs are ordered by prioritization score in the table below. The specific scores for each of the four criteria used to generate the overall community health needs prioritization scores may be viewed in Attachment 8. Note that while the Coalition prioritized access-related drivers, the cross-cutting driver, Access to Health Care Services, was not scored during the prioritization process.

Health Needs by Prioritization Score

Health Need	Overall Average Priority Score
Diabetes	3.0
Obesity	2.9
Violence	2.6
Poor Mental Health	2.6
Poor Oral/Dental Health	2.5
Cardiovascular Disease, Heart Disease, Stroke	2.4
Substance Abuse (Alcohol, Tobacco, and Other Drugs)	2.4
Cancers	2.2
Respiratory Conditions	2.0
STDs/HIV-AIDS	2.0
Birth Outcomes	1.6
Alzheimer's	1.4

7. COMMUNITY ASSETS AND RESOURCES

The following resources are available to respond to the identified health needs of the community.

Existing Hospitals

- El Camino Hospital – Los Gatos
- El Camino Hospital – Mountain View
- Good Samaritan Hospital
- Kaiser Permanente – San Jose
- Kaiser Permanente – Santa Clara
- Lucile Packard Children’s Hospital at Stanford
- O’Connor Hospital
- Regional Medical Center of San Jose
- Santa Clara Valley Medical Center
- Saint Louise Regional Hospital
- Stanford Hospital & Clinics

Existing Health Clinics

- Asian Americans for Community Involvement
- Foothill Community Health Center
 - Medical and Dental Clinic
 - San Jose Foothill Family Community Clinic
 - School Based Clinic Programs
 - Andrew Hill High School
 - Independence High School
 - Mt. Pleasant High School
 - Silver Creek High School
 - Yerba Buena High School
- Gardner Family Health Network
 - Alviso Health Center
 - CompreCare Health Center
 - Gardner Health Center
 - Gardner South County
 - Healthcare for the Homeless
 - St. James Health Center
- Indian Health Center of Santa Clara Valley
 - Main Medical Clinic
 - Medical Clinic at Silver Creek
 - O’Connor Family Health Center
- MayView Community Health Center

- Mountain View
- Palo Alto
- Sunnyvale
- North East Medical Services
- Planned Parenthood Mar Monte
 - Blossom Hill Health Center
 - Eastside Health Center
 - Gilroy Health Center
 - Mar Monte Community Clinic
 - Mountain View Health Center
 - San Jose Health Center
 - Sunnyvale Health Center
- RotaCare Bay Area, Inc.
 - Gilroy
 - Mountain View
 - San Jose
- Santa Clara Valley Health & Hospital System
 - Valley Health Center Bascom
 - Valley Health Center East Valley
 - Valley Health Center Gilroy
 - Valley Health Center Milpitas
 - Valley Health Center Moorpark
 - Valley Health Center Sunnyvale
 - Valley Health Center Tully
- School Health Clinics of Santa Clara County
 - Franklin McKinley
 - Gilroy
 - Overfelt
 - San Jose High
 - Washington

Other existing community resources and programs

Please see the Health Needs Profiles (Attachment 6), which identify:

1. Programs/resources in which Coalition members invest community benefit funds and provide resources to the community; and
2. Programs/resources in which other health care systems, and non-profit organizations provide services to the community.

8. CONCLUSION

The Santa Clara County Community Benefit Coalition partners worked in collaboration to meet the requirements of the new federally required CHNA by pooling expertise, guidance and resources for a shared assessment. By gathering secondary data and doing new primary research as a team, the Coalition partners were able to collectively understand the community's perception of health needs, and prioritize health needs with an understanding of how each compares against benchmarks.

In the spirit of collaboration, the Coalition has committed to working together to continually monitor these prioritized health needs. With the assistance of the Santa Clara County Public Health Department and Applied Survey Research, the Coalition created a **Community Indicator Dashboard** (Attachment 9), which includes the key indicators for each of the prioritized health needs. Many of these indicators are also included in the attached **Health Needs Profiles**, which the hospital partners plan to use to educate and inform advisory boards and community stakeholders.

After making this CHNA report publically available in May 2013, each hospital will develop individual implementation plans based on this shared data, and the Coalition may prioritize some coordinated interventions around shared health needs.

9. LIST OF ATTACHMENTS

1. Secondary Data Sources
2. IRS Checklist
3. Map of Santa Clara County
4. List of Community Leaders and Their Credentials
5. Indicator List
6. Cross-Cutting Drivers
7. Health Needs Profiles
8. Health Needs Prioritization Scores: Breakdown by Criteria
9. Community Indicator Dashboard

Attachment 1: Secondary Data Sources

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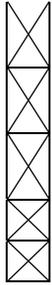
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Attachment 2: IRS Checklist

Federal Requirements Checklist		IRS Notice	Report Reference
I. CHNA Report Requirements			
A. Pre-Assessment			
	CHNA Report includes identification of all of the organizations with which the facility collaborated in preparing the CHNA(s)	Notice 3.03	Section 4
	CHNA Report includes identity and qualifications of any third parties contracted to assist in conducting a CHNA	Notice 3.03	Section 4
	CHNA Report includes a definition of the community served and a description of how the community was determined*	Notice 3.03	Section 3
	Demographics and other descriptors of the hospital service area	IRS Form 990 Schedule H Part V 1.b	Section 3
B. Data Collection			
Secondary Data			
CHNA includes the following documentation of secondary data used for the assessment:			
	Sources and dates of data and other information used	Notice 3.03	Attachment 1
	Information gaps that impact the ability to assess health needs	Notice 3.03	Section 5
Primary Data			
CHNA includes the individuals consulted who have special knowledge of or expertise in public health:		Notice 3.03	
	Name		Attachment 3
	Title		Attachment 3
	Affiliation		Attachment 3
	Brief description of individual's special knowledge or expertise		Attachment 3
	If not public health experts, report provides name and title of at least one such individual in each organization who was consulted		Attachment 3
CHNA includes input from persons who represent the broad interests of the community:		Notice 3.06	Section 5 and attachment 3
	Persons with special knowledge of or expertise in public health		Section 5 and attachment 3
	Federal, tribal, regional, State, or local health or other departments or agencies with current data or other relevant information		Attachment 3
	Leaders, representatives, or members of medically underserved populations		Attachment 3
	Leaders, representatives, or members of low-income populations		Attachment 3
	Leaders, representatives, or members of minority populations		Attachment 3

	Leaders, representatives, or members of populations with chronic disease needs Report describes when the organization consulted with these persons Report describes how mode of consultation (focus groups, key informant interviews, other) Leader/representatives' names Leader/representatives' leadership or representative roles	Attachment 3 Notice 3.03 Attachment 3 Section 5 Attachment 3 Attachment 3
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C. CHNA Methodology

Notice 3.03

CHNA Report includes the following information related to community health needs

	Criteria and analytical methods applied to identify the community health needs Prioritized description of all health needs identified A description of process and criteria used to prioritize the health needs	Section 6 Section 6 and Attachment 6 Section 6
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D. Assets

CHNA Report includes description of the existing health care facilities and resources within the community that are available to respond to the health needs of the community

	Existing health care facilities Other available resources	Section 7 Assets attachment (related to specific needs)
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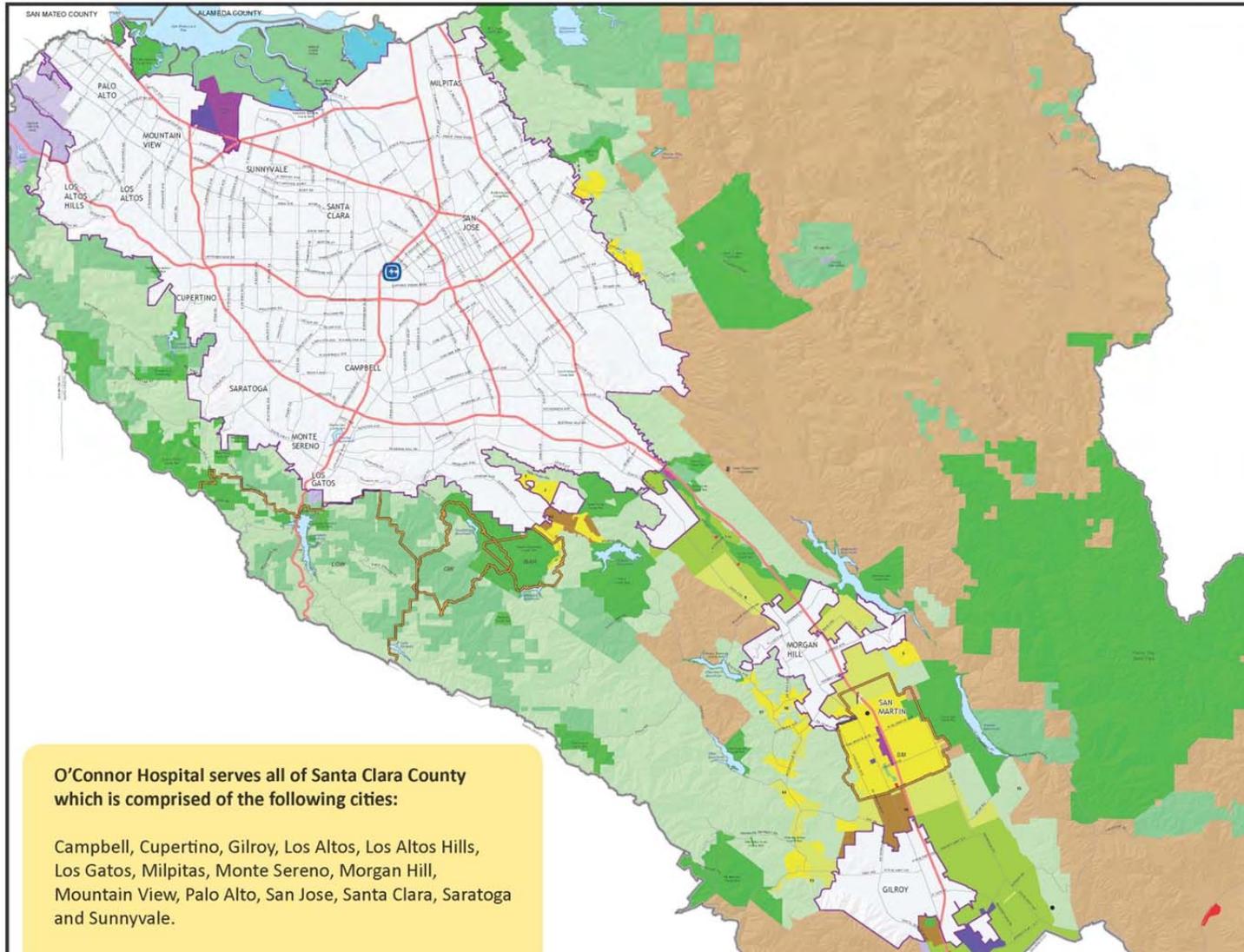
E. Finalizing the CHNA

Notice 3.07

CHNA reports have been made widely available to the public in 2013 according to requirements

H	Written report(s) posted visibly on facility website
H	If facility has no website, report(s) posted visibly on website for the organization
H	Instructions for accessing CHNA report are clear
H	Posted reports exactly reproduce an image of each report
H	Individuals with Internet access can access and print reports without special software and without payment of a fee
H	Individuals requesting a copy of the report(s) are provided the URL
H	Reports remain widely available until a subsequent CHNA is made widely available to the public

Attachment 3: Map of Santa Clara County



Attachment 4: List of Community Leaders and Their Credentials

The following leaders were consulted for their expertise in the community. They were identified based on their professional expertise and knowledge of target groups including children, youth, older adults, low-income populations, minorities, the medically underserved, and those living with chronic conditions. The coalition included leaders from health systems including the Santa Clara County Health & Hospital System including the Department of Public Health, non-profit hospital representatives, local government employees, healthcare consumer advocate organizations, and nonprofit organizations.

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Shamima Hasan	CEO	Mayview Community Health Center	Health Care Provider	Medically Underserved (uninsured)	Leader	Interview	10/2/12
René Santiago	Deputy County Executive	Santa Clara County Health & Hospital System	Public Health	Medically Underserved	Leader	Interview	10/2/12
Dan Peddycord	Director	Santa Clara County Public Health Dept	Public Health	Chronic Conditions	Leader	Interview	10/3/12
Dr. Marty Fenstersheib	Health Officer	Santa Clara County Health & Hospital System	Public Health	Medically Underserved	Leader	Interview	10/3/12
Michelle Lew	Executive Director	Asian Americans for Community Involvement	Health Care Provider	Minority (Asian), Medically Underserved (uninsured)	Leader	Interview	10/4/12
Reymundo Espinoza	CEO	Gardner Health Center	Health Care Provider	Minority (Latino), Medically Underserved (uninsured)	Leader	Interview	10/4/12
Dolores Alvarado	Executive Director	Community Health Partnership	Health Care Advocacy	Medically Underserved (uninsured)	Leader	Interview	10/17/12
Marc Baker	Grants Manager	Second Harvest Food Bank of Santa Clara and San Mateo Counties	Food Access	Low-income, Minority	Leader	Focus Group	10/24/12
Ali Barekat	Executive Director	Sunday Friends	Violence Prevention	Low-income, Minority	Leader	Focus Group	10/24/12
Patty Bennett	Program Director	Next Door Solutions to Domestic Violence	Domestic Violence, Violence Prevention	Low-income, Minority	Leader	Focus Group	10/24/12
Sadie Sponsler	South Bay Food Systems Regional Manager	Community Alliance with Family Farmers	Food Access	Low-income, Minority	Leader	Focus Group	10/24/12
Dee Demitri	Program Coordinator	Community Solutions	Mental Health	Children/Youth, South County	Leader	Focus Group	10/24/12
Lis DuBois	Director of Community Engagement	Bay Area Women's Sports Initiative	Community Wellness Services	Children/ Youth	Leader	Focus Group	10/24/12
Whitney Evans	Program Manager	Girl Scouts of Northern California	Violence Prevention	Youth, Minority	Leader	Focus Group	10/24/12

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NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Marisol Fernandez	Outreach Manager	County of Santa Clara Parks & Recreation	Community Wellness Services	Youth, Minority (Latino)	Leader	Focus Group	10/24/12
Elizabeth Franco	Development Director	Project Cornerstone	Violence Prevention	Children, Low-income	Leader	Focus Group	10/24/12
Linda Franklin	Program Manager	Alum Rock Counseling Center	Substance Abuse Prevention	Youth, Low-income, Minority (Latino)	Leader	Focus Group	10/24/12
Doris Fredericks	Executive Director	CDI/Choices for Children	Early Childhood	Chronic Conditions	Leader	Focus Group	10/24/12
Aimee Frisch	Executive Director	Veggielution	Food Access	Low-income, Minority	Leader	Focus Group	10/24/12
Emily Hennessy	Director of Finance	Santa Clara Family Health Foundation	Health Insurance	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Jennifer Shelton	Program Associate	Santa Clara Family Health Foundation	Health Insurance	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Rhonda McClinton Brown	Executive Director	Stanford University - Pacific Free Clinic	Health Care Provider	Medically Underserved (uninsured), Minority (Asian & Latino)	Leader	Focus Group	10/24/12
Maritza Maldonado	Program Director	Somos Mayfair	Community Wellness Services	Minority (Latino), Low-income	Leader	Focus Group	10/24/12
Marianne Marafino-Johnson	Program Director	Community Solutions	Mental Health	Youth, Low-income, South County	Leader	Focus Group	10/24/12
Dan McClure	Executive Director	Generations Community Wellness	Community Wellness Services	Chronic Conditions	Leader	Focus Group	10/24/12
Patricia Narciso	Director of Development and Marketing	Children's Discovery Museum	Community Services	Youth, Minority	Leader	Focus Group	10/24/12
Elisa Orona	Grants Coordinator	Asian Americans for Community Involvement	Substance Abuse Prevention	Youth, Minority (Asian)	Leader	Focus Group	10/24/12
Joma Briones	Program Manager	Asian Americans for Community Involvement	Substance Abuse Prevention	Youth, Minority (Asian)	Leader	Focus Group	10/24/12
Sonia Padula	Clinic Manager	MayView Community Health Center	Health Care Provider	Medically Underserved (uninsured), Low-Income	Leader	Focus Group	10/24/12
Allison Robinson	Casemanager	InnVision Shelter Network	Homeless	Medically Underserved, Low-income	Leader	Focus Group	10/24/12

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NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Marc Sabin	Director of Montgomery Street Inn	InnVision Shelter Network	Homeless	Medically Underserved, Low-income	Leader	Focus Group	10/24/12
Stephanie Sanchez	Family Support Services Manager	Next Door Solutions to Domestic Violence	Domestic Violence, Violence Prevention	Low-income, Minority	Leader	Focus Group	10/24/12
Julie Smith-Reid	Director of Education	Planned Parenthood	Health Care Provider	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Victor Hernandez	Program Coordinator	Breathe California of the Bay Area	Community Services	Low-income	Leader	Focus Group	10/24/12
Myrna Zendejas	CSH Outreach Specialist	Santa Clara County Office of Education	Education	Low-income	Leader	Focus Group	10/24/12
Mark Balcher	Program Coordinator	Full Circle Farm	Food Access	Chronic Conditions	Leader	Focus Group	10/24/12
Laurel Blankenship	Grants Manager	Happy Hollow Park & Zoo	Community Services	Children/Youth, Minority	Leader	Focus Group	10/24/12
Lorena Madrid	Director of Health Coverage Initiatives	Community Health Partnership	Health Care Advocacy	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Tammy Janosik	Executive Director	RotaCare Bay Area	Health Care Provider	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Zelia Rodriguez	Program Manager	SIREN	Health Care Advocacy	Medically Underserved (uninsured)	Leader	Focus Group	10/24/12
Cindy Clawsen	Program Manager	Community Solutions	Mental Health	Low-income, South County	Leader	Focus Group	10/24/12
Phaik Teoh	Grants Manager	Bay Area Women's Sports Initiative	Community Wellness Services	Youth	Leader	Focus Group	10/24/12
Sister Rachela	Director, Community Health	Saint Louise Regional Hospital	Health Care Provider	Medically Underserved & Low Income, South County	Leader	Focus Group	11/1/12
Lillian Castillo	Nutritionist	Santa Clara County Public Health Dept	Public Health	Chronic Conditions	Leader	Focus Group	11/1/12
Eileen Obata	District Nurse	Gilroy Unified School District School Nurse	Public Health	Medically Underserved & Low-income, South County	Leader	Focus Group	11/1/12
Celia Shanley	Health Services Manager	Rebekah's Children Services	Mental Health	Children/Youth, South County	Leader	Focus Group	11/1/12
Lynn Magruder	Grants Administrator	Community Solutions	Mental Health	Children/Youth, South County	Leader	Focus Group	11/1/12

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NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Marilyn Roaf	HCD Grants Coordinator	City of Gilroy	Community Services	Underserved & Low-income, South County	Leader	Focus Group	11/1/12
Maureen Drewniany	Community Services Manager	City of Morgan Hill	Community Services	Underserved & Low-income, South County	Leader	Focus Group	11/1/12
Susan Fent	Director, Senior Programs & Services	Morgan Hill Senior Center	Community Services	Chronic Conditions, South County	Leader	Focus Group	11/1/12
Susan Valenta	President & CEO	City of Gilroy Chamber of Commerce	Community Services	Underserved & Low - income, South County	Leader	Focus Group	11/1/12
Claudia Rossi	Trustee	Morgan Hill School Board	Education	Underserved & Low-income, South County	Leader	Focus Group	11/1/12
Art Barron	Chair, Advisory Board	CARAS	Community Services	Medically Underserved & Low-income, South County	Leader	Focus Group	11/1/12
Naomi Nakano-Matsumoto	Executive Director	West Valley Community Services	Community Health	Low-income	Leader	Focus Group	11/6/12
Dr. Kent Imai	Medical Director	Community Health Partnership	Health Care Advocacy	Medically Underserved (uninsured)	Leader	Interview	11/6/12
Kathleen King	CEO	Santa Clara Family Health Foundation	Health Insurance	Medically Underserved (uninsured)	Leader	Focus Group	11/6/12
Carol Leigh-Hutton	President & CEO	United Way Silicon Valley	Community Services	Low-income	Leader	Focus Group	11/6/12
Jill Dawson	Program Director	InnVision Shelter Network	Homeless	Low-income	Leader	Focus Group	11/6/12
Marie Bernard	Executive Director	Sunnyvale Community Services	Community Services	Low-income	Leader	Focus Group	11/6/12
Maureen Wadiak	Associate Director	Mountain View Community Services	Community Services	Low-income, North County	Leader	Focus Group	11/6/12
Patricia Gardner	Executive Director	Silicon Valley Council of Nonprofits	Healthcare Advocacy	Low-income	Leader	Focus Group	11/6/12
Poncho Guevara	Executive Director	Sacred Heart Community Service	Community Services	Low –income, Minority (Latino)	Leader	Focus Group	11/6/12
Aimee Reedy	SCC Division Director	Santa Clara County Public Health Dept	Public Health	Chronic Conditions, Low-income, Minority	Leader	Focus Group	11/7/12
Bonnie Broderick	Director, Chronic Disease and Injury Prevention	Santa Clara County Public Health Dept	Public Health	Chronic Conditions, Low-income, Minority	Leader	Focus Group	11/7/12
Fred Ferrer	Executive Director	The Health Trust	Community Health	Chronic Conditions, Low-income	Leader	Focus Group	11/7/12

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NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Ellen Corman	Supr. Injury Prevention & Commtty Outreach	Stanford Hospital & Clinics	Health Care Provider	Chronic Conditions	Leader	Focus Group	11/7/12
Bruce Copley	Director	Santa Clara County Drug and Alcohol Services	Behavioral Health	Low-income	Leader	Focus Group	11/7/12
Sherri Terao	Division Director	Santa Clara County Mental Health	Mental Health	Children, Low-income	Leader	Focus Group	11/7/12
Vivian Silva, MSW	Care Manager	City of Sunnyvale	Community Services	Chronic Conditions	Leader	Focus Group	11/7/12
Pam Gudiño	Program Manager	Somos Mayfair	Community Wellness Services	Minority (Latino) & Low-income	Leader	Focus Group	11/7/12
Cindy McGown	Senior Director	Second Harvest Food Bank	Food Access	Low- income	Leader	Focus Group	11/7/12
Connie Corrales	Director, HICAP	Council on Aging	Older Adults	Chronic Conditions	Leader	Focus Group	11/7/12
Lori Andersen	Director, Healthy Aging	The Health Trust	Older Adults	Chronic Conditions	Leader	Focus Group	11/7/12
Maria Solis	Social Services Administrator	Yu Ai Kai	Older Adults	Chronic Conditions	Leader	Focus Group	11/7/12
Mike Torres	Director, Contracts & Planning	Council on Aging	Older Adults	Chronic Conditions	Leader	Focus Group	11/7/12
Susan Silveira	Program Director	Santa Clara County Public Health Dept	Public Health	Medically Underserved	Leader	Focus Group	11/9/12
Dr. Dorothy Furgerson	Chief Medical Officer	Planned Parenthood	Health Care Provider	Medically Underserved (uninsured), Youth	Leader	Focus Group	11/9/12
Jodi Kazemini	Clinic Manager	Lucile Packard Children's Hospital Adolescent Clinic	Health Care Provider	Medically Underserved (uninsured), Youth	Leader	Focus Group	11/9/12
Geraldo Cadenas	Senior Office Assistant	Columbia Neighborhood Center	Community Services	Children	Leader	Focus Group	11/9/12
Paul Schutz	Associate Director of Development	Community Health Awareness Council	Community Services	Youth, North County	Leader	Focus Group	11/9/12
Petra Rigüero	Program Supervisor	City of San Jose Mayor's Gang Prevention Task Force	Violence Prevention	Youth	Leader	Focus Group	11/9/12
Elaine Glissmeyer	Executive Director	YMCA	Community Wellness Services	Youth	Leader	Focus Group	11/9/12
Marlene Bjornsrud	Executive Director	Bay Area Women's Sports Initiative	Community Wellness Services	Youth	Leader	Focus Group	11/9/12
Rho Henry Olaisen	Director	Abilities United	Community Wellness Services	Disabled	Leader	Focus Group	11/9/12

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NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	TARGET GROUP ROLE	CONSULTATION METHOD	DATE CONSULTED
Melinda Landau	Manager	San Jose Unified School District	Education	Children	Leader	Focus Group	11/9/12
Dr. Thad Padua	Medical Director	Santa Clara Family Health Plan	Health Insurance	Medically Underserved (uninsured)	Leader	Interview	11/9/12
Anne Ehresman	Executive Director	Project Cornerstone	Violence Prevention	Children	Leader	Focus Group	11/9/12
Dana Bunnett	Executive Director	Kids in Common	Children's Advocacy	Children	Leader	Focus Group	11/9/12

For a description of **members** of the community who participated in focus groups, please see Section 5 "Resident Input."

Attachment 5: List of Indicators on Which Data Were Gathered

Indicator	Data Source
Absence of Dental Insurance Coverage	California Health Interview Survey (CHIS), 2007
Access to Primary Care	U.S. Health Resources and Services Administration Area Resource File, 2009 (as reported in the 2012 County Health Rankings)
Adequate Fruit/Vegetable Consumption (Youth)	California Health Interview Survey (CHIS), 2009
Adequate Social or Emotional Support	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Alcohol Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Asthma Hospitalizations (Adult)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Asthma Hospitalizations (Youth)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Asthma Prevalence	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Breast Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009
Breast Cancer Screening (Mammogram)	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007
Breastfeeding (Any)	CA only: California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011; Outside CA: National Survey of Children's Health, 2007

Indicator	Data Source
Breastfeeding (Exclusive)	CA only: California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011; Outside CA: National Survey of Children's Health, 2007
Cancer Mortality	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Cervical Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009
Cervical Cancer Screening (Pap Test)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Change in Total Population (from 2000 to 2010)	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1
Children in Poverty	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Chlamydia Incidence	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009
Colon and Rectum Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2004-2008
Colon Cancer Screening (Sigmoid/Colonoscopy)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010

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Indicator	Data Source
Dental Care Affordability	California Health Interview Survey (CHIS), 2007
Dental Care Utilization (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Dental Care Utilization [Youth]	California Health Interview Survey (CHIS), 2009
Diabetes Hospitalizations (Adult)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Diabetes Hospitalizations (Youth)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Diabetes Management (Hemoglobin A1c Test)	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007
Diabetes Prevalence	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
Facilities Designated as Health Professional Shortage Areas (HPSA)	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012
Fast Food Restaurant Access	CA only: U.S. Census Bureau, ZIP Code Business Patterns, 2009; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Federally Qualified Health Centers	U.S. Health Resources and Services Administration, Centers for Medicare & Medicaid Services, Provider of Service File, 2011
Free and Reduced Price School Lunch Eligibility	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2009-2010
Fruit/Vegetable Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011

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Indicator	Data Source
Grocery Store Access	U.S. Census Bureau, County Business Patterns, 2010
Heart Disease Mortality	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; outside CA Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Heart Disease Prevalence	CA only: California Health Interview Survey (CHIS), 2009; Outside CA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Heavy Alcohol Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
High Blood Pressure Management	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
High School Graduation Rate	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Local Education Agency (School District) Universe Survey Dropout and Completion Data, 2008-2009
HIV Hospitalizations	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
HIV Prevalence	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008
HIV Screenings	CA only: California Health Interview Survey (CHIS), 2005; Outside CA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010

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Indicator	Data Source
Homicide	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Inadequate Fruit/Vegetable Consumption (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2003-2009
Infant Mortality	Centers for Disease Control and Prevention, National Vital Statistics System, 2003-2009
Lack of a Consistent Source of Primary Care	CA only: California Health Interview Survey (CHIS), 2009; Outside CA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Lack of Prenatal Care	CA only: California Department of Public Health, Birth Profiles by ZIP Code, 2010; Outside CA: Centers for Disease Control and Prevention, National Vital Statistics Systems, 2007-2009. Accessed through CDC WONDER
Linguistically Isolated Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Liquor Store Access	CA only: California Department of Alcoholic Beverage Control, Active License File, April 2012; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Low Birthweight	CA only: California Department of Public Health, Birth Profiles by ZIP Code, 2010; Outside CA: Centers for Disease Control and Prevention, National Vital Statistics Systems, 2003-2009. Accessed through the Health Indicators Warehouse

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Indicator	Data Source
Lung Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2004-2008
Median Age	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Motor Vehicle Crash Death	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2008-2010
Obesity (Adult)	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
Obesity (Youth)	CA only: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011; Outside CA: National Survey of Children's Health, 2007
Overweight (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Overweight (Youth)	CA only: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011; Outside CA: National Survey of Children's Health, 2007
Park Access	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; Esri's USA Parks layer (compilation of Esri, National Park Service, and TomTom source data), 2012.
Pedestrian Motor Vehicle Death	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2008-2010

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Indicator	Data Source
Physical Inactivity (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Physical Inactivity (Youth)	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011
Pneumonia Vaccinations (Age 65+)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Poor Air Quality (Ozone)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008
Poor Air Quality (Particulate Matter 2.5)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008
Poor Dental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Poor General Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Poor Mental Health	California Health Interview Survey (CHIS), 2009
Population Below 200% of Poverty Level	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Population Living in a Health Professional Shortage Areas (HPSA)	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012
Population Living in Food Deserts	U.S. Department of Agriculture, Food Desert Locator, 2009
Population Receiving Medicaid	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Population with Any Disability	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Population with No High School Diploma	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates

2013 Community Health Needs Assessment (CHNA)

Indicator	Data Source
Poverty Rate (< 100% FPL)	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Premature Death	Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As Reported in the 2012 County Health Rankings)
Preventable Hospital Events	CA only: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010; outside CA: Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007
Prostate Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2004-2008
Recreation and Fitness Facility Access	CA only: U.S. Census Bureau, ZIP Code Business Patterns, 2009; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Soft Drink Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Stroke Mortality	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Student Reading Proficiency (4th Grade)	States' Department of Education, Student Testing Reports, 2011

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Indicator	Data Source
Suicide	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Supplemental Nutrition Assistance Program (SNAP) Recipients	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009
Teen Births	Centers for Disease Control and Prevention, National Vital Statistics Systems, 2003-2009. Accessed through the Health Indicators Warehouse
Tobacco Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Tobacco Usage (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Total Female Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Male Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 0-4	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 18-24	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 25-34	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates

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Indicator	Data Source
Total Population Age 35-44	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 45-54	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 5-17	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 55-64	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 65 or Older	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Unemployment Rate	U.S. Bureau of Labor Statistics, July, 2012 Local Area Unemployment Statistics
Uninsured Population	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Violent Crime	U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010
Walkability	WalkScore.Com (2012)
WIC-Authorized Food Store Access	U.S. Department of Agriculture, Food Environment Atlas, 2012

Attachment 6: Cross-Cutting Drivers Mentioned During Primary Data Gathering

- Access issues, including insurance/coverage issues (including MediCal), lack of transportation/transportation issues, issues with location, and language barriers
- Accessing primary care providers and the supply of practitioners & specialists (workforce development)
- Being too busy
- Being unemployed
- Caregiver issues
- Concerns about delivery of prevention
- Cultural issues
- Denial/fear
- Disabilities/existing medical conditions exacerbating other drivers
- Eating fast food
- Environmental issues, especially schools, neighborhoods (walkability & personal safety), housing, and lack of grocery stores or other places to buy fresh food
- Experiencing stigma
- Gangs, crime
- Having low income or being in poverty
- Health behaviors, including utilization of health care
- Heredity/genetic predisposition
- Issues of coordination of care
- Issues with prescription drugs (medication management, access to medication, sharing)
- Issues with treatment
- Lack of awareness
- Lack of health education
- Lack of knowledge
- Lack of motivation
- Lack of physical activity
- Lack of services
- Lack of/poor outreach
- Media
- Need for a patient-centered medical home/ “warm handshake”
- Need for best practices to be employed
- Need for partnerships or more effective partnerships
- Poor nutrition, including too much sugar, not cooking at home or cooking unhealthy food, eating processed food
- Social issues, especially poor/no role models, parenting & family issues, peer pressure, and social isolation
- Special populations: Children; youth; older adults; those of particular ethnicities (including being undocumented); adults
- Specific hospital-related delivery issues
- The cost of health care/insurance/prescriptions/activities/fresh food

Attachment 7: Health Needs Profiles

See separate attachments.

Attachment 8: Health Needs Prioritization Scores: Breakdown by Criteria

Health need/ condition	Overall average score	Average Scores of Prioritization Criteria Used by Group			Community Priority Score Based on Primary Data
		Disparities Exist	Prevention/ Intervention Opportunity	Solution Has Multiplier Effect	
Diabetes	3.0	3.0	3.0	2.9	3.0
Obesity	2.9	2.9	2.8	2.9	3.0
Violence	2.6	2.9	2.6	2.9	2.0
Poor mental health	2.6	2.3	2.6	2.4	3.0
Poor oral/dental health	2.5	2.7	2.8	2.3	2.0
Cardiovascular disease, heart attack, stroke	2.4	2.3	2.8	2.4	2.0
Substance use (ATOD)	2.4	2.4	2.8	2.3	2.0
Cancers	2.2	2.1	2.8	1.8	2.0
Respiratory conditions	2.0	2.4	2.6	1.9	1.0
STDs/HIV-AIDS	2.0	2.3	2.5	2.0	1.0
Birth outcomes	1.6	2.0	1.6	1.6	1.0
Alzheimer's	1.4	1.8	1.6	1.3	1.0

Notes: **Access to Health Care** not scored during prioritization process.

Coding of "Community Priority Score Based on Primary Data": Coded 3 if issue was identified as a top need/condition by more than 10 key informant interviews/focus groups (KIIs/FGs); coded 2 if by 1-9 KIIs/FGs; coded 1 if mentioned but not as a top need/condition.

Attachment 9: Community Indicator Dashboard

Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data Source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Cancer	Breast Cancer Screening	% of females ages 50-74 who had a mammogram in the past two years	all females 50-74	CHIS	2009	83%	86%	81.1%
	Breast Cancer Incidence	Age-adjusted breast cancer incidence rate	100,000 females	CA Cancer Reg	2009	161.4	154.1	--
	Breast Cancer Mortality	Age-adjusted mortality rate of females for breast cancer	100,000 females	CA Cancer Reg	2009	20.0	22.1	20.6
	Cervical Cancer screening	% of females ages 21 - 65 who had Pap test 3 yrs ago or less (never had a hysterectomy)	all females 21-65	CHIS	2007	91%	90%	93.3%
	Cervical Cancer Incidence	Age-adjusted cervical or uterine cancer incidence	100,000 female adults	CA Cancer Reg	2009	7.2	7.8	7.1
	Cervical Cancer Mortality	Three-year age-adjusted mortality rate due to cervix uteri cancer	100,000 female adults	CA Cancer Reg	2007-09	1.4	2.3	2.2
	Colorectal cancer screening	% of adults 50+ who ever had a sigmoidoscopy / colonoscopy	100,000 adults 50+	SCC BRFS; Cited by SCC Health Profile	2009	65%	60%	70.5%
	Colorectal cancer incidence	Age-adjusted colon and rectum cancer incidence rate †	100,000 adults	CA Cancer Reg	2009	40.9	43.2	45.4
	Colorectal cancer mortality	Age-adjusted colon and rectum cancer mortality	100,000 adults	CA Cancer Reg	2009	13.9	14.5	14.5
	Liver cancer incidence	Age-adjusted liver cancer incidence rate †	100,000 adults	CA Cancer Reg	2009	10.9	8.6	--
	Liver cancer mortality	Age-adjusted liver cancer mortality	100,000 adults	CA Cancer Reg	2009	6.8	5.6	--
	Lung/bronchus cancer incidence	Age-adjusted lung/bronchus cancer incidence rate †	100,000 adults	CA Cancer Reg	2009	41.8	50.6	--
	Lung/bronchus cancer mortality	Age-adjusted lung/bronchus mortality	100,000 adults	CA Cancer Reg	2009	28.2	37.8	45.5

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Prostate cancer screening	% of adult men ages 50 and older who reported that they had ever had a prostate-specific antigen test	men age 50+	SCC BRFS; Cited by SCC Health Profile	2009	72%		D
Prostate cancer incidence	Age-adjusted prostate cancer incidence rate †	100,000 men	CA Cancer Reg	2009	145.9	131.0	--
Prostate cancer mortality	Age-adjusted prostate cancer mortality rate	100,000 men	CA Cancer Reg	2009	15.8	22.4	21.2
Cancer mortality (all types)	Age-adjusted mortality rate due to all cancers	100,000 adults		2009	137.6	158.3	160.6

† Veteran's Health Admin hospitals did not report to CCR in 2005-2009. Therefore, case counts and incidence rates for males are underestimated.

Need	Short Description	Detailed indicator	Population/Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Cardio/Heart/Stroke	Heart disease mortality	Heart disease deaths	raw number (age-adjusted rate N/F)	CDPH Vital Stats Table 5-20	2010	Age-adjusted rate N/F		
	Stroke hospitalization rate	Hospital discharges due to acute ischemic stroke	raw number (age-adjusted rate N/F)	OSHPD 061-063	2010	Age-adjusted rate N/F		
	Stroke death rate	Stroke deaths	raw number (age-adjusted rate N/F)	CA Vital Stats Table 5-20 (2010)	2010	Age-adjusted rate N/F	CA Vital Stats 2010, Table 5-7	
	High cholesterol	% adults ever diagnosed with high cholesterol	adults	SCC BRFS (cited SCC Health Profile '10)	2009	29%	--	14%
	Hypertension	% adults ever diagnosed with hypertension	adults	SCC BRFS (cited SCC Health Profile '10)	2009	26%	--	27%
	Heart attack	% adults ever had heart attack	adults	SCC BRFS (cited SCC Health Profile '10)	2009	3%	3%	
	Heart disease prevalence	% adults ever diagnosed with coronary heart disease/angina	adults in San Jose/Sunnyvale/Santa Clara Area	CDC BRFS (online query)	2010	3.2%	3.6%	US: 4.3%
	Stroke incidence	% of adults who have ever had a stroke	adults	CDC BRFS 2006-1010	2009	2%	2.20%	--

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Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Respiratory	Asthma: children diagnosed	% children 0-17 diagnosed with asthma (based on parent report)	children 0-17	OSHPD; Cited by CA Breathing SCC Asthma Profile	2009	12%	14%	--
	Asthma: adults diagnosed	% adults ever diagnosed with asthma (lifetime)	adults	CHIS	2009	11%	14%	CA target: 13%
	Asthma: infant/toddler hospitalizations	Age-adjusted asthma hospitalization rate for kids 0-4	10,000 residents	OSHPD; Cited by CA Breathing SCC Asthma Profile	2010	24.5	22.3	18.1
	Asthma: child hospitalizations	Age-adjusted asthma hospitalization rate of kids 5-17	10,000 residents	OSHPD; Cited California Breathing SCC Asthma Profile	2010	4.3	6.9	--
	Asthma: adult hospitalizations	Age-adjusted rate of adult 18-64 hospitalizations for asthma per 10,000 residents	10,000 residents	OSHPD; Cited California Breathing SCC Asthma Profile	2010	3.2	5.7	8.6
	Asthma: senior hospitalizations	Age-adjusted rate of adults 65+ hospitalizations for asthma	10,000 residents	OSHPD; Cited California Breathing SCC Asthma Profile	2010	19.3	20.7	20.3
	COPD prevalence	% of adults ever diagnosed with COPD	adults	--	--	D	--	--
	COPD hospitalizations	Hospital discharges due to COPD	raw number (age-adjusted rate N/F)	OSHPD 190-192	2010	Age-adjusted rate N/F		

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Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Oral Health	Dentists in SCC who accept Medi-Cal (TBD)	Number of general practice dentist offices in the county who accept Denti-Cal	--	Dentical website	2013	102	N/A	--
	Dental decay (adult)	% adults with tooth loss due to gum problems or tooth decay	adults	SCC BRFS; Cited by SCC Health Profile	2009	33%		--
	% of children with caries	% of elem. kids that have a history of tooth decay	"elementary school children"	Health Trust Oral Health Status 2001 Needs Asst; Cited by SCC Health Profile	2001	50% (D)		49%
	School absence due to dental issues	% of children who have missed school due to dental issues	--	--		D	--	--
	Dentist utilization (children)	% of middle and high school students who visited the dentist in the past 12 months	--	CHKS, 2007-2008; Cited by SCC Health Profile	2007-08	80% (D)		--
	Dentist utilization (adult)	% adults who did NOT go to the dentist in the last year	adults	SCC BRFS; Cited by SCC Health Profile	2009	26%		--
	Emergency dental visits	Number of ER visits per year due to dental problems	--	--		D	--	--
Diabetes	Diabetes prevalence (children)	% of adults who were age 0-10 when diagnosed with diabetes	adults	SCC BRFS; Data tables provided by SCC PHD	2009	4%		--
	Diabetes prevalence (adult)	% adults who have diabetes	adults 20+	SCC BRFS; Cited by SCC Health Profile	2009	8%	>8%	US 8% (ADA '07)
	Diabetes hospitalization (child)	Diabetes hospitalizations (child)	--	OSPHD		D		--
	Diabetes hospitalization (adult)	Diabetes hospitalizations (adult)	--	OSPHD		D		--
Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Obesity	Obesity (young children)	% of kids 2-5 years old considered overweight (85-95th%)	kids 0-5 years	CDC PEDS Table 6B (Growth/Anemia	2007-09	16%	16%	10%

2013 Community Health Needs Assessment (CHNA)

				by County)				
Obesity (young children)	% of kids 2-5 years old considered obese (>=95th%)	kids 2-5 years	CDC PEDS Table 6B (Growth/Anemia by County)	2007-09	17%	17%	10%	
Overweight or obese (5th grade youth)	% of students in 5th grade in "Needs Improvement" or "At Risk" zone	5th graders	CDE Fitnessgram (BMI)	2011-12	42%	48%	6-11 yrs: 15.7%	
Overweight or obese (7th grade youth)	% of students in 7th grade in "Needs Improvement" or "At Risk" zone	7th graders	CDE Fitnessgram (BMI)	2011-12	39%	45%	--	
Overweight or obese (9th grade youth)	% of students in 9th grade in "Needs Improvement" or "At Risk" zone	9th graders	CDE Fitnessgram (BMI)	2011-12	35%	41%	--	
Obesity (youth)	% MS/HS students considered obese	5th/7th/9th graders	CHKS 07-08; overall rate by SCC Health Profile	2007-08	10%	--	12-19 yrs: 16.1%	
Overweight/Obese(adult)	% adults considered overweight or obese (BMI >25)	adults	SCC BRFS; Cited by SCC Health Profile	2009	55%	60%	--	
Obesity (adult)	% adults considered obese	adults	SCC BRFS; Cited by SCC Health Profile	2009	18%	23%	31%	

Need	Short Description	Detailed indicator	Population/Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Birth	High birthweight	% infants born at high birthweight (>4000 grams)	live births	CDC PEDS Table 6B (Growth/Anemia by County)	2007-09	8%	8%	--
	Babies low birth weight	% babies born less than 2,500 grams (5.5 pounds)	live births	Overall: CDPH, 2010 Vital Statistics Table 2-20 ; By race: KidsData	2010	7%	7%	8%

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	Mothers with prenatal care	% infants whose mothers received 1st trimester prenatal care	live births	CDPH Vital Stats	2010	85%	84%	78%
	Infant mortality rate	Deaths of infants under 1 year	raw number (age-adjusted rate N/F)	Overall: CDPH Vital Statistics; By SCC Ethn: Table 4-13	2010	Calculated rate N/F	4.7	

Need	Short Description	Detailed indicator	Population/Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
TB	TB infections	TB case rate per 100,000	100,000 people	SCC PHD TB Info Mgmt System 2000-2009; CA Reportable Disease Information Exchange, 2010;	2010	10.8	6.0	1
Sexually Transmitted Diseases	HIV screenings	% of adults screened for HIV	adults			D		17%
	HIV incidence rate	New HIV infections	100,000 people	eHARS 2011; analyzed by SCC PHD	2011	10.3	Rate not calc	--
	Chlamydia incidence rate (female)	Chlamydia incidence rate female	100,000 females		2011	430.9	569.9	--
	Chlamydia incidence rate (male)	Chlamydia incidence rate male	100,000 males		2011	169.1	257.8	--
	Chlamydia incidence rate	Chlamydia incidence (cases) - all ages & genders	raw number (age-adjusted rate N/F)	CDPH STDC prelim data thru 8/07/12; DOF Race/Ethnic Pop Projections Jul '07	2011	31150%	438	
	Chlamydia incidence rate (youth)	Chlamydia incidence (cases) - youth 15-24	raw number (age-adjusted rate N/F)		2011	Age-specific rate N/F		
	Gonorrhea incidence rate	Gonorrhea incidence (cases) - all ages & genders	raw number (age-adjusted rate N/F)		2011	3550%	73.1	
	Gonorrhea incidence rate (youth)	Gonorrhea incidence (cases) - youth 15-24	raw number (age-adjusted rate N/F)		2011	Age-specific rate N/F		
	Syphilis incidence rate	Primary/secondary syphilis incidence (cases) - all ages &	raw number (age-adjusted rate N/F)		2011	380%	6.5	

genders

Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Alzheimer's Disease	Alzheimer's prevalence	number adults 55+ with Alz	adults 55+	Alzheimer's Disease; Facts and Figures in California: Current Status and Future Projections", Alz Assoc, CA Council, Feb 2009	2008	27,658	588,208	--
	Alzheimer's prevalence	Rate of older adults diagnosed with Alzheimer's	adults 55+		--	D		
	Alzheimer's hospitalizations	Age-adjusted rate of Alzheimer's hospitalizations	100,000 population	N/F OSHPD	--	D		D
	Alzheimer's mortality	Age-adjusted Alzheimer's mortality rate	100,000 population	Alzheimer's Disease; Facts and Figures in California: Current Status and Future Projections", Alz Assoc, CA Council, Feb 2009	2003-05	20.8	22.1	--
Unintentional Falls	Fatal, unintentional falls older adults 65-84	Rate of fatal, unintentional falls age 65-84	100,000 adults 65-84	CADPH Epicenter	2010	26.6	21.7	--
	Fatal, unintentional falls 85+	Rate of fatal, unintentional falls age 85+	100,000 adults 85+	CADPH Epicenter	2010	268.8	148.5	--
	Nonfatal falls hospitalizations	Rate of nonfatal hospitalized fall injuries	100,000 adults 18+	CDPH EPicenter "top 5 causes of injury" query; CA DOF Estimates 2000-2010 updated 11/2012	2011	292.4	370.4	--
	Nonfatal falls hospitalizations 65-84	Rate of hospitalizations due to falls for older adults age 65-84	100,000 adults 65-84		2011	1,015	1167.0	--
	Nonfatal falls hospitalizations 85+	Rate of hospitalizations due to falls for older adults age 85+	100,000 adults 85+		2011	4,527	5087.0	--

2013 Community Health Needs Assessment (CHNA)

Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Violence	Recent domestic violence	% adults who experienced physical or sexual violence by intimate partner in past year	all genders age 18-65	CHIS	2009	1.7%	3.5%	D
	Recent domestic violence	% adult women who experienced physical or sexual violence by intimate partner in past year	females age 18-65	CHIS	2009	2.3%	4.0%	
	Domestic violence help-police	Number calls to law enforcement for domestic-violence related assistance	all genders and ages	CA DOJ Criminal Profiles Table 14	2010	4738	--	
	Domestic violence help-CBOs	Number calls to community-based agencies for domestic-violence related assistance	all genders and ages	-	--	D	--	
	Physical bullying (youth)	% MS/HS Students Who Reported Being Physically Bullied on school property in the last 12 months	7th, 9th, and 11th graders	CHKS A6.2 by grade; Overall cited by SCC Violence report	2009-10	28%		18%
	Psychological bullying (youth)	% of youth reporting being psychologically bullied on school property in last 12 months	7th, 9th, and 11th graders	CHKS A6.2 by grade; Overall cited by SCC Violence report	2009-10	44%	--	18%
	Gang membership (youth)	% of MS/HS students who currently consider themselves a gang member	7th, 9th, and 11th graders	CHKS p.42 Table A.62 by grade; overall cited by SCC Violence report p.19	2009-10	7%	--	--
	Violent crime (youth)	Juvenile felony arrest rate for violent offenses	100,000 10-17 years	CDJ, Criminal Justice Profile Table 3C	2010	253.2	294.9	
	Violent crime (adult)	Adult Felony Arrest Rate for Violent Offenses	100,000 adults	CDJ, Criminal Justice Profile	2010	287.8	394.2	--
	Homicide(youth)	Homicide rate youth	100,000 15-24 yrs	CDPH Vital Stats; cited by RDA	2009	7.4	10.8 age 18-29	
	Homicide (adults)	Homicide rate overall	100,000 adults	CA OAG Crimes and Crime Rates 2001-2010 (Table 1)	2010	1.3		5.5
	Child abuse	Rate of substantiated allegations of child maltreatment	1,000 children/youth 0-20 yrs	CA Dept Soc Svc/UC Berkeley Ctr for Soc Svc Research; CA Dept Fin 2000-2010	2011	4.3	9.6	8.5

2013 Community Health Needs Assessment (CHNA)

Need	Short Description	Detailed indicator	Population/ Denominator	SCC Data source	SCC Data Year	SCC Data	CA Data	Nat'l Benchmark
Mental Health	Mental health problems (adult)	% of adults reporting poor mental health in last 30 days	adults	SCC BRFS 2009; Cited by SCC Health Profile	2009	33%		--
	Mental health problems (youth)	% of MS/HS students who felt sad or hopeless almost every day for 2 weeks or more in the past 12 months.	7th, 9th, and 11th graders	CHKS Mental Health Module; cited by SCC Viet report	2009-10	28%	28% 7th graders N/A overall	--
	Suicide attempts (adult)	Nonfatal self-inflicted injury hospitalizations - adults 20+	raw number	CADPH Epicenter Injury Data Summary by Cause and Age	2011	Age-specific rate N/F		
	Suicide rate (adults)	Suicides (adults 20 years +)	raw number	CADPH Epicenter	2010	Age-specific rate N/F		
	Suicide attempts (youth)	Nonfatal self-inflicted injury hospitalizations - youth 15-19	raw number	CADPH Epicenter Injury Data Summary by Cause and Age	2011	Age-specific rate N/F		
	Suicide (youth)	Suicides (youth age 15-19)	raw number	CADPH Epicenter	2010	Age-specific rate N/F		
Substance Abuse	Smoking (youth)	% MS/HS kids smoked cigarettes last 30d		CHKS A5.3; ; Cited by SCC Health Profile	2009-10	8%		16%
	Smoking (adults)	% of adults who are current smokers	adults	SCC BRFS; Cited by SCC Health Profile	2009	10%		12%
	Binge drinking (youth)	% of MS/HS binge drinking last 30 days		CHKS A4.7; Cited by SCC Viet Profile	2009-10	8%		9%
	Binge drinking (adults)	% of adults binge drinking last 30 days	adults	SCC BRFS; Cited by SCC Health Profile	2009	25%	16%	24%
	Marijuana use (youth)	% used marijuana at least once past 30d		CHKS A4.3; ; Cited by SCC Health Profile	2009-10	12%	11%	6%
	Drug use (adult)	% adults used drugs past 12 months	adults	SCC BRFS 2009; Cited by SCC Health Profile	2009	8%		7%

Data is red is statistically unstable and should be interpreted with caution.

D = Developmental

Adult is 18+ unless otherwise specified

National Benchmark is Healthy People 2020 unless otherwise specified.

Santa Clara County Health Need Profile – Special Section

Access to Health Care

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **Access to Health Care** was prioritized as one of the 13 top health needs in the county. This category included insurance, education, and poverty.

The status of health access is described in this profile, in terms of:

- Key indicators
- Geographic regions or subpopulations in which the need is greatest
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US	HP 2020 Benchmark	Data Source
Linguistically isolated population % aged 5 and older who speak a language other than English at home and speak English less than "very well"	22%	20%	9%	--	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Unemployment % of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)	8%	10%	7%	--	U.S. Bureau of Labor Statistics, July, 2012 Local Area Unemployment Statistics
Insurance					
Uninsured % of the total civilian non-institutionalized population without health insurance coverage	11%	18%	15%	--	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Medicaid recipients % of the population that is enrolled in Medicaid	13%	18%	16%	--	

Santa Clara County Health Need Profile – Special Section

Access to Health Care

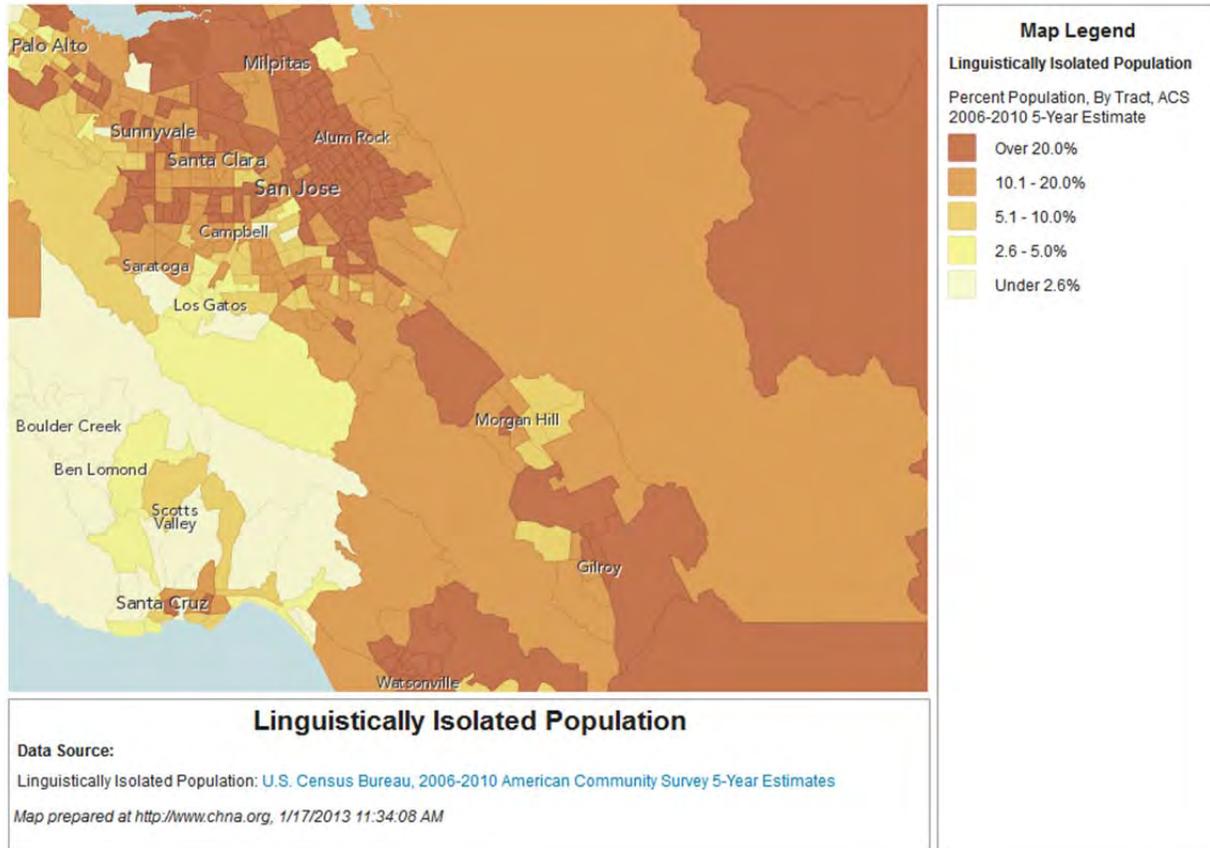
Indicator	Santa Clara County	CA	US	HP 2020 Benchmark	Data Source
Education					
Educational attainment % of the population aged 25 and older without a high school diploma (or equivalency) or higher	14%	19%	15%	--	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
High school graduation rate average freshman graduation rate (based on % of students receiving their high school diploma within four years)	--	82%	82%	82%	The University of Wisconsin, Population Health Institute, County Health Rankings, 2012; the U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe Survey Data, 2005-06, 2006-07 and 2007-08, and NCES Local Education Agency (School District) Universe Survey Dropout and Completion Data, 2008-2009
Grade 4 reading proficiency % of children in grade 4 whose reading skills tested at or above the "proficient" level for the CST English Language Arts portion of the California STAR test	--	64%	71%	64%	States' Department of Education, Student Testing Reports, 2011
Poverty					
Population below 100% FPL % of the population living below 100% of the Federal Poverty Level (FPL)	9%	14%	14%	--	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Children below 100% FPL % of children aged 0-17 living below 100% of the Federal Poverty Level (FPL)	11%	19%	19%	--	
Population below 200% FPL % of the population living below 200% of the Federal Poverty Level (FPL)	21%	33%	32%	--	
Free/reduced lunch % of public school students eligible for free or reduced price lunches	37%	54%	48%	--	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011
SNAP recipients % of the population receiving the Supplemental Nutrition Assistance Program (SNAP) benefits	5%	8%	13%	--	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009

Note: All statistics in this table from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Geographic Areas of Greatest Need

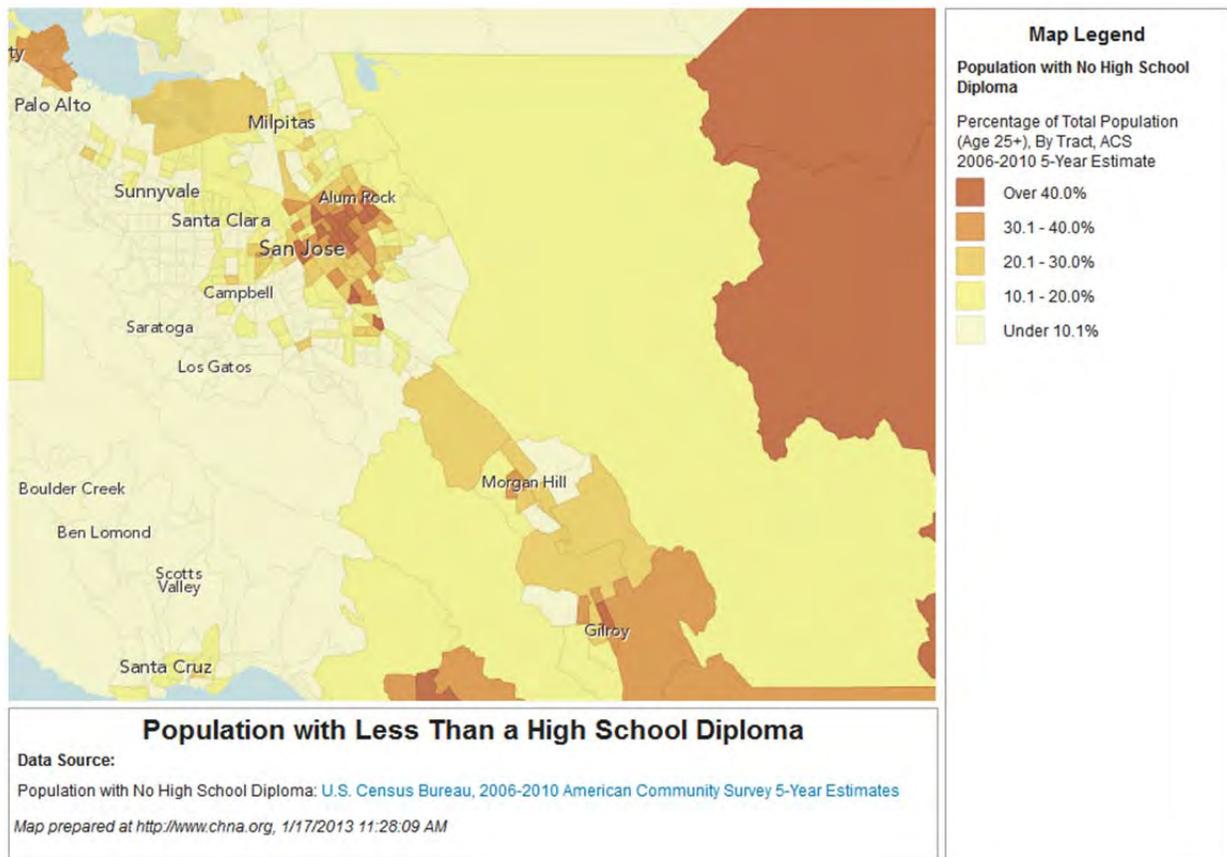
Linguistic isolation is worse in some areas of the county than in others, as displayed in the map of linguistically isolated populations below. East San Jose is the worst off, where up to 45% of area residents are linguistically isolated. In parts of Gilroy, Santa Clara, Sunnyvale, and San Jose, over 30% of residents experience linguistic isolation.



Santa Clara County Health Need Profile – Special Section

Access to Health Care

Educational attainment is also worse in some areas of the county than in others, as displayed in the map of populations without a high school diploma below. Central San Jose is the worst off, where over 56% of residents have not earned a high school diploma. In other parts of San Jose and Gilroy, over 40% of residents have low educational attainment.



Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Poverty has a negative impact on health in that individuals cannot afford the cost of clinical care, copays and medication, and cannot afford healthy foods and activities.
- Lack of oral health and mental health insurance coverage, and health insurance for the undocumented, all impact the ability of individuals to access needed health care, and preventative care in particular.
- Similarly, being underinsured has an impact on access (not all services are covered, including preventative care or screening, certain medications and treatments).

Access to Health Care

- Wait times for doctor appointments (even for severe conditions) and lack of follow-up by clinicians result in overuse of urgent care/emergency room when conditions worsen. Health care leaders expressed a lack of general and specialty care practitioners.
- Lack of transportation impacts the community, especially when it comes to preventative care (such as frequent visits for diabetes check-ups). It also impacts the ability to get to grocery stores with fresh foods, and carry groceries home. Public transportation can also be difficult for families with small children.
- Linguistic isolation: Patients who do not understand the medical conditions or directions for compliance may experience negative outcomes. Also, those who do not speak English may perceive that practitioners do not understand them or their culture and therefore may trust them less.
- Poverty and unemployment are causing stress for youth and adults, and thus are major drivers of poor health overall, and poor mental health in particular.
- Lack of knowledge/awareness of health conditions, their causes, symptoms, and treatments, can keep individuals from accessing needed care.
- Stigma, which is experienced across all populations, prevents people from seeking treatment due to embarrassment, shame, or fear, and causes stress. Stigma can result in lessened social support and increased social isolation.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O'Connor Hospital:
 - Charity care
 - Health Benefits Resource Center provides insurance and CalFresh enrollment assistance and referrals for social services to low-income, underinsured or uninsured individuals
 - Family Medicine Residency Program trains residents to care for underserved populations
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - San Jose Foothill Health Center
 - School Health Clinics of Santa Clara County
- El Camino Hospital
- First 5 Santa Clara County

Access to Health Care

- Good Samaritan Hospital
- Health Insurance Companies (Blue Cross, Atena, etc.)
- Hospital Council of Northern & Central California
- Kaiser Permanente
- Lucile Packard Children’s Hospital at Stanford
- Nurse-Family Partnership in Santa Clara County
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara Family Health Plan
- Santa Clara Valley Health & Hospital System
- Stanford Hospital & Clinics

TRANSPORTATION SERVICES:

- Avenidas
- Cal Train
- City Team Ministries
- Community Services Agency
- Love Inc.
- Outreach & Escort, Inc.
- Santa Clara Valley Transit Authority (VTA)

HOUSING SERVICES:

- Bill Wilson Center
- Casa de Clara
- Community Solutions
- EHC LifeBuilders
- Housing Authority of the County of Santa Clara
- InnVision the Way Home
- Santa Clara County Social Services Agency
- Sacred Heart Community Services
- West Valley Community Services

Summary

Access to health care is a health need in Santa Clara County as marked by the proportion of the community who are linguistically isolated. In addition, there are areas with low-educational attainment, which also impacts health outcomes. The community input indicates that underinsurance and lack of insurance coverage is an issue. Lack of transportation is also an access barrier that affects those in poverty. Stigma and lack of knowledge both impact the seeking of preventative care or treatment. Also, too few general and specialty practitioners, especially in community clinics, results in long wait times for appointments. These issues around lack of access contribute to

Access to Health Care

community members using urgent care and emergency rooms for treatment of conditions that have worsened due to lack of treatment or preventative care.

Santa Clara County Health Need Profile

Alzheimer's Disease

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **Alzheimer's disease** was prioritized as one of the 13 top health needs in the county.

The status of Alzheimer's disease is described in this profile, in terms of:

- Key indicators
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes local data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	Data Source
Estimated Alzheimer's prevalence Estimated number of adults 55+ with Alzheimer's			
2008 estimate	27,658	588,208	"Alzheimer's Disease; Facts and Figures in California: Current Status and Future Projections", Alzheimer's Assoc., CA; 2009 Based on published prevalence rates (2003 and 2006) and CA Department of Finance Race/Ethnic Population with Age and Sex Detail, 2000-2050; 2007
2015 estimate	32,988	678,446	
Increase in Alzheimer's prevalence Estimated % increase in people 55+ living with Alzheimer's 2008-2015	19%	15%	
Alzheimer's mortality Age-adjusted death rate per 100,000 population	20.8	23.4	Alzheimer's Disease; Facts and Figures in California: Current Status and Future Projections, Alzheimer's Assoc., CA (2003-05 data)

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Santa Clara County Health Need Profile

Alzheimer's Disease

Additional Data:

- In 2010, Alzheimer's disease was the third leading cause of death in Santa Clara County, and the fifth leading cause in California. (Ten Leading Causes of Death; California Counties and Selected City Health Departments, California Department of Public Health, 2010).
- The Alzheimer's Association estimates that the number of those diagnosed with Alzheimer's disease in California will double to over 1.1 million by the year 2030. (Alzheimer's Disease; Facts and Figures in California: Current Status and Future Projections, Alzheimer's Association of Northern California).

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- The 2005 age-adjusted Alzheimer's mortality rates for African Americans and Caucasians were the worst (27.3 and 27.8, respectively) when compared with other ethnic groups, and worse than the overall California rate of 23.4 deaths per 100,000.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Alzheimer's or dementia was mentioned in 4 out of 25 groups/interviews.
- The lack of gerontologists and related specialists was mentioned several times.
- Issues of location (isolation) and related lack of transportation were described as combining to exacerbate the impact of Alzheimer's.
- Concerns about caregivers (burnout, lack of knowledge/health education, lack of awareness of supportive services such as respite) surfaced several times.
- Lack of coordination of care and concerns about care transitions were of particular concern for patients with Alzheimer's.
- Costs (of health care, activities, fresh food) make a larger dent in the budgets of older individuals who are on a fixed income than those who are not on a fixed income.
- Issues with medication management
- Relative lack of services; need for programs to partner for more effective/efficient provision of services
- Relative lack of governmental support/funding

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and lack of health insurance coverage) in the **Access to Health Care** profile report.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- Alzheimer's Association
- Avenidas
- Catholic Charities of Santa Clara County
- Council on Aging Silicon Valley
- The Health Trust
- Respite & Research for Alzheimer's Disease
- Santa Clara County Social Services Agency
- Stanford/Veteran's Administration Alzheimer's Research Center

Summary

Alzheimer's disease is a health need in Santa Clara County as marked by Alzheimer's disease being the third leading cause of death. It is the fastest growing cause of death in California and the number of people living with Alzheimer's disease is also growing rapidly. Community input suggests that the impact on caregivers who have few resources (especially for transportation) will affect quality of life for those living with Alzheimer's. Qualitative research also suggests that there is a lack of gerontologists and those who can help coordinate care.

Birth Outcomes

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **birth outcomes** were prioritized as one of the 13 top health needs in the county.

The status of birth outcome needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US‡	HP 2020 Benchmark	Data Source
Low birth-weight % of babies born with low birth-weight: less than 2,500 grams (5.5 pounds)	7%	7%	--	8%	CDPH Vital Statistics Table 2-20, 2010
White	6%				CDPH Birth Files CDC Natality, 2010; WONDER database
African American	10%				
Latino	6%				
Asian/Pacific Islander	8%				
Multiracial	7%				
Infant mortality Infant mortality rate per 1,000 live births	2.8 (66 deaths)	4.7	6.71	6.0	CDPH Vital Statistics, 2010
White	0.71†				
African American	0.13†				
Latino	1.13				
Asian/Pacific Islander	0.75†				
Multiracial	0.04†				

Note: † Size of n is too small to rely upon. ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Birth Outcomes

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- The county’s percentage of low birth-weight babies is no better than the state average, though it is lower than the national benchmark.
- African Americans have the highest preterm birth rate (15%) compared with other ethnic groups (Santa Clara County Public Health Department, Health Profile Report, 2010).
- African Americans have the highest rates of low birth-weight babies (10%) compared with other ethnic groups.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA	HP 2020 Benchmark	Data Source
Clinical care	Prenatal care % infants whose mothers received first trimester prenatal care	85%	84%	78%	CDPH Vital Statistics, 2010; KidsData
	White	92%			
	African American	80%			
	Latino	79%			
	Asian/Pacific Islander	89%			
	Native American	73%			
	Multiracial	81%			

‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

The percentage of Native American women receiving early prenatal care was the lowest compared with other ethnic groups, and fails to meet the benchmark. Note that percentages of African American, Latino, and multi-ethnic women receiving early prenatal care also fall below the state average, though they do meet the benchmark.

See data regarding additional cross-cutting drivers influencing this health need, such as poverty or lack of health insurance, in the **Access to Health Care** profile report.

Community Input

The health needs assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives and residents. Themes from discussions regarding the health need are identified below.

- Poor birth outcomes were mentioned in 2 out of 25 groups/interviews.

Birth Outcomes

- It was of concern that mothers who are low-income, unemployed, or living in poverty are much more likely to have poor birth outcomes than mothers who are not.
- Concerns about limited prenatal visits surfaced, potentially driven by lack of knowledge of the importance, by language barriers, cultural issues such as body modesty, or by the cost of care.
- Access to and cost of fresh food and of activities arose in thinking about pregnant mothers' overall health.
- Relative lack of parenting support services was of concern.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- American Cancer Society
- March of Dimes
- Lucile Packard Children's Hospital at Stanford
- Santa Clara Valley Health & Hospital System

Summary

Birth outcomes are a health need in Santa Clara County, as marked by the percentage of low birth-weight babies, which is no better than the state average (though below the HP 2020 benchmark). African Americans are disproportionately affected, with the percentage of African American babies of low birth-weight higher than the state average and HP 2020 benchmark. While infant mortality is not a concern county-wide, it is possible that some subgroups (e.g., African American infants) are disproportionately affected; however, the data are too sparse to rely upon. The health need is likely being impacted by certain social determinants of health, and by the percentage of women receiving early prenatal care. While this is not an issue on the county-wide level, a disproportionately smaller percentage of Native American women receive early prenatal care in comparison to other ethnic groups. Community feedback indicates that the health need is affected by concerns about the cost of care, and poor access to primary care providers and specialists due to lack of insurance, particularly among low-income residents. In addition, community input suggested that limited prenatal visits may be driven by lack of knowledge of the importance of prenatal care, language barriers between patients and specialists, cultural issues such as body modesty, as well as the cost of care.

Santa Clara County Health Need Profile

Cancers

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **cancers** were prioritized as one of the 13 top health needs in the county. This category included breast cancer, cervical cancer, colorectal cancer, liver cancer, lung cancer, prostate cancer, and all cancers.

The status of cancer needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US‡	HP2020 Target	Data Source
All Cancers					
Mortality					
Age-adjusted mortality rate due to all types of cancer per 100,000 people	137.6	158.3	--	160.6	CA Cancer Registry 2009
White	151.8				
African American	219.2				
Latino	121.2				
Asian/Pacific Islander	110.0				
Breast Cancer					
Incidence (New Cases)					
Age-adjusted breast cancer incidence rate per 100,000 females	161.4	154.1	122	--	CA Cancer Registry 2009
White	190.0				
African American	143.9				
Latino	116.9				
Asian/Pacific Islander	134.6				

Santa Clara County Health Need Profile

Cancers

Indicator	Santa Clara County	CA	US‡	HP2020 Target	Data Source
Breast Cancer Mortality					
Age-adjusted mortality per 100,000 females	20.0	22.2	--	20.6	CA Cancer Registry 2009
White	22.8				
Latino	14.9				
Asian/Pacific Islander	17.4				
Cervical Cancer					
Incidence (New Cases)					
Age-adjusted incidence per 100,000 females	7.2	7.8	8	7.1	CA Cancer Registry 2009
White	5.8				
African American	0				
Latino	8.8				
Asian/Pacific Islander	9.2				
Mortality					
3-year age-adjusted mortality rate per 100,000 females	1.41	2.31	--	2.2	CA Cancer Registry 2007-09
Colorectal Cancer					
Incidence (New Cases)					
Age-adjusted incidence per 100,000	40.9	43.2	40.2	45.4	CA Cancer Registry 2009
White	42.7				
African American	44.7				
Latino	37.3				
Asian/Pacific Islander	39.0				
Mortality					
Age-adjusted mortality per 100,000	13.9	14.5	--	14.5	CA Cancer Registry 2009
White	13.3				
Latino	15.5				
Asian/Pacific Islander	12.2				
Liver Cancer					
Incidence (New Cases)					
Age-adjusted incidence per 100,000	10.9	8.6	--	--	CA Cancer Registry 2009
White	6.2				
Latino	17.5				
Asian/Pacific Islander	17.1				

Santa Clara County Health Need Profile

Cancers

Indicator	Santa Clara County	CA	US‡	HP2020 Target	Data Source
Liver Cancer Mortality Age-adjusted mortality per 100,000	6.8	5.6	--	--	CA Cancer Registry 2009
White	3.6				
Latino	9.0				
Asian/Pacific Islander	11.9				
Lung Cancer					
Incidence (New Cases) Age-adjusted lung cancer incidence rates per 100,000 adults	41.8	50.6	67.2	--	CA Cancer Registry 2009
White	46.4				
African American	68.9				
Latino	26.7				
Asian/Pacific Islander	31.3				
Lung Cancer Mortality Age-adjusted lung mortality per 100,000 adult	28.2	37.8	--	45.5	CA Cancer Registry 2009
White	32.6				
Latino	19.1				
Asian/Pacific Islander	23.0				
Prostate Cancer					
Incidence (New Cases) Age-adjusted prostate cancer incidence rates per 100,000 men	145.9	131.0	151.4	--	CA Cancer Registry 2009
White	170.8				
African American	222.0				
Latino	118.3				
Asian/Pacific Islander	101.7				
Mortality Age-adjusted mortality rate of men due to prostate cancer per 100,000 males	15.8	22.4	--	21.2	CA Cancer Registry 2009
White	19.4				
Asian/Pacific Islander	10.5				

Note: ‡ Statistics from CARES Platform.

Data in red indicates that it fails to meet a benchmark or is worse than the state average.

Santa Clara County Health Need Profile

Cancers

In Santa Clara County, the following indicators are failing to meet overall benchmarks (or state averages, if no benchmarks are available):

- Breast cancer incidence rate
- Cervical cancer incidence rate
- Liver cancer incidence rate
- Liver cancer mortality rate
- Prostate cancer incidence rate

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals' behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA	HP 2020 Benchmark	Data Source
Behaviors	Colorectal, Liver, Lung & Prostate Cancers				
	Inadequate fruit/vegetable consumption (adults) % of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day	70%	70%	—	CDC BRFSS 2003-2009
	Adequate fruit/vegetable consumption (youth) % of children aged 2 and older who are reported to consume 5 or more servings of fruits and vegetables each day	47%	48%	—	California Health Interview Survey (CHIS), 2009

Santa Clara County Health Need Profile
Cancers

Category	Driver/indicator	Santa Clara County‡	CA	HP 2020 Benchmark	Data Source
Clinical Care	Breast Cancer Screening % of females ages 50-74 who had a mammogram in the past 2 years	62%	59%	81%	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-2007
	Cervical Cancer Screening % of females ages 21 - 65 who had Pap test in past 3 years	91%	90%	93%	CDC BRFS 2004-2010
	Colorectal Cancer Screening % of adults age 50+ who ever had sigmoidoscopy or colonoscopy exam	62%	52%	71%	CDC BRFS 2004-2010
	Prostate Cancer Screening % of men age 50+ who ever had a prostate-specific antigen test	72%	--	--	SCC PHD BRFS 2009

Note: * Statistic is unstable and should be used with caution.

‡ Statistics from CARES data platform.

Data in red indicates that it fails to meet a benchmark or is worse than the state average.

Additional Data:

- Countywide, the percentage of adults consuming inadequate servings of fruits/vegetables (a contributing factor in colorectal, liver, lung, and prostate cancers) is no better than the state average.

See data regarding additional cross-cutting drivers such as lack of health insurance in the **Access to Health Care** profile report.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- Mortality (overall): Overall, Santa Clara County mortality rates due to cancer are lower than that of the state, and meet benchmarks. However, the rate for African Americans is highest among any ethnicity, and misses the benchmark.

- With regard to **breast** cancer:
 - White women have the highest incidence and mortality rates compared with other ethnic groups, and their rate is higher than the statewide average and Healthy People 2020 benchmark for these indicators.
- With regard to **cervical** cancer:
 - Latina and Asian/Pacific Islander women have the highest incidence rates compared with other ethnic groups, and their rates are too high compared to the state average and Healthy People 2020 benchmark for this indicator.
- With regard to **colorectal** cancer:
 - Latinos have the highest mortality rate compared with other ethnic groups, and their rate is too high compared to the state average and Healthy People 2020 benchmark for this indicator.
- With regard to **liver** cancer:
 - Latinos and Asian/Pacific Islanders have the highest incidence and mortality rates compared with other ethnic groups, and their rates are higher than the state and national averages for these indicators.
- With regard to **lung** cancer
 - African Americans have the highest incidence rates compared with other ethnic groups, and their rate is higher than the county, state and national averages for this indicator.
 - Key informants expressed concern that smoking rates are not dropping among youth.
- With regard to **prostate** cancer:
 - White and African American men have the highest incidence rates compared with other ethnic groups, with African Americans by far the highest, and the rates for both Whites and African Americans are higher than the county, state and national averages for this indicator.

Community Input

The health needs assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives and residents. Themes from discussions regarding the health need are identified below.

- Cancer was of high concern in 3 out of 25 groups/interviews, and was mentioned in many others.
- Costs of health care and cancer treatments were of concern, particularly for uninsured and underinsured, low-income persons, the unemployed, and those living in poverty.
- Fear of cancer and/or of the treatments can lead people to denial and/or to avoidance of check-ups.
- Relative lack of alternative treatments from radiation/chemotherapy
- Lack of knowledge and lack of education about prevention was mentioned.
- Concern about environmental toxins (PCBs, pesticides, etc.).

- Cancer screenings (breast, cervical, colon) require staff time for effective follow-up.
- Tobacco use (related to lung and oral cancers) not dropping among youth; social environment (ads, TV/movies, easy access, peer pressure) pushing minors to smoke; education not working, need better prevention efforts (e.g., increase tobacco taxes, restrict smoking in public places, support policy changes, law enforcement).

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O'Connor Hospital:
 - Cancer support groups meet onsite
 - Hepatitis B awareness campaign to prevent liver cancer in Asian/Pacific Islanders
- American Cancer Society
- Cancer Support Community
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - San Jose Foothill Health Center
- El Camino Hospital
- Good Samaritan Hospital
- Hospice of the Valley
- Kaiser Permanente
- Latinas Contra Cancer
- Leukemia & Lymphoma Society
- Lucile Packard Children's Hospital at Stanford
- Pathways Home Health & Hospice
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara Valley Health & Hospital System
- Stanford Hospital & Clinics
- Vietnamese Reach for Health Coalition

Summary

Cancer is a health need in Santa Clara County as marked by incidence rates of breast, cervical, liver, and prostate cancer that are too high compared to benchmarks/state averages, and a liver cancer mortality rate that is too high compared to the state average. Breast and prostate cancer disproportionately affect Whites; lung and prostate cancer disproportionately affect African Americans. Latinos and Asian/Pacific Islanders have higher incidence rates of cervical and liver cancer than other ethnic groups, and disproportionately high mortality rates due to liver cancer as well. Latinos additionally are unduly burdened by mortality from colorectal cancer. The health need is likely being impacted by health behaviors such as rates of screening that do not meet established benchmarks, and low fruit and vegetable consumption that are no better than average (as diet has been shown to have an impact on many types of cancer). Community input indicates that the health need is also affected by lack of knowledge about cancer prevention and treatment, fear and denial, lack of staff time for follow-up with those who are at risk and should be screened, concerns about the costs of treatment, and poor access to primary care providers and specialists due to lack of insurance, particularly among low-income residents. There was also some concern about youth tobacco use (as smoking has also been shown to have an impact on various types of cancer).

Cardiovascular Disease, Heart Attack, Stroke

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, cardiovascular disease, heart attack, and stroke were prioritized as one of the 13 top health needs in the county. This category included cerebrovascular disease.

The status of cardiovascular needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

	Santa Clara County	CA	US‡	HP 2020 Benchmark	Data Source
High cholesterol % adults ever been told by a health professional that they have high cholesterol	29%		--	17%	Santa Clara County Public Health Department, BRFSS 2009
White	36%	--	--		
African American	31%	--	--		
Latino	20%	--	--		
Asian/Pacific Islander	30%	--	--		
Hypertension % adults told they have hypertension	26%		--	16%	Santa Clara County Public Health Department, BRFSS 2009
White	33%	--	--		
African American	37%	--	--		
Latino	15%	--	--		
Asian/Pacific Islander	24%	--	--		

Cardiovascular Disease, Heart Attack, Stroke

	Santa Clara County	CA	US‡	HP 2020 Benchmark	Data Source
Heart disease					
Prevalence of heart disease % of adults ever told they have any kind of heart disease	5%‡	6%‡	--	--	California Health Interview Survey (CHIS) 2009
Heart attack % adults ever told they had a heart attack	3%	3%	--	--	Santa Clara County Public Health Department, BRFSS 2009
Stroke					
Prevalence of stroke % of adults who have ever had a stroke	2%	2%	--	--	Santa Clara County Public Health Department, BRFSS 2009
Stroke mortality Age-adjusted death rate due to cerebrovascular disease per 100,000 adults	27.4	48.4	41.8	33.8	CDPH, Death Statistical Master File, 2010
White	25.7				(Provided by Santa Clara County Public Health Department)
African American	41.3				
Latino	27.0				
Asian/Pacific Islander	30.6				
Multiracial	37.1				

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- Whites experience the highest percentage of high cholesterol compared with other ethnic groups, followed by African Americans and Asian/Pacific Islanders.
- African Americans experience the highest percentage of hypertension compared with other ethnic groups, followed by Whites.
- African Americans had the highest rates of stroke mortality compared with other ethnic groups, followed by those who identify as multiracial.

Cardiovascular Disease, Heart Attack, Stroke

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA	Data Source
Health Behaviors	High blood pressure management % of adults aged 18 and older who self-report that they are taking medication for their high blood pressure	73%	70%	CDC BRFSS 2006-10
	Alcohol consumption (adult) % of adults reporting heavy alcohol consumption	13%‡	17%	CDC BRFSS 2004-10
	Smoking (adult) % of adults who currently smoke	10%	14%	CDC BRFSS 2004-10
	Smoking (youth) % of 11th graders who smoked cigarettes past 30 days	13%	—	CA Healthy Kids (CHKS), 2009-10
	Inadequate fruit/vegetable consumption (adult) % of adults who consume less than five servings of fruits and vegetables daily	70%	70%	CDC BRFSS 2003-2009
	Adequate fruit/vegetable consumption (youth) % of kids 2+ who consume five or more servings of fruits and vegetables daily	47%	48%	California Health Interview Survey (CHIS), 2009
	Physical inactivity (adult) % of adults 18+ reporting no leisure time for physical activity	18%	22%	CDC BRFSS 2004-10
	Physical inactivity (youth) % of 5 th , 7 th & 9 th graders ranking within the "High Risk" or "Needs Improvement" zones for aerobic capacity on the Fitnessgram physical fitness test	28%	37%	CA Dept of Education, Fitnessgram Physical Fitness Testing Results, 2011
Physical Environment	Fast food restaurant access Establishments per 100,000 pop	72.0	69.5	U.S. Census Bureau, ZIP Code Business Patterns, 2009
	Grocery store access Establishments per 100,000 pop	20.4	22.2	U.S. Census Bureau, County Business Patterns, 2010
	WIC-authorized food store access Establishments per 100,000 pop	9.45	15.8	U.S.D.A. Food Environment Atlas, 2012
	Recreation and fitness facility access Establishments per 100,000 pop	12.7	8.9	U.S. Census Bureau, ZIP Code Business Patterns, 2009

‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Cardiovascular Disease, Heart Attack, Stroke

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and lack of health insurance coverage) in the **Access to Health Care** profile report.

Community Input

The health needs assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Heart disease was mentioned in at least half of the groups/interviews, though only rose to the top for two interviewees.
- High blood pressure and hypertension were the most common conditions/drivers named by residents related to cardiovascular disease.
- See the related health need of obesity for drivers related to poor nutrition and lack of exercise.
- Lack of education about the signs of heart disease and high blood pressure
- Lack of recognition because it is an invisible disease
- Can be caused/exacerbated by stress, smoking and drinking alcohol

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O'Connor Hospital:
 - Blood pressure, cholesterol and glucose screenings provided at health fairs
 - Cardiac Rehabilitation Center provides free blood pressure screenings weekly
 - ICD support group meets onsite and is facilitated by O'Connor employees
 - Living Well Classes
 - Stroke support group meet onsite and is facilitated by O'Connor employees
- American Heart Association and American Stroke Association
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.

Cardiovascular Disease, Heart Attack, Stroke

- San Jose Foothill Health Center
- Good Samaritan Hospital
- El Camino Hospital
- Kaiser Permanente
- Pacific Stroke Association
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara Valley Health & Hospital System
- Stanford Hospital & Clinics
- Stroke Awareness Foundation
- YMCA

Summary

Cardiovascular Disease, Heart Attack, and Stroke are health needs in Santa Clara County as marked by high overall percentages of high cholesterol and hypertension, both of which fail HP 2020 benchmarks. African Americans and those who identify as multiracial have a higher stroke mortality rate than the HP 2020 benchmark. African Americans and Whites disproportionately experience hypertension and high cholesterol. Heart disease deaths are worst in the South County area and in East San Jose. Poor nutrition, which is related to cardiovascular disease, is of concern in the county. Adult and youth consumption of fruits and vegetables, and household expenditures on the same, is no better than the state average, and in some cases is worse. There are also more fast food restaurants, and fewer grocery stores and WIC-authorized stores, than the state average. Community input reflected this, as well as a concern about lack of exercise. The community also indicated that the health need is being affected by stress and lack of knowledge about stroke and heart disease.

Santa Clara County Health Need Profile

Diabetes

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **diabetes** was prioritized as one of the 13 top health needs in the county.

The status of needs associated with diabetes is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County‡	CA State‡	HP 2020 Benchmark	Data Source
Diabetes prevalence (adults) % adults who have ever been told by a doctor that they have diabetes	8%	—	8%	Santa Clara County Public Health Department, BRFSS 2009
White	7%			
Latino	11%			
African American	14%			
Asian/Pacific Islander	5%			
Diabetic hospitalization Rate of discharge per 10,000 hospitalizations	7.9			CA Office of Statewide Health Planning & Development (OSHDP) 2010-11
White	0.7%	0.8%		CA Office of Statewide Health Planning & Development (OSHDP) 2010-11
Latino				
African American	1.5%	1.6%		
Asian/Pacific Islander	0.4%	0.6%		
Other	0.8%	.09%		

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Santa Clara County Health Need Profile

Diabetes

Key indicators for diabetes indicate that Santa Clara County rates are very similar to California overall, and very near the Healthy People 2020 benchmark of 8% prevalence. However, some ethnic subgroups are disproportionately diagnosed with, and hospitalized for, diabetes.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- African Americans and Latinos experience the highest rates of diabetes compared with other ethnic groups
- African Americans represent a higher percentage of those hospitalized for diabetes than any other ethnic group.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals' behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County	CA State	Data Source
Behaviors	Soft drink expenditures % of total household expenditures	.37%	.46%	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
	Adequate fruit/vegetable consumption (youth) % of kids 2+ who consume five or more servings of fruits and vegetables daily	47%	48%	California Health Interview Survey (CHIS), 2009
	Inadequate fruit/vegetable consumption (adult) % of adults who consume less than five servings of fruits and vegetables daily	70%	70%	CDC BRFSS 2003-2009
	Physical inactivity (youth) % of 5 th , 7 th & 9 th graders ranking within the "High Risk" or "Needs Improvement" zones for aerobic capacity on the Fitnessgram physical fitness test	28%	38%	CA Dept of Education, Fitnessgram Physical Fitness Testing Results, 2011
	Physical inactivity (adult) % adults who self-report not participating in any physical activities or exercises	18%	22%	CDC BRFSS 2004-2010
Physical Environment	Fast food restaurant access Establishments per 100,000 pop	72.0	69.4	U.S. Census Bureau, ZIP Code Business Patterns, 2009

Diabetes

Category	Driver/indicator	Santa Clara County	CA State	Data Source
	Grocery store access Establishments per 100,000 pop	20.4	22.2	U.S. Census Bureau, County Business Patterns, 2010
	WIC-authorized food store access Establishments per 100,000 pop	9.5	15.8	U.S.D.A. Food Environment Atlas, 2012
	Recreation and fitness facility access Establishments per 100,000 pop	12.7	8.9	U.S. Census Bureau, ZIP Code Business Patterns, 2009
Delivery	Older adult diabetes management % of diabetic Medicare patients who had a hemoglobin A1c (hA1c) test in past year	77%	76%	Dartmouth Atlas of Healthcare, Selected Measures of Primary Care Access and Quality, 2003-07

‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and lack of health insurance coverage) in the **Access to Health Care** profile report. In addition, overweight and obesity are seen as drivers of diabetes. See the **Obesity** health profile for details on obesity as a health need and its associated drivers.

Community Input

The health needs assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Diabetes was of high concern in 8 out of 17 groups and in 6 of 9 key informant interviews, and was mentioned in almost all of them.
- Lack of grocery stores or farmers' markets was mentioned as a driver for diabetes or poor nutrition in seven separate groups/interviews; it was noted that food stamps/EBT were not accepted at farmers' markets; that poor neighborhoods were disproportionately lacking stores that sold fresh produce and other healthy food ("more liquor stores than grocery stores in some neighborhoods"); that lack of transportation affected access to grocery stores; that Asian & Latino families are more likely to choose fresh over processed food. It was suggested that policies/ordinances be supported that increased the quality of the food that "corner stores" would carry, and increased the number of farmers' markets.

- One group mentioned that grocery stores decide how Women, Infants and Children (WIC) benefits can be used. One WIC beneficiary noted that consumers can't buy low-sugar options because they have artificial sweetener. (USDA states: "Federal WIC regulations do not prohibit foods that contain artificial sweeteners. However, WIC State agencies are responsible for determining the brands and types of foods to authorize on their State WIC food lists. Some State agencies may allow foods sweetened with artificial sweeteners on their foods lists, but this will vary by state").
- Six groups/interviews mentioned the cost of healthy food. Many groups/interviews discussed the need for more healthy/good quality food, but only one group specifically mentioned fruits and vegetables, saying that "children and parents need..to understand the benefits of eating fruits and vegetables" and discussed access issues related to this (i.e. Distribution channels not established to enable farmers to get their produce to stores, schools and families).
- Fast food mentioned as a driver for diabetes or poor nutrition in eight groups/interviews; belief that fast food is cheaper, more accessible ("available on every corner"), faster, and provides more calories per dollar than healthy food, but is more unhealthy (fatty, "starchy", has as its companion "sugary drinks"); is being pushed by the media, found on school campuses, and makes portion size an issue ("supersized").
- Lack of healthy eating:
 - Lack of education about healthy eating
 - Decrease in families preparing meals at home
 - Large portion size (restaurant trends having an influence on home cooks)
- Lack of exercise:
 - Busy lifestyles
 - Unsafe neighborhoods
 - High cost of physical fitness programs
- Social factors:
 - Parents may be poor models for children
 - Families used to overeating, eating unhealthy foods

Assets to Address the Need

Santa Clara County Public Health has shown commitment to obesity prevention through its Communities Putting Prevention to Work (CPPW) Obesity Prevention program, funded through September 2012. It is unclear whether or not the grants will continue in 2013. The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O'Connor Hospital:
 - Breastfeeding support group meets onsite and is facilitated by O'Connor employees
 - Diabetes support group meets onsite
 - Family medicine residency training program where residents learn how to care for individuals living with diabetes and teach self-care management

Diabetes

- Health Benefits Resource Center provides health insurance and CalFresh enrollment assistance
- Living Well Classes
- Bay Area Nutrition & Physician Activity Collaborative
- Community Alliance with Family Farmers
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - San Jose Foothill Health Center
 - School Health Clinics of Santa Clara County
- El Camino Hospital
- FIRST 5 Santa Clara County
- Good Samaritan Hospital
- Lucile Packard Children’s Hospital at Stanford
- Regional Medical Center of San Jose
- Sacred Heart Community Service
- Saint Louise Regional Hospital
- San Jose Department of Parks, Recreation & Neighborhood Services
- Santa Clara Family Health Foundation
- Santa Clara County Office of Education Coordinated School Health Program
- Santa Clara County Public Health Department
 - Breastfeeding support
 - Childhood Feeding Collaborative
 - *Eat Healthy, Eat Smart Innovative Nutrition Education Program*
 - WIC program
- Santa Clara Valley Health & Hospital System
- Second Harvest Food Bank of Santa Clara and San Mateo Counties
- Silicon Valley HealthCorps
- Somos Mayfair
- Stanford Hospital & Clinics
- Sunnyvale Community Services
- West Valley Community Services

Summary

Diabetes is a health need in Santa Clara County as marked by relatively high rates of diabetes. The overall adult rate meets the HP 2020 benchmark, but Latino and African American residents are disproportionately diabetic, and worse off in comparison with the county and state averages and benchmark. Of all ethnic groups, African Americans experience highest percentage of hospitalizations due to diabetes. Community input about diabetes was strong, and expressed the connection between the disease and related health behaviors such as poor nutrition and lack of physical activity. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, soda consumption, the proximity of fast food establishments, and a lack of grocery stores and WIC-authorized food sources.

Santa Clara County Health Need Profile

Mental Health

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **mental health** was prioritized as one of the 13 top health needs in the county.

The status of mental health needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

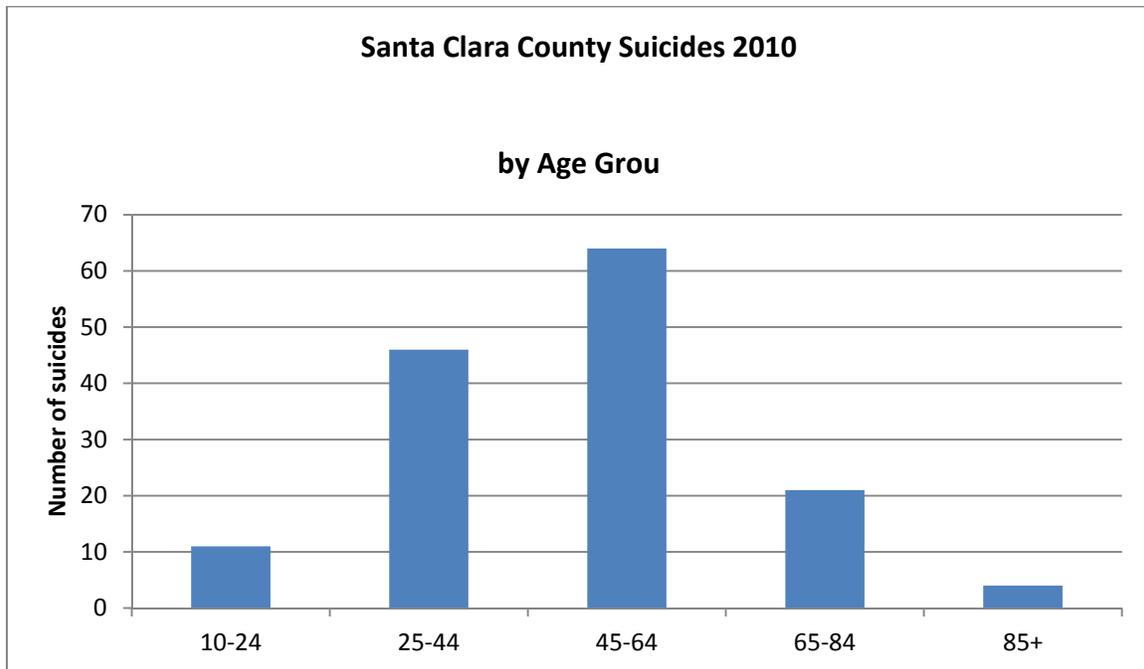
Indicator	Santa Clara County	CA State Ave	HP 2020 Benchmark	Data Source
Poor mental health (adults 18+) % who felt they might need to see a professional because of problems with their mental health, emotions, nerves, or use of alcohol or drugs in last 12 months	17%‡	14%‡	--	California Health Interview Survey (CHIS) 2009
Depression (youth) % of middle/HS students with depressive symptoms in past 12 months	28%	28%		CA Healthy Kids Survey (CHKS) 2009-10
White	24%			
African American	30%			
Latino	31%			
Asian/Pacific Islander	26%			
Suicidal ideation (youth) % of middle/HS students who seriously considered suicide in past 12 months	16%	19%	--	
White	15%			
African American	22%			
Latino	17%			
Asian/Pacific Islander	17%			
Suicide rate Age-adjusted suicide rate per 100,000 pop	7.9	9.8	10.2	CDC 2005-09

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Additional Data:

The overall suicide rate does not fail HP 2020 benchmark. Although the low number of suicides (146 total in the county) makes it difficult to calculate reliable rates, it is worth noting the number of suicides by age group. While there seems to be a perception that teen suicide is the most common, the raw numbers show us that most suicides are committed by middle-aged adults ages 45-64.



SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- Latino and African American youth exhibit depression in higher proportions than the state average.
- The percentage of African American youth who experience suicidal ideation is higher than both the county and the state-wide averages.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA State Ave‡	US Ave‡	Data Source
Behaviors	Adequate social or emotional support (adults) % adults who report receiving sufficient social / emotional support all /most of the time	78%	75%	80%	CDC BRFSS, 2006-2010

Note: ‡ Statistics from CARES Platform.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty, linguistic isolation, and lack of health insurance coverage) in the **Access to Health Care** profile report. Also, see data regarding related health needs of **Substance Abuse** and **Violence**.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Mental Health was of high concern in 16 out of 22 groups/interviews, and was mentioned in almost all of them. Residents identified specific conditions of stress, depression, suicide, and abuse (trauma).
- Social/emotional support as a driver of mental health was mentioned in at least half of the groups/interviews that identified mental health as a priority.
- Bullying, abuse and overwork can cause stress and mental health issues.
- Lack of knowledge about the effects of stress and how to cope.
- Poor mental health (stress) can cause physical problems such as heart issues, insomnia and poor diet.
- High stigma prevents people from identifying poor mental health in themselves and in getting treatment.
- Lack of mental health insurance benefits.
- Lack of affordable treatment resources.
- Lack of treatment for episodic mental health issues such as depression and stress.
- Inability to qualify for enough resources, especially after-care.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- ACT for Mental Health
- Alum Rock Counseling Center
- Asian American Recovery Services, Inc.
- Bill Wilson Center
- Billy DeFrank LGBT Community Center
- Central Wellness & Benefit Center
- Chamberlain’s Mental Health
- Catholic Charities of Santa Clara County
- Children’s Shelter Mental Health Clinic
- City of San Jose Parks, Recreation & Neighborhood Services
- Community Health Awareness Council
- Community Health Partnership
 - Asian Americans for Community Involvement
 - Foothill Community Health Center
 - Gardner Family Health Network
 - Indian Health Center of Santa Clara Valley
 - MayView Community Health Center
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - School Health Clinics of Santa Clara County
- Community Solutions
- Downtown Mental Health
- East Valley Mental Health
- EHC LifeBuilders
- EMQ FamiliesFirst
- El Camino Hospital
- Fair Oaks Mental Health
- Family & Children’s Services
- HOPE Rehabilitation Services
- Hospital Council of Northern and Central California
 - Medical Respite Program

- New Directions Program
 - Kaiser Permanente
 - John F. Kennedy University-Sunnyvale Community Counseling Program
 - Lucile Packard Children’s Hospital at Stanford
 - Mekong Community Center
 - Momentum for Mental Health
 - Palo Alto University – The Gronowski Center
 - Project Cornerstone, a YMCA of Silicon Valley Initiative
 - Rebekah’s Children's Services
 - Santa Clara County Mental Health Department
 - Santa Clara County Social Services Agency
 - Santa Clara Valley Health & Hospital System
 - South County Mental Health

Summary

Mental health is a health need in Santa Clara County as marked by a percentage of self-reported poor mental health that is higher than the state average. Latino and African American youth disproportionately exhibit symptoms of depression, and African American youth additionally experience suicidal ideation rates higher than the county-wide average. Community input indicates that the health need is likely being affected by stress (driven by financial/economic concerns) and the lack of education about how to cope with stress, stigma about mental illness leading to fear and denial, lack of knowledge about mental health treatment, and poor access to mental health care providers and specialists due to lack of insurance and/or mental health benefits among those who are insured, and/or due to a lack of providers (i.e., workforce development issues). Related to poor mental health are the health needs around violence and substance abuse.

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **obesity** was prioritized as one of the 13 top health needs in the county.

The status of needs associated with obesity is described in this profile, in terms of:

- Key indicators
- Geographic regions or subpopulations in which the need is greatest
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2013

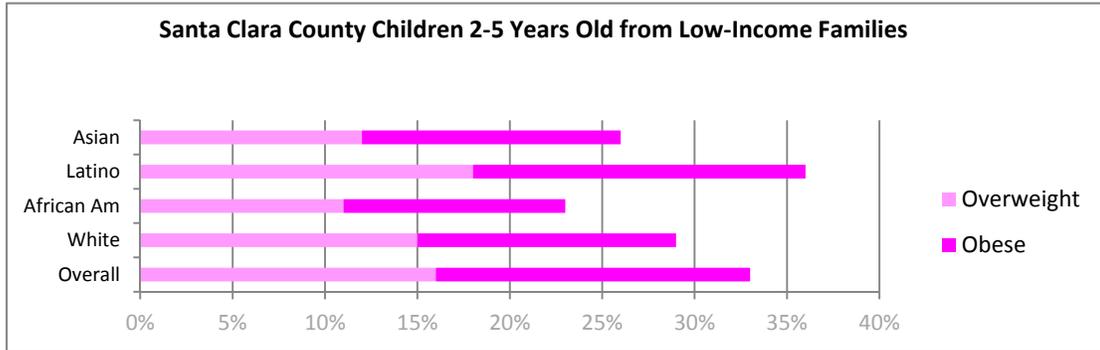
The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US	HP 2020 Benchmark	Data Source
Overweight adults % who self-report a BMI between 25-30	36%	36%	36%	31% overweight <u>or</u> obese adults	CDC BRFSS 2006-2010
Obese adults % who self-report a BMI over 30	21%	23%	27%		CDC BRFSS 2006-2010
Overweight or obese adults % with BMI over 25	55%			31% overweight <u>or</u> obese adults	SCC PHD BRFS 2009
White	55%				
Latino	68%				
African American	63%				
Asian/Pacific Islander	39%				

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Additional data:

- Low-income children have high proportions of overweight and obesity, as demonstrated by the table below.



Source: Dept. Health Care Services, Child Health & Disability Prevention Program, Pediatric Nutrition Surveillance System, 2009

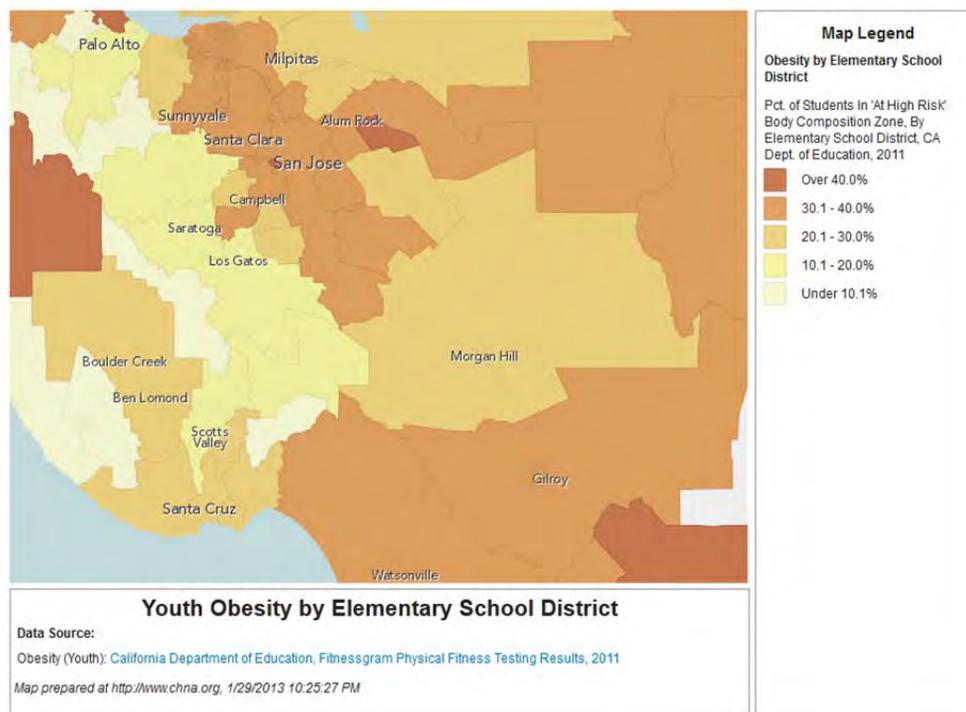
SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- Latinos and African Americans have higher proportions of overweight or obese adults compared with other ethnic groups.

Geographic Areas of Greatest Need

Obesity among elementary school children is worse in some areas of the county, as displayed in the map of elementary school districts below. Mount Pleasant Elementary School District in East San Jose is the worst off, with 41.65% of students testing in the high risk zone for body composition.

Gilroy Unified, San Jose Unified, Oak Grove Elementary, Santa Clara Unified, and Campbell Union Elementary School Districts reported 30%-40% of its students outside of the healthy zone.



Certain health drivers of obesity are also worse in some communities than in others.

- Fruit/vegetable expenditures: Worst in Morgan Hill, South San Jose, Saratoga, Los Gatos, and the western parts of Sunnyvale.
- Youth obesity: Worst in Gilroy and Southwest San Jose

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County	CA	Data Source
Behaviors	Soft drink expenditures % of total household expenditures	0.4%	0.5%	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
	Adequate fruit/vegetable consumption (youth) % of kids 2+ who consume five or more servings of fruits and vegetables daily	47%	48%	California Health Interview Survey (CHIS), 2009
	Inadequate fruit/vegetable consumption (adult) % of adults who consume less than five servings of fruits and vegetables daily	70%	70%	CDC BRFSS 2003-2009
Behaviors	Physical inactivity (youth) % of 5 th , 7 th & 9 th graders ranking within the "High Risk" or "Needs Improvement" zones for aerobic capacity	28%	37%	CA Dept of Education, Fitnessgram Physical Fitness Testing Results, 2011
	Physical inactivity (adult) % adults who self-report not participating in any physical activities or exercises	18%	22%	CDC BRFSS 2004-2010
Physical environment	Fast food restaurant access Establishments per 100,000 pop	72	69	U.S. Census Bureau, Business Patterns, 2009
	Grocery store access Establishments per 100,000 pop	20	22	U.S. Census Bureau, County Business Patterns, 2010
	WIC-authorized food access Establishments per 100,000 pop	9.5	15.8	U.S.D.A. Food Envir. Atlas, 2012
	Recreation/fitness access Establishments per 100,000 pop	12.7	8.9	U.S. Census Bureau, ZIP Code Business Patterns, 2009

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and insurance coverage) in the **Access to Health Care** profile report.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Obesity/overweight was of high concern in 13 out of 22 groups/interviews, and was mentioned in almost all of them.
- Lack of grocery stores or farmers' markets was mentioned as a driver for obesity or poor nutrition in seven separate groups/interviews; it was noted that food stamps/EBT were not accepted at farmers' markets; that poor neighborhoods were disproportionately lacking stores that sold fresh produce and other healthy food ("more liquor stores than grocery stores in some neighborhoods"); than lack of transportation affected access to grocery stores; that Asian & Latino families are more likely to choose fresh over processed food. It was suggested that policies/ordinances be supported that increased the quality of the food that "corner stores" would carry, increased the number of farmers' markets.
- One group mentioned that grocery stores decide how Women, Infants and Children (WIC) benefits can be used. One WIC beneficiary noted that consumers can't buy low-sugar options because they have artificial sweetener. (USDA states: "Federal WIC regulations do not prohibit foods that contain artificial sweeteners. However, WIC State agencies are responsible for determining the brands and types of foods to authorize on their State WIC food lists. Some State agencies may allow foods sweetened with artificial sweeteners on their foods lists, but this will vary by state").
- Six groups/interviews mentioned the **cost** of healthy food. Many groups/interviews discussed the need for more healthy/good quality food, but only one group specifically mentioned fruits and vegetables, saying that "children and parents need...to understand the benefits of eating fruits and vegetables" and discussed access issues related to this (i.e. Distribution channels not established to enable farmers to get their produce to stores, schools and families).
- Fast food mentioned as a driver for obesity or poor nutrition in eight groups/interviews; belief that fast food is cheaper, more accessible ("available on every corner"), faster, and provides more calories per dollar than healthy food, but is more unhealthy (fatty, "starchy", has as its companion "sugary drinks"); is being pushed by the media, can be found on school campuses, makes portion size an issue ("supersized").
- Lack of healthy eating:
 - Lack of education about healthy eating
 - Decrease in families preparing meals at home
 - Large portion size (restaurant trends having an influence on home cooks)
- Lack of exercise:
 - Busy lifestyles
 - Unsafe neighborhoods
 - High cost of physical fitness programs

- Social factors:
 - Parents may be poor models for children
 - Families used to overeating, eating unhealthy foods

Assets to Address the Need

Santa Clara County Public Health has shown commitment to obesity prevention through its Communities Putting Prevention to Work (CPPW) Obesity Prevention program, funded through September 2012. It is unclear whether or not the grants will continue in 2013. The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O'Connor Hospital:
 - Access to primary care services
 - Breastfeeding support group
 - Diabetes support group
 - Family medicine residency training program where residents learn how to care for individuals living with obesity and teach self-care management
 - Health Benefits Resource Center provides health insurance and CalFresh enrollment assistance
 - Living Well Classes & Resources
- Bay Area Nutrition & Physician Activity Collaborative
- Bay Area Women's Sports Initiative
- Community Alliance with Family Farmers
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - San Jose Foothill Health Center
 - School Health Clinics of Santa Clara County
- El Camino Hospital
- FIRST 5 Santa Clara County
- Good Samaritan Hospital
- Kaiser Permanente
- Lucile Packard Children's Hospital at Stanford
- Regional Medical Center of San Jose
- Sacred Heart Community Service
- Saint Louise Regional Hospital
- San Jose Department of Parks, Recreation & Neighborhood Services

- Santa Clara Family Health Foundation
- Santa Clara County Office of Education Coordinated School Health Program
- Santa Clara County Public Health Department
 - Breastfeeding support
 - *Childhood Feeding Collaborative*
 - *Eat Healthy, Eat Smart Innovative Nutrition Education Program*
 - WIC program
- Santa Clara Valley Health & Hospital System
- Second Harvest Food Bank of Santa Clara and San Mateo Counties
- Silicon Valley HealthCorps
- Somos Mayfair
- Stanford Hospital & Clinics
- Sunnyvale Community Services
- Veggielution
- West Valley Community Services

Summary

Obesity is a health need in the Santa Clara County as marked by high rates of overweight and obesity among both youth and adults. Overall rates are just below state averages, but the adult overweight rate misses the HP 2020 benchmark. Latino and African American residents are disproportionately overweight and obese, and worse off in comparison with California (and in some cases, U.S.) averages. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, soda consumption, the proximity of fast food establishments, and a lack of grocery stores and WIC-authorized food sources.

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **oral health** was prioritized as one of the 13 top health needs in the county.

The status of oral health needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US	Data Source
Poor dental health (adult) % of adults reporting having had 6 or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection	8%‡	11%‡	16%‡	CDC BRFSS 2006-10
Condition of teeth (youth) % of teens reporting the condition of their teeth was fair or poor	16%	12%	--	California Health Interview Survey (CHIS), 2007
White	12%	--	--	
Black	0%	--	--	
Latino	20%	--	--	
Asian/Pacific Islander	17%	--	--	
Multi-ethnic	11%	--	--	

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- Although adults in Santa Clara County fare well compared to the state with regard to dental health, a greater percentage of Santa Clara County youth report that their teeth are in fair/poor condition, compared to youth in the state overall.
- Latino and Asian/Pacific Islander youth have the highest percentages of fair/poor teeth compared with other ethnic groups.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA ‡	Data Source
Access	Absence of dental insurance % of adults who had no dental insurance	28%	34%	California Health Interview Survey (CHIS), 2007
	White	25%		
	African American	20%		
	Latino	32%		
	Asian/Pacific Islander	31%		
	Native American	32%		
	Multi-ethnic	17%		
Behaviors	Dental care utilization % reporting they have visited a dentist, dental hygienist or dental clinic within the past year			
	Teens	--	10%	CHIS 2009
	Adults	81%	70%	CDC BRFSS 2006-10
	Soft drink expenditures estimated expenditures for carbonated beverages, as a percentage of total household expenditures	.37%	0.46%	Nielsen Claritas SiteReports, Consumer Buying Power, 2011

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Although the absence of dental coverage in Santa Clara County is not as high as in the state overall, several subpopulations fare worse than others in the county. In particular, the percentages of Native Americans, Latinos, and Asian/Pacific Islanders without dental insurance verge on the state average (and worse than the county average).

See data regarding additional cross-cutting drivers influencing this health need (such as poverty) in the **Access to Health Care** profile report.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Oral/dental health was mentioned in 6 out of 25 groups/interviews.
- There was concern particularly about dental care for adults who are uninsured and who may also have chronic conditions.
- It was noted that Medicaid discontinued its dental care for adults.
- Getting annual dental check-ups is low-priority among those who have to pay out-of-pocket.
- Desire a patient-centered medical home with a patient navigator to help connect patients to dental care options.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- Carrington College California – San Jose Dental Hygiene
- First 5 Santa Clara County
- Foothill College Dental Hygiene Clinic
- Foothill Community Health Center
- Gardner Family Health Network
- The Health Trust’s Children’s Dental Centers
- Indian Health Center of Santa Clara Valley
- Ronald McDonald Care Mobile Unit
- Santa Clara County Health & Hospital System
- Tooth Mobile

Summary

Oral/dental health is a health need Santa Clara County as marked by the percentage of youth reporting their teeth in fair or poor condition, which is higher than the state average. Latino and Asian/Pacific Islander youth are disproportionately affected. While adult dental health is not identified as a concern county-wide, some subgroups (Latinos, Native Americans, Asian/Pacific Islanders) are more likely than others not to have dental insurance, at rates nearing the statewide average. The health need is likely being impacted by certain social determinants of health, and by the cost of dental care. Community feedback indicates that the health need is affected by concerns about poor access to dental care providers and specialists due to lack of insurance, particularly among residents with chronic conditions.

Respiratory Conditions

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **respiratory conditions** were prioritized as one of the 13 top health needs in the county. This category includes asthma, and will be developed to include Chronic Obstructive Pulmonary Disease (COPD).

The status of respiratory health needs is described in this profile, in terms of:

- Key indicators
- Geographic regions or subpopulations in which the need is greatest
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	HP 2020	Data Source
Asthma				
Lifetime prevalence (youth) % of children ages 0-17 ever diagnosed (parent report)	12%	14%	--	CHIS 2009; cited by Breathe CA
Lifetime prevalence (adult) % of adults 18+ ever diagnosed	11%	14%	--	
Hospitalizations (children) rate of asthma hospitalizations for children age 0-4	24.5	22.3	18.1	OSPHD 2010; cited by Breathe CA
Hospitalizations (youth) rate of hospitalizations per 10,000 children age 0-17	9.7	11.0	--	
Hospitalizations (adult) rate of hospitalizations per 10,000 adult 18+	6.0	8.3	8.6	

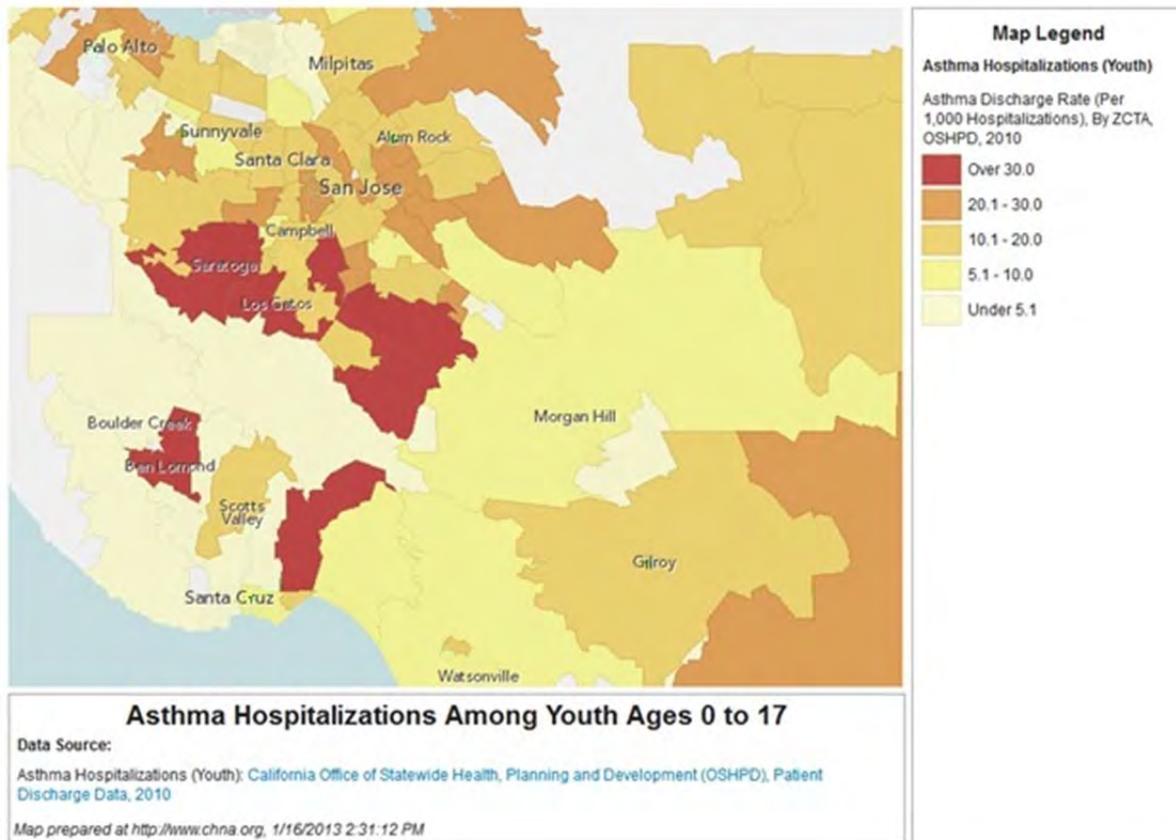
Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Geographic Areas of Greatest Need

Asthma hospitalizations among youth ages 0-17 is worse in some areas of the county than in others, as displayed in the map of zip code tabulation areas. The outlying area of Saratoga/Los Gatos is the worst off, with a youth asthma hospitalization rate of 71.4.

Saratoga itself, as well as parts of South San Jose and Campbell all reported asthma hospitalization rates of 30 or higher among youth.



Respiratory Conditions

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals’ behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA ‡	US ‡	Data Source
Behaviors	Smoking (adult) % of adults who currently smoke	10%	14%‡	18%	CDC BRFSS 2004-2010
	Smoking (youth) % of middle- and high-school youth who smoked cigarettes in past 30 days	8%	--	--	CA Healthy Kids (CHKS), 2009-10
Physical environment	Poor air-quality % of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard	3.7%	4.2%	1.2%	CDC National Environmental Public Health Tracking Network, 2008

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and lack of health insurance coverage) in the **Access to Health Care** profile report.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Respiratory conditions, including asthma, COPD, and allergies were mentioned in 6 out of 25 groups/interviews.
- There was concern about lack of insurance and underinsurance generally for those dealing with chronic respiratory conditions
- Environmental causes were also mentioned, such as pollution.
- The cost of prescription medication and equipment for the un/underinsured and those who are low-income, unemployed, or living in poverty was noted.

Respiratory Conditions

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- Allergy & Asthma Associates of Santa Clara Valley Research Center
- American Cancer Society
- American Lung Association
- Breathe California
- California Smoker’s Hotline
- El Camino Hospital
- Good Samaritan Hospital
- Kaiser Permanente
- Lucile Packard Children’s Hospital at Stanford
- O’Connor Hospital
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara County Public Health Department
- Tobacco Free Coalition of Santa Clara County
- Santa Clara Valley Health & Hospital System
- Stanford Health & Clinics
- Vietnamese Reach for Health Coalition

Summary

Respiratory conditions are a health need in Santa Clara County as marked by hospitalization rates of children ages 0-4. Asthma hospitalization rates of youth ages 0-17 show geographical disparities, with the worst rates in Saratoga, South San Jose, parts of Los Gatos and Campbell. The health need is likely being impacted by health behaviors such as percentage of youth smoking, and by issues in the physical environment such as air-quality levels. Community input indicates that the health need is also affected by concerns about the costs of treatment (including prescription medication and equipment) due to underinsurance or lack of insurance, particularly among low-income residents.

Santa Clara County Health Need Profile

STDs, including HIV/AIDS

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, sexually transmitted diseases were prioritized as one of the 13 top health needs in the county. This category included HIV/AIDS and other sexually transmitted diseases.

The status of **sexually transmitted diseases** is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	HP 2020 Benchmark	Data Source
HIV prevalence prevalence rate of HIV per 100,000 population	191.6†	345.5†	--	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008
HIV hospitalizations hospitalization rate due to HIV per 100,000 pop	0.89†	1.67†	--	CA Office of Statewide Health Planning & Development (OSHPD), 2011
HIV incidence new HIV infection case rate per 100,000 population	10.3	--	--	eHARS 2011; cited by Santa Clara County Public Health Department Latino Report
White	8.7			
African American	50.4			
Latino	15.6			
Asian/Pacific Islander	4.9			
Chlamydia incidence Chlamydia incidence rate per 100,000 population	312.0	438.0	--	CDPH STDC prelim data thru 8/07/12
Female	430.9	569.9	Percent only	
Male	169.1	257.8	Percent only	
Syphilis incidence Primary & Secondary syphilis incidence rate per 100,000	3.8†	6.5	--	CDPH STDC prelim data thru 8/07/12
Female	0.4†	0.5	1.4	
Male	6.8†	11.8	6.8	

Santa Clara County Health Need Profile

STDs, including HIV/AIDS

Indicator	Santa Clara County	CA	HP 2020 Benchmark	Data Source
Gonorrhea incidence Gonorrhea incidence rate per 100,000	35.5	73.1	--	CDPH STDC prelim data thru 8/07/12
Female	24.7	54.5	257	
Male	43.5	83.7	198	

Note: † Size of n is too small to rely upon. ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- African Americans and Latinos have the highest incidence rate of HIV compared with other ethnic groups, far higher than the county average. No state average or national benchmark is available for comparison.
- Men county-wide appear to have an incidence rate of primary and secondary syphilis that is no better than the nationally benchmarked maximum for males, although the number of cases on which this statistic is calculated is too small to rely upon.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals' behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County‡	CA ‡	Data Source
Clinical care	Lack of HIV screening % of teens and adults age 12-70 <u>never</u> screened for HIV	56%	49%	California Health Interview Survey (CHIS), 2005

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

The county-wide percentage of teens and adults being screened for HIV is lower than the state average.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and insurance coverage) in the **Access to Health Care** profile report.

Santa Clara County Health Need Profile

STDs, including HIV/AIDS

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- STDs, including HIV/AIDS, were mentioned in 3 out of 25 groups/interviews.
- There was concern about poor outreach, lack of knowledge and lack of health education affecting prevention efforts and treatment (i.e., many people are not aware of how STDs can be transmitted and when they might be at risk or might be putting others at risk, do not know what the symptoms are, or that they can and should be tested for STDs).
- Some mentioned that those with STDs feel they will be stigmatized (by family, peers, or even physicians) if they come forward to obtain a diagnosis and/or treatment.
- Issues with access to/cost of condoms and other means of STD prevention, particularly for adolescents, those in poverty, and the uninsured.
- Peer pressure was mentioned in relation to adolescents.
- Need for programs to partner for more effective/efficient provision of services.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- Bill Wilson Center
- Billy DeFrank LGBT Community Center
- College Health Centers (public and private universities, community colleges)
- Community Health Awareness Council
- Community Health Partnership
 - Asian American for Community Involvement
 - Indian Health Center of Santa Clara County
 - Gardner Family Health Network
 - MayView Community Health
 - North East Medical Services
 - Planned Parenthood Mar Monte
 - RotaCare Bay Area, Inc.
 - San Jose Foothill Health Center
 - School Health Clinics of Santa Clara County
- El Camino Hospital
- Good Samaritan Hospital

Santa Clara County Health Need Profile

STDs, including HIV/AIDS

- The Health Trust
- Kaiser Permanente
- Lucile Packard Children's Hospital at Stanford
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Santa Clara County Public Health Department
- Santa Clara Valley Health & Hospital System
- Stanford Hospital & Clinics

Summary

STDs including HIV and AIDS are a health need in Santa Clara County as marked by high incidence rates of HIV among African Americans and Latinos, as well as high primary & secondary syphilis incidence rates among males county-wide. The rate of HIV hospitalizations is worst in central San Jose. The health need is likely being impacted by low screening rates for HIV (county-wide, the percentage of teens and adults ever screened for HIV is lower than the state average), as well as certain social determinants of health. Community feedback suggests that the health need is perceived as primarily affecting youth, and is impacted by poor outreach, lack of knowledge/health education about transmission, risk, and screening, the fear of stigmatization by others, access to and costs of prevention (e.g., condoms), and peer pressure.

Santa Clara County Health Need Profile

Substance Abuse (ATOD)

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **substance use** was prioritized as one of the 13 top health needs in the county. This category included smoking, alcohol and other drugs.

The status of substance use needs is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	US‡	HP 2020 Benchmark	Data Source
Smoking					
Adult % of adults who currently smoke	10%	14%‡	18%	12%	Santa Clara County Public Health Department, BRFSS, 2009
Youth % of 11th graders who smoked cigarettes past 30 days	13%	--		16% (high school youth only)	CA Healthy Kids (CHKS), 2009-10
Alcohol					
Adult heavy use % of adults reporting heavy alcohol consumption	13%‡	17%‡	16%	--	CDC BRFSS 2004-10
Adult binge drinking % of adults reporting binge drinking in last 30 days	25%	16%		24%	Santa Clara County Public Health Department, BRFSS, 2009
Youth binge drinking % of youth reporting binge drinking in last 30 days	12%	--		9%	CA Healthy Kids (CHKS), 2009-10
Other drugs					
Any drug use (adult) % adults who reported drug use in the past 12 months	8%	--		--	Santa Clara County Public Health Department, BRFSS, 2009

Santa Clara County Health Need Profile

Substance Abuse (ATOD)

Indicator	Santa Clara County	CA	US‡	HP 2020 Benchmark	Data Source
Marijuana abstinence (youth) % 11 th graders in public school reported <u>never</u> using marijuana	64%	61%		--	CA Healthy Kids (CHKS), 2009-10

Note: ‡ Statistics from CARES Platform.

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

See **Mental Health** and **Access to Health Care** profile reports for additional cross-cutting drivers influencing Substance Abuse (such as poverty and lack of health insurance coverage).

Community Input

The health needs assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives, and residents. Themes from discussions regarding the health need are identified below.

- Substance use (addiction to alcohol, tobacco, or other drugs [ATOD], misuse of prescription medication) and overall poor behavioral health were of high concern in 8 out of 25 groups/interviews, and were mentioned in many others.
- It was acknowledged that legal and illegal drugs are relatively easy to obtain.
- Medication mismanagement (including sharing prescriptions with others) and lack of knowledge about medications (appropriate dosages, risks of overdose, risks of addiction, appropriate use) were mentioned.
- Some respondents focused on adolescents and young adults, describing concerns such as peer pressure, stress and poor coping skills, curiosity, media portrayals, and parental permissiveness (up to and including supplying ATOD to their children).
- Other respondents focused on adult ATOD use/abuse, identifying stress and poor coping skills as drivers.
- Many expressed concerns about coordination of care and the need for a patient-centered medical home; a “warm handshake” is a better transfer of care of a patient from one provider to another when referring patients for sensitive issues such as ATOD use/abuse or mental health matters.
- Behavioral health support not covered by all insurance plans
- Lack of support groups and practitioners who specialize in behavioral health/addiction.
- Family modeling
- “Self-medicating” with alcohol or illicit drugs instead of dealing with root issues.
- Life worries (financial, family [including separation among the undocumented], high expectations, major losses) and being “too busy” (working multiple jobs, long hours, lengthy commutes) drive stress.
- Impact on those who are un/underinsured and cannot otherwise afford treatment.
- Unsafe neighborhoods (where gangs or others are dealing drugs)

Santa Clara County Health Need Profile

Substance Abuse (ATOD)

- Stigma of addiction, especially in some cultures, can extend to family and doctors, leading those who are addicted to remain untreated.
- Relative lack of services; need for programs to partner for more effective/efficient provision of services.

Assets to Address the Need

The Santa Clara County Community Benefits Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- Asian American Recovery Services, Inc.
- Catholic Charities of Santa Clara County
- Community Health Awareness Council
- Community Health Partnership
 - Asian Americans for Community Involvement
 - Gardner Family Health Network
 - Indian Health Center of Santa Clara Valley
 - RotaCare Bay Area, Inc.
- Hospital Council of Northern and Central California
 - Medical Respite Program
 - New Directions Program
- John F. Kennedy University-Sunnyvale Community Counseling Program
- Lucile Packard Children's Hospital at Stanford
- Santa Clara Valley Health & Hospital System

Summary

Substance abuse is a health need in Santa Clara County as marked by levels of binge drinking among youth and adults that are higher than HP 2020 benchmarks. Community feedback indicates that the health need is impacted by stress and poor coping skills across all sub-populations, concerns about the cost of treatment, fear of being stigmatized, and poor access to primary care providers, specialists, and other support options due to lack of insurance or underinsurance, particularly among low-income residents. Medication misuse and mismanagement was also discussed, and was thought to be due to a lack of knowledge about medications and their associated risks. In addition, community input suggested that adolescents are especially vulnerable to this health need, as it was believed they are more affected by peer pressure, curiosity, media portrayals, accessibility of alcohol, tobacco, and other drugs, and parental permissiveness.

Santa Clara County Health Need Profile

Violence

In 2012, the Santa Clara County Community Benefit Coalition conducted a county-wide assessment of health needs. Based on this scan of quantitative and qualitative data, **violence** was prioritized as one of the 13 top health needs in the county.

The status of violence is described in this profile, in terms of:

- Key indicators
- Key drivers or factors affecting the condition
- Community input
- Assets within the community that can make a difference

Status of Key Indicators, 2012

The table of indicators below includes Santa Clara County data that can be compared to statewide (CA) data and Healthy People 2020 (HP 2020) indicators where available.

Indicator	Santa Clara County	CA	HP 2020 Benchmark	Data Source
Domestic violence (recent) % experienced physical or sexual violence by intimate partner in past year	2%	4%	--	California Health Interview Survey (CHIS) 2009
Domestic violence (ever) % females 18-64 ever experienced sexual/ physical violence by intimate partner since age 18	16%	21%	--	
Child abuse Rate of substantiated allegations of child maltreatment	4.3	9.6	--	CA Dept. Social Services/UC Berkeley Center for Social Service Research (2011)
White	3.0			
African American	13.5			
Latino	7.9			
Asian/Pacific Islander	1.3			
Native American	8.3			
Multiracial	0			

Santa Clara County Health Need Profile

Violence

Indicator	Santa Clara County	CA	HP 2020 Benchmark	Data Source
Bullying % of middle- and high-school students who reported being physically bullied on school property in the last 12 mos	28%		--	CA Health Kids (CHKS), 2009-10
Homicide victims of homicide per 100,000 population	2.7		5.5	CDPH Vital Statistics, 2009
White	1.2			
African American	9.5			
Latino	3.9			
Asian	2.5			
Homicide (child/youth) victims of homicide ages 0-14 per 100,000 of that age	0.80		5.5 all ages	CDPH Vital Statistics, 2009
Homicide (youth/young adult) victims of homicide ages 15-24 per 100,000 of that age	7.4		5.5 all ages	

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

Additional data:

- Since 2009, Santa Clara County has seen an increase in homicides. According to the San Jose Mercury News, there were 40 homicides in San Jose alone in 2011, and 46 in San Jose in 2012, which would substantially increase homicide rates. Data on the ages of victims was not available.

SUBPOPULATIONS EXPERIENCING THE GREATEST IMPACT:

- African Americans have the highest rate of substantiated child abuse allegations compared with other ethnic groups, and this rate is higher than the state average.
- Homicide rates among African Americans and among youth/young adult both fail against the Healthy People 2020 benchmark for overall homicide rate.

Factors Influencing the Health Need

Full understanding of the health need requires a review of other elements that can have an impact on it, such as individuals' behaviors, socioeconomic factors, the physical environment, or the provision of preventative care or early intervention. Such factors relevant to this health need are identified in the table below.

Category	Driver/indicator	Santa Clara County	CA	Data Source
Behaviors	Gang membership (youth) % of 7th/9th/11th graders who consider themselves a gang member	7%	--	CA Healthy Kids (CHKS), 2009-10
	White	5%		
	African American	14%		
	Latino	10%		
	Asian/Pacific Islander	5%		
	Native American	11%		
	Violent crime Violent felony arrest rate per 100,000			CA Dept. Justice Profile, 2010
	Adults	287.8	394.2	
	Youth (ages 10-17)	253.2	294.9	
	Alcohol consumption (adult) % of adults reporting heavy alcohol consumption	13%‡	17%‡	CDC BRFSS 2004-2010
Alcohol binging (adult) % of adults reporting binge drinking in last 30 days	25%	16%	Santa Clara County Public Health Department BRFS 2009	
Alcohol binging (youth) % of youth reporting binge drinking in last 30 days	12%	--	CHKS, 2009-10	
Any Drug Use (Adult) % adults who reported drug use in the past 12 months	8%	--	SCC PHD, BRFS 2009	
Physical environment	Recreational facilities number per 100,000 population of recreation and fitness facilities as defined by NAICS Code 713940	11	8.7	U.S. Census Bureau, ZIP Code Business Patterns, 2009

Red font indicates that an indicator fails to meet a benchmark or is worse than the state average.

See data regarding additional cross-cutting drivers influencing this health need (such as poverty and linguistic isolation) in the **Access to Health Care** profile report. Also, see data regarding related health needs of **Substance Abuse** and **Mental Health**.

Community Input

The health-needs-assessment process would be incomplete without community input about the health need. Key informant interviews were conducted with local health experts, as well as focus groups with community leaders, representatives and residents. Themes from discussions regarding the health need are identified below.

- Violence was of high concern in 7 out of 22 groups/interviews, and was mentioned in others

Violence

- With regard to gang violence, frequent themes included the cost of and/or lack of healthy outlets and activity options for youth; not feeling they have better life alternatives; gang membership as a way to belong, or as protection from other forms of violence/abuse; and unsafe communities.
- With regard to domestic violence, themes included underreporting; lack of awareness of support and services; social isolation; financial/economic stress; and unaddressed mental and/or behavioral (e.g., ATOD abuse) health issues on the part of the perpetrator.
- With regard to bullying, themes included underreporting; lack of policy enforcement; the rise in social media as a venue for bullying; and concern about bullying as a “gateway” to gangs and other forms of violence.
- Unemployment
- High stigma prevents people from reporting domestic violence and getting help.
- Poor family models; can be generational.
- Lack of parenting support.
- Cultural/societal acceptance of violence, including media promotion
- Lack of education about coping skills, conflict resolution
- Language barriers to seek support/protection.
- Incarceration, which can foreclose future life options, promote gang membership.
- Easy access to weapons.

Assets to Address the Need

The Santa Clara County Community Benefit Coalition members and a representative from the Santa Clara County Public Health Department were consulted to identify existing internal and community assets that could be accessed to address the health need. These include:

- O’Connor Hospital
 - A hospital associate is the chair of the Membership Committee of the Child Abuse Council of Santa Clara County
 - The hospital sponsors the Annual Child Abuse Symposium
- Alum Rock Counseling Center
- Asian Americans for Community Involvement
- Asian American Recovery Services, Inc.
- Catholic Charities of Santa Clara County
- Child Abuse Council of Santa Clara County
- Community Health Awareness Council
- Community Solutions
- EMQ FamiliesFirst
- First 5 Santa Clara County
- John F. Kennedy University-Sunnyvale Community Counseling Program

- Kids in Common, a program of Planned Parenthood Mar Monte
- Lucile Packard Children's Hospital at Stanford
- Next Door Solutions to Domestic Violence
- Rebekah's Children's Services
- Project Cornerstone, a YMCA of Silicon Valley Initiative
- Santa Clara County Social Services Agency
- Santa Clara County Office of Human Relations
- Santa Clara County Office of Women's Policy
- Santa Clara Valley Health & Hospital System
- YWCA

Summary

Violence is a health need in Santa Clara County as marked by rates of youth homicide that are higher than the HP 2020 benchmark for homicide overall. Rates of bullying are also high, though no statewide data are available for comparison. In addition, while county-wide levels of child abuse and domestic violence do not fail against state averages, the percentage of child abuse among African Americans is much higher than the state average. The health need is likely being impacted by health behaviors such as binge drinking (where the county adult rate is higher than the state average) and gang membership (percentages of gang identification among African American, Native American, and Latino youth are higher than the county-wide levels). Community input indicates that the health need is also affected by the cost of and/or lack of activity options for youth, financial/economic stress, lack of policy enforcement, poor family models, unaddressed mental and/or behavioral health issues among perpetrators, cultural/societal acceptance of violence, lack of awareness of support and services for victims, and linguistic isolation. Community members also suggested that violence is underreported by victims, possibly due to stigma and/or cultural norms.