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Community Health Needs Assessment

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STANFORD
HOSPITAL & CLINICS

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- **Hospital Council of Northern and Central California**, Jo Coffaro, Regional Vice President
- **Kaiser Permanente, Santa Clara and San Jose**
  - Elizabeth Sills, South Bay Community Benefit Manager
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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 (IRS).

The IRS requires the hospital to 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 Stanford Hospital & Clinics (SHC), the due date is August 31, 2013.

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

Process and Methods

The Santa Clara County Community Benefit Coalition, which includes eight local non-profit hospitals, Santa Clara County Public Health Department, United Way Silicon Valley and other partners, and the Healthy Community Collaborative of San Mateo County, a coalition of seven local non-profit hospitals, San Mateo County Health System and other partners (see acknowledgements) began the CHNA process in 2012. The goal was to collectively gather community feedback, understand existing data about health status and prioritize local health needs in each county.

In Santa Clara County, community input was gathered during the fall of 2012 through interviews with local health experts, focus groups with community leaders and representatives, and resident focus groups. Secondary data was obtained from a variety of sources (Attachment 1).

In San Mateo County, resident input was gathered through the 2013 Community Health Needs Assessment: Health & Quality of Life Survey. The survey was conducted using a random sample of 1,000 adults in San Mateo County via landline and cell phones. In addition to the countywide random sampling, additional surveys were conducted in Coastside zip codes as well as oversampling of African-American residents and low-income residents, resulting in a total of 1,724 interviews. The secondary data was collected, synthesized and analyzed from multiple sources by San Mateo County Health System (Attachment 2).

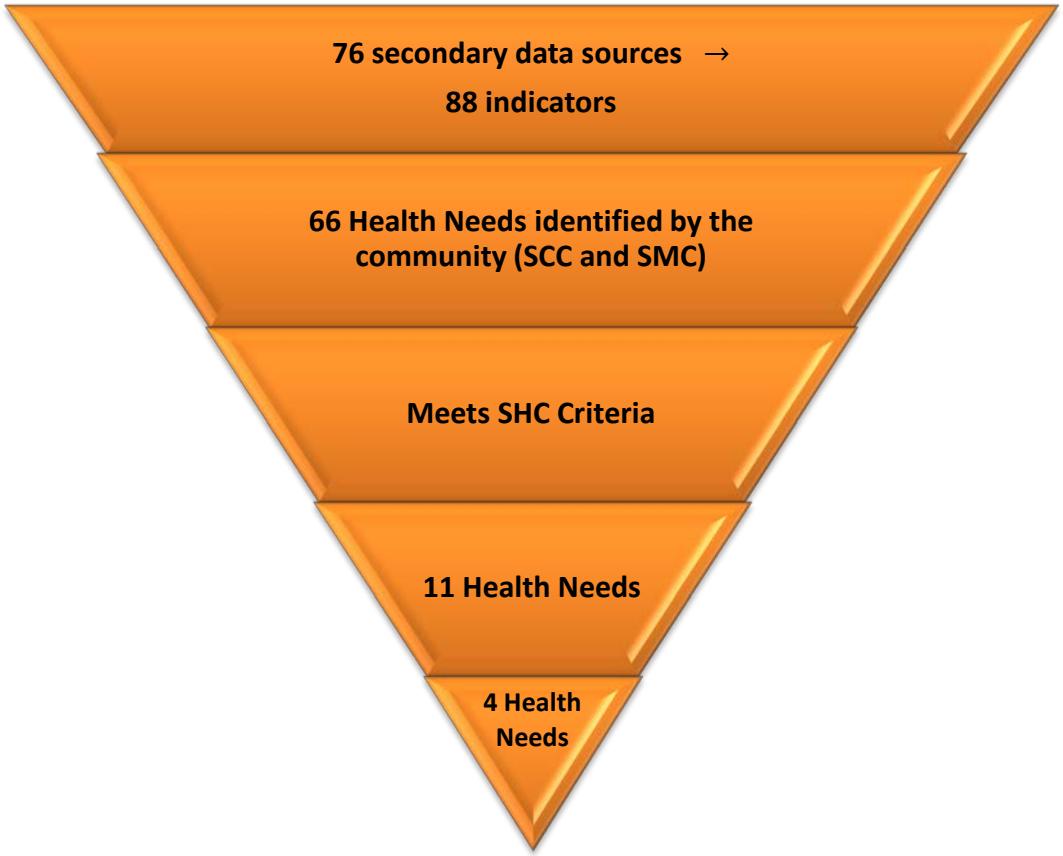
In late 2012 through early 2013, health needs were identified by synthesizing primary qualitative research and secondary data, and then filtering those needs against a set of criteria. Needs were then reviewed and prioritized by countywide groups consisting of members of the county coalitions and community leaders using another set of criteria. The coalition's then met again to identify the community resources available to address the health needs identified through the CHNA process, including hospitals, clinics and community-based programs and services.

Prioritization of Health Needs

In February 2013, the SHC Community Partnership Program Steering Committee met to review the data collection and prioritization process that occurred in the community. The purpose of the meeting was to find those health needs that met certain criteria and would form the basis for SHC's implementation plan.

The prioritization process is outlined in the pyramid below. The 66 health needs[1] were identified by community input in both counties and the 88 indicators were selected from multiple secondary data sources. From the 11 health needs[2] that met all criteria, the committee selected four to address: cancer, access to care, chronic disease and unintentional injuries (falls). See pages 22-26 for a description of the 11 health needs.

PROCESS PYRAMID



[1] The basic 66 health needs identified by community input have not been assessed against secondary data at this point.
[2] The 11 health needs were selected after evaluation against secondary data and other criteria.

The health needs highlighted in the table below represent those selected by the SHC Community Partnership Program Steering Committee.

11 Health Needs Identified by CHNA Process
4 Health Needs Selected by SHC Steering Committee

Health Needs
1. Diabetes
2. Mental health
3. Obesity/overweight
4. Cancer
5. Cardiovascular Disease, Heart Disease, Stroke
6. Access to health care
7. Arthritis
8. Chronic disease
9. Alzheimer's/dementia
10. Unintentional injuries (falls)
11. Respiratory conditions (asthma, COPD, allergies)

Next Steps

SHC developed its implementation plan for investments in improving the health and well-being of the community based on:

- The health needs identification and prioritization process conducted in each county, which synthesized primary and secondary data
- The health needs prioritization and selection process undertaken by the SHC Community Partnership Program Steering Committee
- A review of SHC's current community health improvement initiatives

Both the CHNA and implementation plan are publically available on SHC's website as of May 2013.

In addition, the countywide coalitions will continue to meet to explore opportunities for coordinated interventions around shared health needs.

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 (Attachment 3).

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
- 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 IRS 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 Community Assessments

Compared to SB 697, the California-specific legislation enacted in 1994 that requires a CHNA, the ACA regulations for how to conduct and document the needs assessment are more stringent. 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 CHNA at least once every 3 years	Yes	Yes
CHNA identifies and prioritizes community health needs	Yes (Prioritization of 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 (plan filed with the state)
$50,000 excise tax for failure to meet CHNA requirements for any taxable year	Yes	No

3. ABOUT STANFORD HOSPITAL & CLINICS

Stanford Hospital & Clinics (SHC) is dedicated to providing leading-edge and coordinated care to each and every patient. It is internationally renowned for expertise in areas such as cancer treatment, neuroscience, surgery, cardiovascular medicine and organ transplant, as well as for translating medical breakthroughs into patient care. Throughout its history, Stanford has been at the forefront of discovery and innovation, as researchers and clinicians work together to improve health on a global level. SHC's vision is healing humanity through science and compassion, one patient at a time. Its mission is to care, to educate, to discover.

Hospital	
Licensed beds	613 (475 staffed)
Licensed ICU beds	67 (66 operating)
Operating rooms	49
Staff	
Medical	2,136
Interns and residents	711
RNs	2,154
LVNs	15
Nursing assistants	141
Nonmedical employees	2,779
Total	**7,936**
Admissions Per Year	
Inpatient visits	25,164
Outpatient visits	643,806
ER visits	53,908

Community Served

SHC is a regional referral center for an array of adult specialties, drawing patients from throughout California, across the country, and internationally. However, a majority of SHC's patients are residents of San Mateo and Santa Clara counties. Therefore, for purposes of its community benefit program initiatives, SHC has identified these two counties as its target community. SHC maintains a strong commitment to the health of its community members and dedicates considerable resources to support its community partnership program.

SANTA CLARA COUNTY

With 1.8 million residents, Santa Clara County (SCC) is the sixth most populated of California's 58 counties, and the most populated county in the Bay Area. More than half of the residents live in San Jose. SCC's population is projected to grow from the current level to more than 2.3 million by 2030.

The North County area is extensively urbanized. Thirteen of the county's 15 cities and more than 88 percent of the county's residents are located in the North County. Gilroy and Morgan Hill, with approximately 5 percent of the county's population, are located in the South County, which remains predominantly rural, with low-density residential developments scattered though the valley and foothill areas.

According to the 2010 US Census, approximately 36 percent of the population in SCC was born outside of the United States, outpacing the rate for California by nearly 10 percent. SCC's racial/ethnic composition is 47 percent White, 32 percent Asian, 27 percent Latino and 3 percent African American. In the most recent census, approximately 12 percent selected "some other race" and 5 percent selected "more than one race." The predominantly reported sub-groups of the Asian population are Chinese (27 percent), Vietnamese (22 percent), Asian Indian (22 percent) and Filipino (15 percent). More than 100 languages and dialects are spoken in SCC.

Latinos represent the fastest-growing demographic. According to the Silicon Valley Latino Report Card, 82 percent of Latinos in Silicon Valley are from Mexico, with another 8.5 percent from Central America. The Vietnamese population is another demographic that is growing rapidly in SCC. While there are currently more Chinese (27 percent) in SCC than Vietnamese (22 percent), the Vietnamese population has grown very quickly in the last few decades, from 11,717 in 1980 to 134,525 in 2010. The population is the second largest of any county in the U.S., surpassed only by Orange County, California. San Jose has the largest Vietnamese population of any U.S. city.

People ages 60 and older make up slightly less of the population in SCC than in California as a whole (16.1 percent vs. 16.8 percent); however, according to the Council on Aging Silicon Valley, "In the coming years, seniors will comprise a larger and larger share of the local population. In 1990, fewer than 1 in 8 county residents was age 60 or older. By 2010, that ratio had grown to 1 in 6. By 2030, over 1 in 4 county residents will be over age 60."[3]

While SCC is one of the most diverse counties in the US, the older adult population is less diverse. Nearly 60 percent of the county's senior residents are White (non-Latino), 24 percent are Asian and 12 percent are Latino (any race). It is projected that by 2030, the demographic makeup of the county will change dramatically among the population of adults who are ages 60 and older. By 2030, about 47 percent of older adults will be White, 29.5 percent will be Asian, and 17.8 percent will be Latino.

On the other hand, young people (ages 17 years and younger) are more diverse than the general population. These young people make up about 25 percent of SCC's population. While Latinos are 27 percent of SCC's overall population, they represent more than 35 percent of the youth population. In 2011, more than 25 percent of children were English-language learners.

The percentage of children living below the Federal Poverty Level (FPL) has increased by 2.6 percent since 2000. In SCC, more Hispanic/Latino and African-American children are living in poverty compared to children of other racial/ethnic groups and the county overall. In 2012, the national FPL for a family of four was $23,050. According to this measure, nearly 1 in 10 children (11 percent) and 1 in 12 adults (9 percent) are living in poverty.

Because the FPL does not take into consideration local conditions such as cost of living, other measures of economic security are used to provide a more realistic measure of poverty in SCC. The Family Economic Self-Sufficiency Standard (FESSS) estimates that an annual income of $59,140 is necessary for a family of three

[3] Council on Aging Silicon Valley Area Plan 2012-2016; 2012

(one adult and two children ages 3-5) to meet their most basic expenses; this is equivalent to more than four full-time minimum-wage jobs.[4]

Nearly half of SCC older adults are economically insecure, with incomes too low to meet their basic needs without additional assistance. According to the Elder Economic Security Index[5] (Elder Index), a measure that provides a county-specific indicator of senior poverty, 67 percent of Latino seniors and 76 percent of Asian seniors are living in impoverished conditions, compared with just 32 percent of White (non-Latino) seniors. Additionally, female seniors and seniors ages 75 and older (any gender) are more likely to experience poverty compared to male seniors and those between the ages of 65 and 74.

SAN MATEO COUNTY

San Mateo County (SMC), located on the San Francisco Peninsula is made up of 20 cities and towns, bordered by the City of San Francisco on the north, the San Francisco Bay on the east, Santa Clara County on the south, and the Pacific Ocean on the west. SMC is a mix of urban and suburban industrial, small business, and residential use. The coastal area is a mix of suburban and rural with significant agricultural, fishing, small business and tourism land use. According to the 2010 U.S. Census, the county's population is 719,467. SMC's population is expected to increase by 14 percent from 2010 to 2050.

SMC is among the richest counties in terms of ethnic diversity. From 2006 to 2010, 34 percent of the county population was foreign born and nearly half (45 percent) of those ages 4 and older spoke a language other than English at home. Over the next four decades, the White population is expected to decrease by nearly 50 percent, while Hispanic and Asian/Pacific Islander populations are expected to increase dramatically. By the year 2050, the ethnic makeup of the county is projected to be 38 percent Hispanic, 32 percent Asian/Pacific Islander, 22 percent White, 5 percent African-American, and 4 percent other/multi-race.

While other age groups will decrease in terms of the percentage of the county population from 2010 to 2050, those ages 60 and older will increase from 18.9 percent to 30.9 percent. Asian/Pacific Islander and Hispanic seniors will comprise the largest proportion of seniors in SMC in 2050. At the other end of the age spectrum, the ethnic makeup of children ages 14 and younger is projected to be Hispanic, Asian/Pacific Islander, White, African-American, and multi-race in 2050.

In 2010, median income for SMC residents ages 25 and older was $47,060 and the average weekly wage was $1,450, down 13 percent from 2000. According to the U.S. Census Bureau, from 2006 to 2010, the percentage of SMC individuals below the FPL was 7 percent, with 9.1 percent of children ages 18 and younger below the FPL.

According to the FESSS, a single parent with two children living in SMC must earn approximately $78,000 annually to meet the family's basic needs, the equivalent of nearly five full-time minimum-wage jobs.

According to the Elder Index, 36 percent of seniors struggle to cover basic expenses and if their annual income exceeds the FPL ($10,830), they may be ineligible for public-assistance programs.

[4] Developed by the Insight Center for Community Economic Development, the FESSS is a comprehensive measure of how much it costs for working families to live, adjusted for regional differences in prices and the ages of the children in the household; 2011

[5] The Elder Index is a county level indicator to measure the minimum income necessary to cover all of an older adult's basic expenses, including housing, food, medical care and transportation.

4. PROCESS AND METHODS

The coalitions in both counties have been working together for several years on prior assessments and other projects. The data collection process for this Community Health Needs Assessment (CHNA) took place over a seven-month period as illustrated below.

CHNA Process

Community Assessment Teams

The Santa Clara County Community Benefit Coalition— a collaboration of eight local non-profit hospitals, Santa Clara County Public Health Department, Hospital Council of Northern and Central California, and United Way Silicon Valley— worked together to complete the CHNA. Non-profit hospital members included El Camino Hospital, Kaiser Permanente Santa Clara, Kaiser Permanente San Jose, Lucile Packard Children's Hospital at Stanford, O'Connor Hospital, Saint Louise Regional Hospital, and Stanford Hospital & Clinics. This team contracted with Applied Survey Research (ASR) and Research Development Associates (RDA) to assist with the CHNA in 2012.

The Healthy Community Collaborative of San Mateo County is a coalition of seven local non-profit hospitals including Kaiser Permanente South San Francisco, Kaiser Permanente Redwood City, Lucile Packard Children's Hospital at Stanford, Sequoia Hospital, Seton Medical Center, Stanford Hospital & Clinics, and Sutter Health Peninsula Coastal Region as well as San Mateo County Health System, Health Plan San Mateo, Hospital Consortium of San Mateo County, San Mateo County Human Services Agency, Peninsula Health Care District, San Mateo Medical Center, and San Mateo County Health System. The collaborative conducted the SMC CHNA with assistance from ASR and Professional Research Consultants, Inc. (PRC) in the prioritization of health needs and the collection of primary data.

Qualifications of Consultants

ASR, a non-profit social research firm, was commissioned to assist with the 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 in a report.

ASR is well known for its expertise in community assessments. IN 2007, the firm won a national award from the Community Indicator Consortium and the Brookings Institution 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.

The Santa Clara County Community Benefit Coalition also contracted with RDA to do secondary data collection. RDA is a 28-year-old Bay Area consulting firm supporting government agencies and community-based organizations with assessment, planning, evaluation, data system development and analysis, and grant writing. RDA employs a full-time staff of 24 professionals with credentials in public health, clinical services, social welfare, organizational development and planning.

In San Mateo County, the 2013 Community Health Needs Assessment: Health & Quality of Life Survey was conducted by PRC, a nationally recognized healthcare consulting firm. PRC has extensive experience conducting community health needs assessments in hundreds of communities across the United States since 1994. The secondary data was collected from multiple sources (Attachment 2) by San Mateo County Health System.

5. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY HEALTH NEEDS

Secondary Data Collection

In San Mateo County, the secondary data was collected from multiple sources. It was then synthesized and analyzed by San Mateo County Health System under the direction of the San Mateo County Health Officer, Dr. Scott Morrow, MD, MPH, and the Director of Health Policy and Planning, San Mateo County Health System, Sara T. (ST) Mayer.

In Santa Clara County, Research Development Associates (RDA) created a compendium of secondary data (Attachment 1). The Santa Clara County Community Benefit 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" due to its comprehensive compilation of recent countywide public health data.

As a further framework for the assessment, the coalition requested that 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. Secondarily, it was created with an understanding of how hospitals could make

use of this data to plan their community benefit priorities, conduct their outreach and education efforts, and develop strategies for engaging partners to address identified needs.

Information Gaps & Limitations

The coalitions 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, effects of gun violence, ethnic subgroups affected by hepatitis B, suicide among LGBTQ[6] youth, diabetes among children, Asian population by subgroup, chronic disease prevalence, more granular geographical data (e.g., by neighborhood or street address), and lack of extended data on breastfeeding.

There were also limitations on how the coalitions were able to understand the needs of special populations including LGBTQ individuals and undocumented immigrants. Due to the small numbers of these community members, many data are statistically unstable and do not lend themselves to predictability.

Primary Data (Community Input)

Overview

In Santa Clara County, Applied Survey Research (ASR) conducted the primary research using three strategies for collecting community input: interviews with health experts, focus groups with community leaders and stakeholders, and resident focus groups.

In San Mateo County, primary research was gathered by Professional Research Consultants, Inc. (PRC) through a telephone survey of adults, the 2013 Community Health Needs Assessment: Health & Quality of Life Survey (Attachment 4). The phone surveys reached populations represented by those who are medically underserved and have chronic conditions as well as low-income and minority populations.

Resident Input San Mateo County

The phone survey was conducted among a random sample of 1,000 adults in San Mateo County; 80 percent were landline telephones and 20 percent were cell phones. In addition to the countywide random sampling, additional surveys were conducted, resulting in a total of 1,724 interviews:

- 300 additional interviews in Coastside ZIP Codes in order to augment samples and enhance reliability within that area and to make it comparable to data collected in previous surveys
- Oversample of African-American residents to allow for analysis of this important subsample
- Oversample of low-income residents (those living below 400 percent of the Federal Poverty Level (FPL) to allow for better analysis of this population segment

The interviews were conducted randomly. The final responses were then “weighted” by several key geographic and demographic characteristics to more closely match the countywide and sub-county populations, and to achieve greater statistical representativeness.

[6] LGBTQ: Lesbian, Gay, Bisexual, Transgender, Questioning

The numbers of actual interviews conducted by key demographic segments are outlined in the following table, as well as the distribution of weighted respondents. The table also describes the confidence intervals and population estimates associated with key demographic and geographic segments. Note that some categories may not add up to the total number of interviews due to non-response/non-classification, or in the case of race/ethnicity and region, because respondents may fall within more than one classification. Error rate estimates are made at the 95 percent confidence level (p= .05). Population equivalents are based on estimates of the adult population (ages 18 and older). Estimates for education, poverty, and race/ethnicity are based on proportions achieved through random sampling.

Numbers of Actual Interviews, Weighted Responses, Confidence Intervals & Populations Estimates				
	Interviews Conducted	**Weighted Responses**	**Maximum Error Rate**	**Population Equivalent (1%= # Adults)**
Gender				
Male	747	833	±3.6%	2,760
Female	977	891	±3.1%	2,953
Age				
18 to 39 Years	298	631	±5.7%	2,142
40 to 64 Years	832	773	±3.4%	2,624
65 Years or Older	547	279	±4.2%	947
Education				
High School or Less	340	301	±5.3%	1,002
Postsecondary Education	1,374	1,415	±2.6%	4,711
Poverty Status				
<200% Poverty Level	298	250	±5.7%	1,080
200%-400% Poverty Level	357	321	±5.2%	1,386
>400% Poverty Level	670	752	±3.8%	3,247
Race/Ethnicity				
White	1,145	850	±2.9%	2,835
Hispanic	345	377	±5.3%	1,257
Asian/Pacific Islander	149	431	±8.1%	1,437
Black	125	55	±8.8%	183
Region				
North County	476	663	±4.5%	2,194
Mid-County	390	563	±5.0%	1,866
South County	512	433	±4.3%	1,435
Coastside	346	66	±5.2%	219
TOTAL SAMPLE	**1,724**	**1,724**	**±2.4%**	**5,713**

Community Leader Input San Mateo County

In San Mateo County, ASR conducted a focus group of 20 local community leaders and stakeholders on January 30, 2013. The purpose of this convening was to elicit feedback and assistance in prioritizing health needs identified through the CHNA process.

Community leaders who attended the focus group are listed in the following table.

Name	Title	Organization Representing
Bowdish, Rev. Dr. Lynn	Pastor, Community Activist	Holy Child and St. Martin Episcopal Church
Brown, Pat	Executive Director	Redwood City 2020
Clark, Erin	Intern	Peninsula Health Care District
Dambrowski, Kristen	Associate Executive Director	Peninsula Family YMCA
Fama, Cheryl	CEO	Peninsula Health Care District
Gillette, Kimberly	Director	Daly City Youth Health Center
Groom, Carole	Supervisor	San Mateo County Board of Supervisors
Herzberg, Sam	Senior Planner	San Mateo County Parks and Recreation
Kandals, Lori	Executive Director	Caminar
Liedtke, Barbara	South City Home Share Coordinator	Human Investment Project Housing
Liu, Daisy	Health Educator	Health Plan of San Mateo
Michelson, Lee	CEO	Sequoia HealthCare District
Mitchell, Sara Larios	CEO	Star-Vista
Myers, Ron	Chief, North County Fire	San Mateo County Fire Chief
Peterson, Sharon	Director of Operations	Samaritan House
Roberts, Emily	Child Health and Development Specialist	FIRST 5 San Mateo County
Tauaalo, Foncet	Intern	San Mateo County Human Services Agency
Times, Rita	Advisory Board Member	African American Community Health Advisory
Torres, Deborah	Director	San Mateo County Human Services Agency
Wolf, Art	Sr. Development Officer	Peninsula Jewish Community Center

Results of the focus group yielded the health needs listed in the following table.

Health Need	Indicators of Need
Obesity	Percentage of people who are obese is rising
Cardiovascular disease, heart attack, and stroke (cerebrovascular disease)	Percentage of people who exhibit more than one risk factor for cardiovascular disease is not decreasing
Substance use (ATOD)	Youth drug arrests and binge drinking are rising
Poor oral health	High self-reported lack of access to dental care in youth, and percentage of people who lack dental insurance is rising
Violence	Perception of violence and lack of neighborhood safety is a concern, particularly gang and domestic violence
Infectious disease	Tuberculosis is increasing
Diabetes	Percentage of people with diabetes is continually rising
Poor mental health	Poor mental health indicators are staying the same or rising (e.g., depression and suicide rates)
Cancer	Incidence rates of breast, cervical, colorectal and prostate cancer are failing Healthy People 2020 benchmarks
Births	C-sections are rising and some ethnicities receive inadequate prenatal care
Asthma and respiratory conditions	Asthma prevalence is worsening
STDs, including HIV/AIDS	HIV screening is low among some populations and STDs are on the rise

Participants identified additional health needs that they felt were important:

- Accidents and injuries (e.g., falls, motor vehicle)
- Chronic disease (both age-related and due to disabilities)
- Health of older adults
- Cognitive issues (Alzheimer's disease, autism)
- Access to care issues
- Hospital readmissions
- Sexual abuse/trafficking of teens
- Suicides
- Child maltreatment among African-Americans and immigrants

Prioritization of Health Needs San Mateo County

Each health need was ranked across four dimensions on a scale of one to three. The dimensions were:

- Clear disparities or inequities exist
- Presents a prevention/early intervention opportunity
- Impacts quality of life
- Is a priority for the community

Each participant was given an electronic voting device. Their votes were averaged for each of the dimensions, and an overall average score was generated for each health need (Attachment 5).

Resident Input Santa Clara County

ASR conducted eight resident focus groups in Santa Clara County in October and November 2012. The discussion centered around four questions that were modified appropriately for the audience.

- How healthy is our community?
- What are the health needs that you see in the community?
- What are the most pressing health needs on this list?
- What are the drivers of these prioritized conditions?

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

These groups were located in various geographic areas around the county. Residents were recruited by non-profit hosts such as Community Health Partnership, which serves the uninsured.

Resident Participant Demographics

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

- 90 percent of participants were ethnic minorities and English was a second language for most
- 44 percent of residents were younger than age 40, including seven youth younger than age 20
- 36 percent were middle-aged (ages 40 to 50)
- 16 percent were older adults (ages 60 and older)
- Almost a third of the participants were uninsured, while 46 percent had benefits through Medi-Cal, Medicare, or another public insurance program
- Almost two-thirds of the 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 age 26 and older(65 percent)and a child or youth ages 24 and younger
- About half (48 percent) of the participants had children ages 17 and younger in their households.
- 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 ages 18 to 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 less than $45,000 per year.

- The vast majority of participants (79%) earned less than $25,000 per year, which is near the FPL 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
Under $25,000	37
$25,000-$44,000	8
$45,000-$64,000	1
$65,000-$84,000	1
Missing	3
Grand Total	**50**

Community Leader Input Santa Clara County

In all, ASR consulted with more than 50 community representatives of the organizations and sectors listed below. These representatives either work in the health field, or improve health conditions by serving those from the target populations.

- Santa Clara County Public Health Department
- Santa Clara County Health and Hospital System
- Hospitals/hospital systems
- Health Insurance providers
- Mental/behavioral health or violence prevention providers
- School system representatives
- Community center representatives
- Non-profit agencies providing basic needs
- Other non-profit agencies serving children, seniors, and families

See Attachment 6 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

In Santa Clara County, ASR conducted primary research through interviews with nine South Bay experts from various organizations in the health sector including public health officers, community clinic managers, and clinicians.

Health experts were interviewed by telephone and were asked to discuss 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.

Key Informant Interviews

Name	Position	Agency
1. René Santiago	Deputy County Executive	Santa Clara Valley Health and Hospital System
2. Shamima Hasan	CEO	Mayview Community Health
3. Dan Peddycord	Director	Santa Clara County Public Health Department
4. Dr. Marty Fenstersheib	Health Officer	Santa Clara County
5. Reymundo Espinoza	CEO	Gardner Health Center
6. Michelle Lew	Executive Director.	Asian Americans for Community Involvement
7. Dolores Alvarado	Executive Director	Community Health Partnership
8. Dr. Kent Imai	Medical Director	Community Health Partnership
9. Dr. Thad Padua	Medical Director	Santa Clara Family Health Plan

Stakeholder Focus Groups

Focus groups with stakeholders were conducted in October and November 2012. The groups represented various community-based organizations including those that serve populations with chronic conditions, seniors, children and youth, the medically underserved, those requiring basic needs, etc. See Attachment 6 for a full list of community leaders/stakeholders and their credentials.

The discussion centered around four questions, which were modified appropriately for the audience.

- How healthy is our community?
- What are the health needs that you see in the community?
- What are the most pressing health needs on this list?
- What are the drivers of these prioritized conditions?

Each group and interview was recorded and summarized. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulated 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.

Collectively, the community identified a diverse set of health conditions (see the table below). They spoke about prevention, access to care, clinical practices that work and don't work, and their overall perception of the community's health.

All Health Conditions Named During Primary Data Gathering- Santa Clara County

Substance abuse/behavioral health (including prescription medication abuse)
Diabetes, poor nutrition
Cardiovascular disease (heart disease, stroke, congestive heart failure, hypertension)
Poor mental health, trauma, suicide, depression, anxiety, stress, cutting
Obesity/overweight
Violence (including abuse and bullying)
Respiratory conditions (asthma, allergies, bronchitis, COPD)
Cancer
Poor oral/dental health
Teen pregnancy
Access to care
Acute/episodic issues (e.g., ulcers, skin diseases)
ADD/ADHD, learning disabilities
Anemia
Arthritis
Autism/Asperger's
Chronic diseases
Deformities
Dementia/Alzheimer's
Drowning
Emphysema
Falls/injury
Fatigue
Hepatitis B and C

High cholesterol
Infant mortality
Jaundice
Kidney stones
Low birth weight
Parkinson's
Pregnancy-related conditions
Premature births
Sciatica
Sleep apnea/sleep disorders
Social/emotional development
STDs/unhealthy sexual behavior
Stroke
Thyroid disease
Trauma
Viruses
Vision problems (e.g., glaucoma and cataracts)

Prioritization of Health Needs Santa Clara County

Before beginning the prioritization process, the coalition chose a set of criteria to use. The criteria were:

- Existence of clear disparities/inequities among subpopulations in the community
- An opportunity to intervene at the prevention or early intervention level
- A successful solution has the potential to solve multiple problems.
- The community prioritizes the issue over other issues

The results of this process are presented in rank order in Attachment 7.

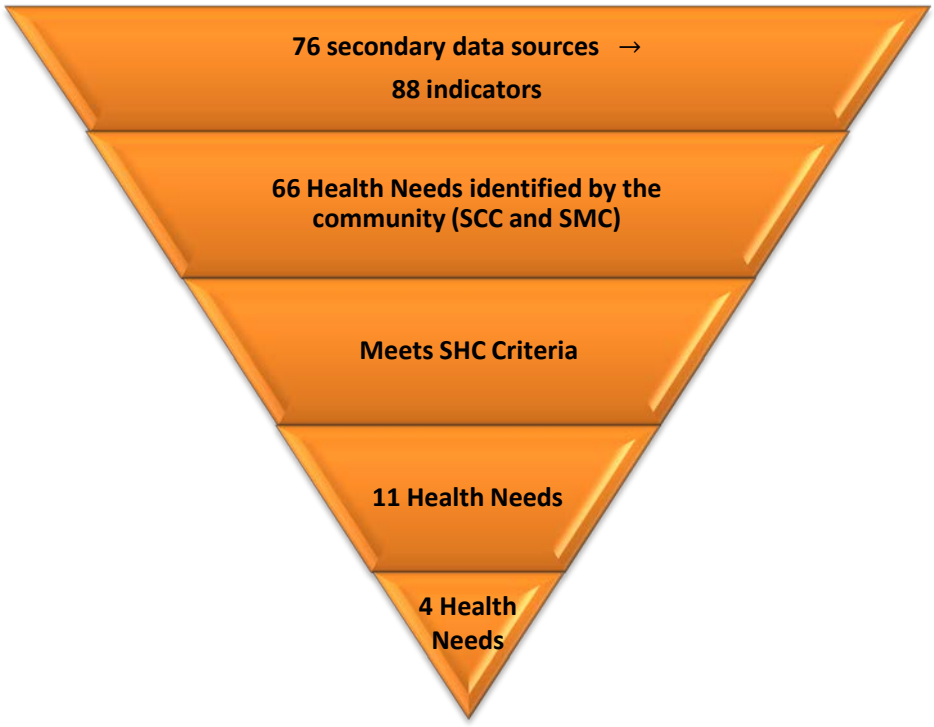
Prioritization of Health Needs San Mateo and Santa Clara Counties

In February 2013, the Stanford Hospital & Clinics (SHC) Community Partnership Program Steering Committee met to review the data collection and prioritization process that occurred in the community. The purpose of the meeting was to find those health needs that met the criteria listed below and would form the basis for SHC's implementation plan.

The committee consists of Chairperson Nancy Lee, Chief Nursing Officer and Vice President of Patient Care Services; Bryan Bohman, MD, Associate Chief Medical Officer; Jason Wong, MD, Medical Director of Samaritan House Redwood City Free Clinic; Andy Coe, Chief Government and Community Relations Officer; Eric Williams, Executive Director Solid Organ Transplant; Nora Cain, Director of the Stanford Health Library; and Sharon Keating-Beauregard, Executive Director of Community Partnerships.

The prioritization process is outlined in the pyramid below. The 66 health needs were identified by community input in both counties (Attachment 8) and the 88 indicators (Attachment 9) were selected from multiple secondary data sources.

Process Pyramid



The 88 indicators were selected to present the most robust picture of the health of the community. They are meant to answer the following questions:

- Who lives in the community?
- Where are the areas of greatest need within the target area?
- What are the major health issues faced by the community?
- What is causing the health issues identified?

The SHC Community Partnership Program Steering Committee identified 11 health needs (shown in the table below) by applying the following criteria to the list of 66 health needs:

- Supported by primary data (community input) and secondary data
- Misses a benchmark (HP 2020 or California state average)
- Cuts across both San Mateo and Santa Clara counties
- Affects a relatively large number of individuals
- If left unaddressed, is likely to become more serious
- Has a serious impact at the individual, family, or community level
- Is one in which SHC has the required expertise and human and financial resources to make an impact

The committee also reviewed SHC's current community health improvement initiatives and, along with the health needs from the CHNA process, selected four of the health needs to address: cancer, access to care, chronic disease and unintentional injuries(falls). Of the seven other health needs, four are indirectly addressed through the current Community Partnership Program health initiatives: diabetes, cardiovascular disease and stroke, arthritis, and respiratory conditions such as asthma and COPD).

11 Health Needs Identified by CHNA Process
4 Health Needs Selected by SHC Steering Committee

Health Needs
1. Diabetes
2. Mental health
3. Obesity/overweight
4. Cancer
5. Cardiovascular disease, heart disease, stroke
6. Access to health care
7. Arthritis
8. Chronic disease
9. Alzheimer's/dementia
10. Unintentional injuries (falls)
11. Respiratory conditions (asthma, COPD, allergies)

SHC developed its implementation strategy for investments in improving the health and well-being of the community based on:

- The health needs identification and prioritization process conducted in each county, which synthesized primary and secondary data
- The health needs prioritization and selection process undertaken by the SHC Community Partnership Program Steering Committee
- A review of SHC's current community health improvement initiatives

Summarized Descriptions: Prioritized Santa Clara County and San Mateo County Health Needs

For more details, see Attachment 10, Health Needs Profiles.

Access to health care is a health need in Santa Clara County and San Mateo County.

In Santa Clara County (SCC), the percentage of uninsured residents ages 18-64 increased from 9 to 21 percent from 2000 to 2009 and is now higher than both state and national figures. A higher percentage of Whites (90 percent) reported having health insurance than Asian/Pacific Islanders (86 percent), African Americans (68 percent) and Hispanics (60 percent). Even with implementation of the Affordable Care Act (ACA), estimates for the number of uninsured people countywide are 130,000-150,000 (2014) and 120,000-140,000 (2019).

In San Mateo County (SMC), the proportion of the community who are uninsured is higher than the national benchmark. Community input corroborates that lack of insurance coverage is an access issue in the county. The proportion of those who are linguistically isolated is fairly high, nearing the state average. The proportion of Medicaid recipients is also close to the state average. In SMC, there are currently 80,000 uninsured individuals. Estimates for post-ACA implementation place the number of those remaining uninsured at more than 34,000.

In both counties, the lack of transportation is a barrier to health care access. Also, too few primary care physicians, especially in community clinics, results in long wait times for appointments, a challenge that will be exacerbated when the ACA is implemented in 2014. 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 SCC and SMC.

In SCC, Alzheimer's disease is the third-leading cause of death. By 2030, SCC will see a 112 percent increase in Alzheimer's disease.

In SMC, Alzheimer's disease is the fifth-leading cause of death. There will be a 70 percent increase in older adults with Alzheimer's disease by 2030.

Alzheimer's disease 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.

Arthritis is a health need in SCC and SMC.

In SCC, the prevalence of arthritis and related conditions among older adults is of concern. On average, the median age of the population in the county is higher than the state median age, making the county as a whole more likely to experience this health need.

In SMC, not only is the prevalence of arthritis and related conditions among older adults a concern but arthritis-specific prevalence among adults ages 18 and older is at a higher percentage than the state average. On average, the median age of the county population is higher than the state median age, and the proportion of older adults in the population in the year 2020 is estimated to be higher than the state average, making the county as a whole more likely to experience this health need. The need is impacted by the existence of a percentage of overweight adults that is higher than the state average. The level of physical inactivity among adults is also higher than the state average.

Community feedback indicates that older adults who are the most concerned about arthritis are focused on mobility and related access issues. They also identified concerns around lack of education about the condition among patients and lack of the latest information on treatments among doctors. Additional materials on arthritis were requested by the Spanish-speaking community.

Cancer is a health need in SCC and SMC.

In SCC, the incidence rates of breast, cervical, liver and prostate cancer are higher than benchmarks/state averages. The liver cancer mortality rate is higher than the state average. Breast and prostate cancer disproportionately affect Whites while 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.

In SMC, the incidence and mortality rates due to all types of cancer are higher than benchmarks/state averages. In particular, breast and colorectal cancer incidence and mortality rates are too high compared to benchmarks, as is the prostate cancer incidence rate. Breast cancer disproportionately affects Whites; cervical cancer disproportionately affects Latinas; and colorectal, lung and prostate cancer all disproportionately affect African-Americans. Community input also identified tobacco use as a continuing concern.

In both counties, the health need is likely being impacted by behaviors such as screening rates that do not meet established benchmarks and fruit and vegetable consumption that is no better than average. 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 cost of treatment, and poor access to primary care providers and specialists due to lack of insurance, particularly among low-income residents.

Cardiovascular Disease, heart disease and stroke are health needs in SCC and SMC.

In SCC, factors that contribute to this health need include high overall percentages of high cholesterol and hypertension, both of which fail Healthy People 2020 benchmarks, and higher-than-benchmark stroke mortality rates among African-Americans and those who identify as multiracial. 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 also of concern in the county. Adult and youth consumption of fruits and vegetables, and household expenditures on them, 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[7]-authorized stores than the state average. Community input reflected this concern 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.

In SMC, the issues are similar: high overall percentages of high cholesterol, which fails the Healthy People 2020 benchmark, and higher-than-benchmark mortality rates for stroke and heart disease. Heart disease is the second-leading cause of death in the county and stroke (cerebrovascular disease) is the fourth. African-Americans disproportionately die of heart disease and stroke compared to other ethnic groups. Physical inactivity, which is related to cardiovascular disease, is also of concern to the community. In addition, there are fewer WIC-authorized food stores than the state average. Community input reflected a concern about obesity, lack of access to healthy food or safe places to exercise, the impact of poverty, and the inadequate supply of primary care physicians.

Chronic disease is a health need in in SCC and SMC.

In SCC, risk factors that lead to chronic disease, such as obesity, are on the rise. The top three causes of death are cancer, heart disease and Alzheimer's disease. One-third of adults reported having one or more chronic conditions. Among those reporting, 57 percent reported frequent health care use, defined as four or more doctor visits or one or more emergency room visits, in the past 12 months.

In SMC, the top four causes of death are cancer, heart disease, cardiovascular disease and Alzheimer's disease. In addition, the prevalence of high blood pressure, high cholesterol, asthma, chronic lung disease and diabetes among adults has increased markedly since 1998.

Chronic diseases are among the most common, costly, and preventable health problems. Many can be effectively controlled through appropriate health behaviors and access to health care services. An American Hospital Association report states that the Medicare population is not only living longer but that they are also sicker. According to the Centers for Medicare and Medicaid Services (CMS), in 2008 two-thirds of all Medicare recipients had two or more chronic conditions. The report further states that health care expenses for an individual with one chronic condition are about three times higher than those for a person without chronic conditions. That figure rises to 17 times higher for a person with five or more chronic conditions.

Diabetes is a health need in SCC and SMC.

In SCC, there are relatively high rates of diabetes. The overall adult rate is just below the state average, but Latino residents are disproportionately affected by diabetes and worse off in comparison with the state average. Of all ethnic groups, African-Americans experience the highest percentage of hospitalizations due to diabetes.

[7] Women, Infants and Children Program (WIC) is a federally-funded health and nutrition program for women, infants, and children

In SMC, there were statistically significant increases in diabetes prevalence among all groups, but especially seniors, and higher rates of diabetes hospitalizations among African-Americans than the state average. Asians/Pacific Islanders are disproportionately affected by diabetes compared to those of other ethnic groups.

In both counties, community input about diabetes made the connection between the disease and related health behaviors such as poor nutrition and lack of physical activity. The community also expressed concern about access issues for those suffering from diabetes. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, neighborhoods that are less walkable, the proximity of fast food restaurants, and a lack of grocery stores and WIC-Authorized food sources.

Mental health is a health need in SCC and SMC.

In SCC, a survey yielded a higher percentage of self-reported poor mental health than the state average. Latino and African-American youth disproportionately exhibit symptoms of depression and African-American youth experience suicidal ideation in rates higher than the countywide average.

In SMC, the issue is the same: a higher percentage of self-reported poor mental health than the state average. In addition, the percentage of older adults with Alzheimer's disease is higher than the state average. Latino adults appear to experience poor mental health at higher rates than adults of other ethnicities, while both Latino and Pacific Islander youth disproportionately exhibit symptoms of depression. The Asian population experiences a much higher suicide rate than the national benchmark.

In both counties, community input indicated that the health need is likely being affected by stress (especially financial/economic concerns) and the lack of education about how to cope with stress, stigma about mental illness leading to fear and denial, and lack of knowledge about mental health treatment. It is also impacted by poor access to mental health 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.

Obesity is a health need in the SCC and SMC.

In SCC, there are 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 Healthy People 2020 benchmark. Latino and African-American residents are disproportionately overweight and obese, and worse off compared to California averages.

In SMC, there are also high rates of overweight among adults and obesity among youth. Adult obesity is above the state average and youth obesity is above the national benchmark. Latino youth have higher rates of overweight and obesity than other ethnic groups. African-American youth are also disproportionately obese. Health experts also pointed to low-income seniors as a population at greater risk for obesity. Certain parts of the county are less walkable than the state average and a higher percentage of the population also lives in census tracts designated as "food deserts" than the state average. Community input reflects some of these issues. The community was also concerned about poor diet and lack of physical fitness, including lack of affordable/accessible fitness activities, lack of time for exercise/cooking, cost of healthy food, and the school environment.

In both counties, the health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, soda consumption, the proximity of fast food restaurants and a lack of grocery stores and WIC-Authorized food sources. Other drivers of this health need include lack of access to care and cost.

Respiratory conditions are a health need in SCC and SMC.

In SCC, the issue is marked by hospitalization rates of children ages 4 and younger for asthma. Asthma hospitalization rates of youth ages 17 and younger 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 who are 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 the lack of insurance, particularly among low-income residents.

In SMC, there are high rates of asthma prevalence among youth, rates of overall asthma hospitalizations that are no better than the state average and statistically significant increases over time in the prevalence of asthma and chronic lung disease, particularly among seniors. Poor air quality, a driver of respiratory conditions, is a concern for certain geographic areas, particularly those near the San Francisco International Airport. Community input indicated concerns about access to primary care and various environmental causes such as pollution and mold.

Unintentional injuries (falls) are a health need in SCC and SMC.

In SCC, the rate of death by falls among older adults is higher than the state average. In addition, falls were the leading cause of fatal and non-fatal hospitalization among seniors in 2009 according to the Council on Aging Silicon Valley, Area Plan 2012-2016. Both African-Americans and Whites experience fatal falls at rates higher than the benchmark.

In SMC, the rate of death by falls was higher than the national benchmark. Falls are a key issue leading to hospitalization, loss of independence and death among seniors according to the Community Assessment: Health & Quality of Life in San Mateo County, 2011.

In both counties, the health need in the county is likely impacted by social determinants of health such as poverty. Falls rates in particular are likely driven by the rising older adult population, percentages of which are higher than state averages. Community feedback indicates that the fall rate for older adults is affected by social isolation, particularly among residents who are obese or who have mobility issues, and among those with chronic conditions.

6. COMMUNITY ASSETS

The following resources are available to address the health needs identified in the CHNA.

Existing Health Care Facilities

- El Camino Hospital
  - Los Gatos
  - Mountain View
- Good Samaritan Hospital
- Kaiser Permanente
  - San Jose
  - Santa Clara
  - South San Francisco
  - Redwood City
- Lucile Packard Children's Hospital at Stanford
- O'Connor Hospital
- Regional Medical Center of San Jose
- Saint Louise Regional Hospital
- Stanford Hospital & Clinics
  - Stanford Medicine Outpatient Center , Redwood City
  - Menlo Clinic
- Santa Clara Valley Medical Center and related clinics
  - Tully
  - Bascom
  - Sunnyvale
  - East Valley
  - Silver Creek
  - Moorpark
  - Gilroy
- Mayview Community Health Centers
  - Palo Alto
  - Mountain View
  - Sunnyvale
- CompreCare Health Center
- St. James Health Center
- Gardner Health Center

- Indian Health Center of Santa Clara Valley
- Pacific Free Clinic, San Jose (Stanford School of Medicine)
- RotaCare Bay Area Free Clinics
  - Mountain View
  - San Jose
  - Gilroy
  - Daly City
  - Half Moon Bay
- Planned Parenthood Clinics
  - Blossom Hill
  - Eastside
  - East Valley Community Clinic
  - Mountain View
  - The Alameda
  - Sunnyvale
- Santa Clara County CRANE Center (STD testing)
- Mobile Dental Van
- Veterans Affairs Palo Alto Health Care System
  - Palo Alto
  - San Jose clinic
- Valley Health Center at Fair Oaks
- Mills-Peninsula Health Services
  - San Mateo
  - Montara
- Sequoia Hospital
- Seton Medical Center
  - Daly City
  - Moss Beach
- Veterans Affairs Palo Alto Health Care System
  - San Bruno VA Outpatient Clinic
  - Menlo Park Division
  - Peninsula Vet Center, Redwood City
- San Mateo Medical Center and related clinics
  - Daly City
  - Coastside
  - Daly City Youth Health Center
  - Edison
  - Fair Oaks Children's Clinic

- Fair Oaks
- Mobile Health
- Senior Care Center
- Sequoia Teen Wellness Center
- South San Francisco

- Palo Alto Medical Foundation clinics
  - Menlo Park Surgical Hospital
  - Redwood City Center
  - Redwood City Women's Health Center
  - Redwood Shores Health Center

- Samaritan House Free Clinics
  - San Mateo
  - Redwood City

- Ravenswood Family Health Center
  - East Palo Alto
  - Belle Haven

- Arbor Free Clinic, Menlo Park (Stanford School of Medicine)

Other community resources, programs and services available to address CHNA identified health needs are listed in Attachment 11**.**

7. CONCLUSION

Both the CHNA and implementation plan are publically available on the Stanford Hospital & Clinics website at www.stanfordhospital.org/communitypartnership in accordance with IRS notice 2011-52 instructions.

The Santa Clara County Community Benefit Coalition and the Healthy Community Collaborative of San Mateo County 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. With the CHNA complete, the coalitions will continue to meet to explore opportunities for collaboration on addressing shared health needs.

8. LIST OF ATTACHMENTS

Attachment 1: Secondary Data Sources Santa Clara County

Attachment 2: Secondary Data Sources San Mateo County

Attachment 3: IRS Checklist

Attachment 4: 2013 Community Health Needs Assessment: Health & Quality of Life Survey

Attachment 5: Prioritized Health Needs San Mateo County

Attachment 6: Persons Representing the Broad Interests of the Community

Attachment 7: Health Needs Prioritization Scores: Breakdown by Criteria

Attachment 8: CHNA – All Conditions Named During Primary Data Gathering SMC and SCC (66)

Attachment 9: List of Indicators on Which Data Were Gathered (88)

Attachment 10: Health Needs Profiles

Attachment 11: Community Assets San Mateo and Santa Clara counties