STANFORD HEALTH CARE
COMMUNITY HEALTH AND
PARTNERSHIPS PROGRAM

2023 Community Benefit Report

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Letter from the President & CEO

Improving health, enhancing wellness, and advancing equity are at the heart of Stanford Health Care's mission. In our hospitals and clinics, we embody these values through our high-quality care, cutting-edge innovations, and world-class patient experience. In our surrounding communities, we're committed to meeting our neighbors where they are and actively supporting their health and wellbeing. We further this vision through our Community Health & Partnership Program, where we collaborate with local organizations to target obstacles and address unmet needs. Together, we continuously strive to make a meaningful difference for our most vulnerable and underserved populations.

In FY23, Stanford Health Care invested $734.3 million in services and activities to support our neighbors through charity care, health improvement programs, and training of health providers in community-focused care. Throughout the year, we worked closely with our trusted partners to make positive strides. Our community contributions and investments continued to support direct services, targeted to improve access to care, reduce economic and food insecurity, and prevent homelessness. As gaps emerged, we looked for ways to help. We increased our financial assistance for patients, expanded our support of housing and post-hospital care, and bolstered our community-based education and training for the next generation of health care providers. We also launched initiatives for specific populations, including the SAFE program, a unique partnership with Santa Clara County that provides compassionate care for survivors of sexual assault and intimate partner violence. Additionally, we continued to donate services from behavioral health providers to ease the impact of a critical shortage at community-based safety net clinics.

Looking to the future, we remain sharply focused on our community's health. We recently completed our latest community health needs assessment in partnership with local public health departments, community health experts, and residents. This important evaluation, conducted every three years, reaffirmed the growing social, economic, and health care gaps in our local communities, while also examining the role of racism in causing health inequities. We're grateful for the enhanced understanding afforded by this assessment, and we look forward to using the insights as a road map to build a healthier future for all.

To learn more about our community engagement, I invite you to take a look at this year's community benefit report. I couldn't be prouder of how Stanford Health Care and our extraordinary partners work together to help our neighbors thrive.

Sincerely,

David Entwistle
President and CEO, Stanford Health Care

Stanford MEDICINE

Health Care

Stanford Health Care (SHC) is a leading academic health system and is part of Stanford Medicine. It seeks to heal humanity through science and compassion, one patient at a time. Its mission is to care, to educate, and to discover. SHC delivers clinical innovation across its inpatient services, specialty health centers, physician offices, virtual care offerings, and health plan programs. SHC also maintains a strong commitment to the health of its community members, including efforts to dismantle systemic racism and discrimination, and dedicates considerable resources to support its community benefit program.

Stanford Health Care, along with Stanford Health Care Tri-Valley and Stanford Medicine Partners, is part of the adult health care delivery system of Stanford Medicine. Combining clinical care, research, and education to advance the understanding and practice of medicine, Stanford Health Care provides compassionate, coordinated care personalized for the unique needs of every patient.

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

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

By the Numbers

Services

448 Life Flight Transports
604 Licensed Beds
119 Licensed ICU Beds

Patient Visits

1,252,533 Outpatient
74,299 Adult Emergency Room
23,506 Pediatric Emergency Room
466,355 Video Visits

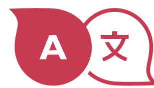
Community Support

$734.3M Community Benefit Investment
$5.5M COVID-19 Response

Our People

18,002 Employees
2,283 Physicians on Active Medical Staff
4,153 Nurses
1,615 Residents & Fellows

98.1% ★★★★★
Stanford Health Care Physicians
With a Star Rating of 4.5 or Higher



8 **Stanford Medicine**
Nobel Prize laureates

Patient Experience

Interpreters & Translators

Staff interpreters are available on demand in person, by phone, and by video in the most commonly requested languages, including Spanish, Mandarin, Cantonese, Vietnamese, Russian, American Sign Language (ASL), Farsi/Dari, and Korean. Translators work on vital documents, such as consents, medical records, and patient education. *Access to 200+ other languages available upon request.*

Health Education, Engagement, and Promotion

1,110 Patient Experience Classes
18,625 Class Encounters
85 Non-English Classes

Awards & Recognition

***U.S. News & World Report* Best Hospital**
Ranked among the top 10 hospitals in the nation

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

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

Stanford Health Care was first designated as a Magnet Hospital in 2007 and was redesignated in 2012, 2016, and 2020. Magnet Recognition is a prestigious award developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that provide nursing excellence. Only 8% of U.S. health care organizations achieve this honor.

In 2022, Stanford Health Care earned a top score from the **Healthcare Equity Index**, a leading LGBTQ+ rights organization. The HEI is the national LGBTQ+ benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of their LGBTQ+ patients, visitors, and employees.

Stanford Medicine is an integrated academic health system comprising the Stanford School of Medicine and pediatric and adult health care delivery systems. Together, we harness the full potential of biomedicine through collaborative research, education, and clinical care.

Data is based on FY 2022 Health System Statistics for Stanford Health Care, only. It does not include Stanford Health Care Tri-Valley and Stanford Medicine Partners.

Total Quantifiable Community Benefit Investment for FY23

This report covers fiscal year 2023 beginning September 1, 2022, and ending August 31, 2023. During this time, Stanford Health Care invested over $734.3 million in services and activities to improve the health of the communities it serves. In addition to providing details on this investment, this report describes the community benefit planning process and the Community Benefit Plan for fiscal year 2023.

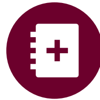
Stanford Health Care FY23 Community Benefit Investment

Stanford Health Care provides programmatic and philanthropic support to expand access to care and address the social drivers of health for our most vulnerable and underserved patients and communities each year.

FINANCIAL ASSISTANCE AND CHARITY CARE

$478,684,931

- Uncompensated costs of medical services for patients enrolled in Medi-Cal, out-of-state Medicaid, and other means-tested government programs: $465,934,466
- Charity Care: $12,750,465



HEALTH PROFESSIONS EDUCATION

$161,989,085

- Resident physician, fellow, and medical student education costs (excluding federal graduate medical education reimbursement)
- Nurse and allied health professions training

COMMUNITY HEALTH IMPROVEMENT SERVICES

$6,816,414

- Community health education programs
- Patient Financial Advocacy – Health Advocates Program
- Programs to support healthy lifestyles for seniors
- Sexual Assault Response Team
- Stanford Health Library
- Stanford Supportive Care Programs for Cancer and Neuroscience
- Uncompensated costs of COVID-19 emergency response activities: $5.5 million since FY20

SUBSIDIZED HEALTH SERVICES

$6,049,402

- Stanford Life Flight
- Community-based second opinion services

RESEARCH

$64,133

Research into improved care delivery and better health outcomes

FINANCIAL AND IN-KIND CONTRIBUTIONS

$90,429,175

- Community clinic capacity building and support
- Community health improvement grants
- Donations of medical equipment, supplies, and food
- Fundraising support for nonprofit organizations
- Stanford University health professions education, community health improvement and access to care, and research

COMMUNITY BUILDING ACTIVITIES

$252,719

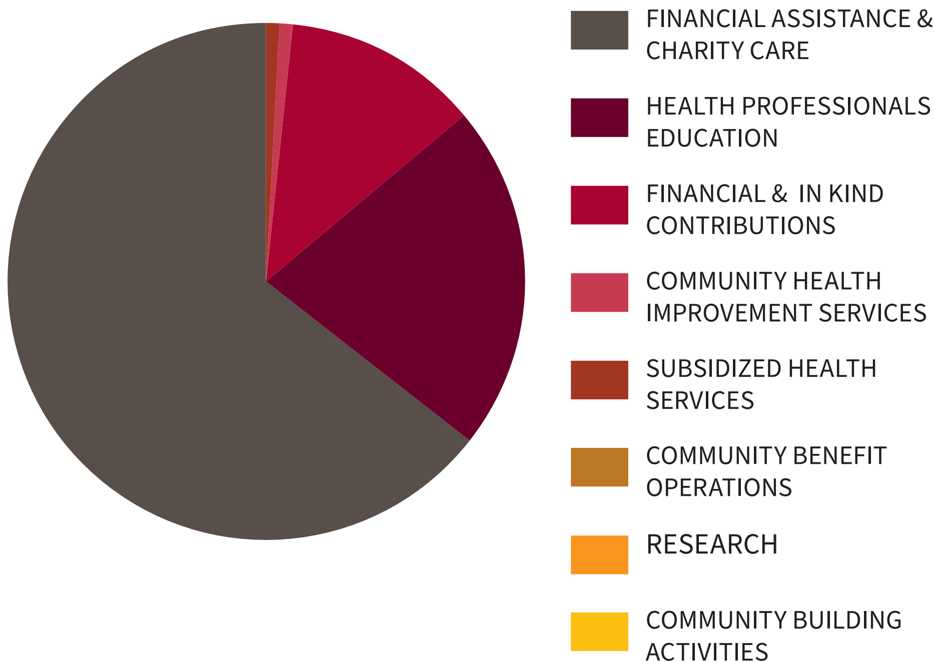
- Nonprofit sponsorship support
- Support for community emergency management

COMMUNITY BENEFIT OPERATIONS

$1,121,118

- Community health needs assessment costs
- Dedicated Community Benefit staff
- Reporting and compliance costs
- Training and staff development

Stanford Health Care FY23 Community Benefit Investment Summary



Community Served

Stanford Health Care is a regional referral center for an array of adult specialties, drawing patients from throughout California, across the country, and internationally.

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

State of California

In 2021, the Insight Center published The Cost of Being Californian, which cites significant income, ethnic, and gender disparities exist across California.

The report cites households of color in California have suffered from the highest rates of COVID-19-related illness and are overrepresented among essential workers who have borne the brunt of a dual health and economic crisis.

Women in California are more economically disadvantaged than men across many factors, including earning lower pay, taking unpaid time to care for children or family members, being underemployed, and experiencing occupational segregation.

For more information, visit the Insight Center's report here.

RACE/ETHNICITY	
Households of color in California	59%
% living on the edge of economic security	73%

GENDER
Having children nearly doubles the chance of living below the California Self-Sufficiency Standard.
To address gender-specific disparities, policy change is needed: increase wages and close gender pay gaps, institute comprehensive family leave, curb rising housing costs, and establish universal child care.

INCOME & EDUCATION In California, many households with two full-time working adults are barely keeping their heads above water.	
% living paycheck to paycheck	27%
Households without a college degree fare the worst in California's economy.	
% who dropped out of high school and are unable to make ends meet	70%
Households with only a GED or high school diploma barely scraping by	1 in 2
Households of color without a college degree are severely penalized in the labor market.	
Asian-male head of household with only a high school diploma are more likely to struggle than their white peers	1.7 X
Black women with only a high school diploma are most penalized. % who barely have enough income to live on	66%

ETHNICITY	
Latinx = 39% of population	Asian = 15% of population
71% of California's cooks	90% of California's manicurists
77% of California's diswashers	24% of California's waitstaff
80% of California's housekeepers	20% of California's home health & personal care aides

Stanford Health Care's Service Area

Due to its location in Palo Alto, California at the northern end of Santa Clara County bordering San Mateo County, more than half of Stanford Health Care's patients reside in San Mateo and Santa Clara counties. Therefore, for purposes of its community benefit initiatives, SHC has identified these two counties as its target community.

	Santa Clara County	San Mateo County
Population	1,870,945	729,181
Residents under the age of 18	20.3%	19.3%
Residents over the age of 65	15.1%	18.3%
Residents over the age of 65 living with a disability	4.9%	4.8%
Cities	18 cities and large areas of unincorporated rural land	19 cities and more than two dozen unincorporated towns and areas

RACE/ETHNICITY	Santa Clara County	San Mateo County
White	30%	57.1%
Asian	41.4%	32.8%
Latinx (of Any Race)	24.7%	23.8%
Black/African American	2.9%	2.7%
American Indian/Alaskan Native	1.2%	0.9%
Native Hawaiian/Pacific Islander	0.5%	1.4%
Two or More Races	4.3%	5.0%
Foreign-Born	40.4%	35.2%

Sorce: census.gov

INCOME	Santa Clara County	San Mateo County
Income	$101,173[3]	$98,546[3]
Minimum necessary to afford basic needs	$57,034	$68,454
Minimum Wage	$15.50 /hour	$15.50 /hour
For 2 Adults (1 working) with 2 children, self-sufficiency requires:	$51.82 /hour[1]	$54.28 /hour[2]
Hours per week to be self-sufficient	131	158
Cost of Living Increase between 2018 and 2021	23%[4]	23%[5]
Below Self-Sufficiency % of households	28%	33%

HOUSING	Santa Clara County[8]	San Mateo County[8]
Median Rent	$2,374	$2,451
Median Home Price	$1.4M[5]	$1.6M[5]
% income for mortage	36%	39%

UNINSURED	
% of people who are uninsured	4%[11]

Community Assessment Process and Prioritization of Community Health Needs

As required by California Senate Bill 697, nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties, with additional support from a nonprofit multi-specialty group, collaboratively conducted a dual-county, triennial CHNA in compliance with current federal requirements. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs in each county. Stanford Health Care (SHC) was an active participant in both collaboratives.

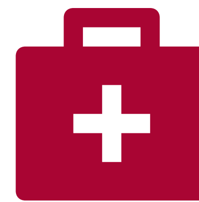
Health needs were identified by synthesizing primary qualitative research and secondary data and filtering those needs against a set of criteria. Needs were then prioritized by leaders with knowledge and expertise in local community health needs and trends after reviewing the CHNA findings and supporting data for each need. The Community Health and Partnerships steering committee, comprised of experts and stakeholders from across Stanford Medicine (Stanford hospitals and School of Medicine) and the local community, completed a comprehensive strategic planning process to select the health needs and strategies. The committee paid special attention to the needs and desires of the community that were identified during the CHNA. Committee members reviewed the data, prioritization process, and current SHC community health initiatives. Members participated in several prioritizing and ranking exercises to determine which needs SHC would address and what strategies SHC would pursue to address them.

Racism and Health

Racism, both structural and interpersonal, are fundamental causes of health inequities, health disparities and disease. The impact of these inequities on the health of Americans is severe, far reaching, and unacceptable. Across the country and locally, racial and ethnic minority populations experience higher rates of poor health and disease in a range of health conditions, when compared to their white counterparts. The Community Health Needs Assessment considered systemic racism as a root cause of racial and ethnic health inequities.

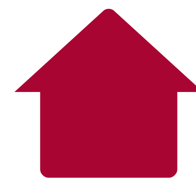
Selected Health Needs

The Community Health & Partnerships steering committee members, by consensus, selected five health needs.



Access and Delivery of Health Care

Behavioral Health



Housing

Economic Security

- Income Security
- Food Security

Community Investment to Address Community Health Needs

Stanford Health Care (SHC) understands that good health is achieved through access to high-quality care as well as social and physical environments that promote good health. As such, all community grant investment from FY23 – FY25 will improve access to and delivery of care and/or the social drivers of health for our most vulnerable community members, including the medically underserved, low-income, and populations affected by health disparities.

Access and Delivery of Health Care

Based on SHC's 2022 Community Health Needs Assessment findings, SHC's interventions to address access and delivery to care include improving access to health care, specialty care, medical social work and case management for vulnerable community members, including older adults and under- and uninsured populations.

For more information about Stanford Health Care's Community Health Needs Assessment, please visit: [https://stanfordhealthcare.org/about-us/community-partnerships.html.](https://stanfordhealthcare.org/about-us/community-partnerships.html)

AC Care Alliance

Advanced Illness Care Program Expansion in Santa Clara and San Mateo Counties

Through faith-based care navigation, AC Care Alliance supports the expansion of the Advanced Illness Care Program program into Santa Clara and San Mateo Counties, particularly underserved East Palo Alto.

- 9 relationships cultivated among faith, health, and community organization leaders with additional:
  - 16 congregations
  - 9 health organizations
  - 10 community organizations in progress
- Over 65 faith leaders participated in workshop training series to understand advance care planning and end-of-life discussions with congregants and community members
- 46 community members enrolled in the program and received 811 services including presentations and one-on-one sessions

Investment: $240,362
Persons served: 111
Target: Vulnerable populations

Avenidas – Rose Kleiner Center

Community-Based Home Health Program

This program provides intensive care coordination for low-income seniors with highly complex medical, cognitive, and behavioral health conditions.

- 88% of participants had no emergency room visits
- 88% of participants had no hospital admissions
- 99% of participants have a family caregiver involved in care

Investment: $195,000
Persons served: 50
Target: Vulnerable populations

New Directions

Community-based Case Management Program

This program provides case management to reduce access barriers to healthcare and housing for unhoused community members in need of psychosocial services.

- 93% of case managed clients received a full housing needs assessment and were connected to resources
- 96% of clients were connected to at least one basic need service that addressed food, housing, or income insecurity
- 91% of clients established care with a primary care provider

Investment: $350,000
Persons served: 46
Target: Vulnerable populations

Operation Access
Access to Surgical Services and Specialty Care

The program partners with local hospitals and health systems to link donated surgical preventive care to uninsured and underinsured patients in San Mateo and Santa Clara Counties at no charge to patients.

- 117 surgical procedures and diagnostic services provided
- 100% of patient survey respondents reported improved health or quality of life
- 92% of patients reported a reduction of pain post-procedure
- 80% of patients reported a reduction in emergency department use post-procedure

Investment: $120,000
Persons served: 86
Target: Vulnerable populations

Peninsula Healthcare Connection
Improved Clinic Efficiency and Capacity

Through improved clinic efficiency and capacity achieved by a full-time clinic administrator, the program provides health care services to unhoused individuals and individuals at-risk for homelessness

- 64 diagnostic tests, including COVID-19, TB, and Hep B, were administered to homeless and high risk for homeless individuals
- 16 Backpack Medicine visits conducted throughout the community
- 45% of new uninsured clients who were seen for services were enrolled in Medicaid

Investment: $200,644
Persons served: 280
Target: Vulnerable populations

Ravenswood Family Health Center
Social Work/Case Management Department

The program supports a social services manager and clinical nurse manager in Medication Assisted Treatment/Enhanced Care Management, and a social service patient navigator to address the social drivers of health needs of high-risk and vulnerable patients

- 36% increase in the number of medically high-risk, complex patients who received community resources/social services within 30 days of screening/identification
- 90% of medically high-risk, complex patients who needed a home visit received one within 30 days of referral
- 100% of Emergency Department discharges sent by Stanford Health Care received a follow-up

Investment: $250,000
Persons served: 1,031
Target: Vulnerable populations

Roots Community Health Center
Establish Research, Evaluation and Training Program

The Research, Evaluation and Training Program expands clinical, education, and research partnerships to enhance high quality care and clinic capacity to serve more patients.

- 43 clinical learners were accepted into the Roots Community Health Training Program and successfully increased the clinic's overall capacity by supporting delivery of culturally competent care and improved access to affordable, high-quality health care services for at-risk community members
- 664 patients were supported by the patient services team, linking qualifying patients to low-cost internet, devices for telehealth, and training on how to utilize telehealth

Investment: $103,585
Persons served: 644
Target: Vulnerable populations

Samaritan House
Free Clinic Care Coordination and Care Delivery Redesign

Adopting the Rush University Total Health Collaborative model, the program improves health outcomes through reduced inequities caused by social, economic, and structural determinants of health

- 97 patients accessed additional supportive services based on Samaritan House referrals
- 3,782 medical, dental, and mental health patient visits provided for uninsured, low-income residents of San Mateo County
- 368 medical patient visits provided for diabetes care

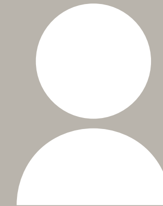
Investment: $160,000
Persons served: 951
Target: Vulnerable populations

Sonrisas Dental Health, INC.
Oral Health Access to Care Program Expansion

The program increases critical access to high-quality dental and oral health care for low-income adults in San Mateo County. The Access to Care Program provides a range of high-quality dental services, including diagnostic, preventative, and restorative procedures, for patients facing financial barriers.

- 71% of active dental patients received one or more hygiene visits
- 100% of patients received prevention education and supply kits at clinic visits to support their at-home routine

Investment: $68,000
Persons served: 177
Target: Vulnerable populations



Jaime is a 49-year-old diabetic who came to Samaritan House for help. He had run out of diabetes medication 4 years ago. He was losing weight, tired, and had blurred vision.

"I didn't know what to do," said Jaime, "I was so desperate."

Thanks to services provided by Samaritan House, his sugar levels are now under control and he was able to receive an expensive medication that will stabilize his sugar levels and weight, lower his risk of cardiovascular disease, and hopefully stabilize his retinal eye condition, for a low cost. Untreated, his condition could have led to blindness.

"I feel so much better," said Jaime. "I don't know what I would have done without Samaritan House. They may have saved my life."

Behavioral Health

Based on Stanford Health Care's 2022 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve behavioral health in our community are focused on screening and referral for mental and behavioral health services and substance use services/treatment for co-occurring mental illness and addiction, as well as supporting initiatives aimed at increasing the supply of diverse mental/behavioral health providers in community/safety net clinics.

For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

LifeMoves
Behavioral Moves

This program improves access to high-quality behavioral healthcare for adolescents, adults, parents and children who are experiencing homelessness, many of whom have struggled with additional trauma, including poverty, serious mental illness, substance use disorders, and interpersonal violence.

- 100% of adults and children over age five received a comprehensive assessment, including a behavioral health assessment upon entering emergency interim housing or enrolling in drop-in services
- 44% of single adults who engaged in behavioral health services exited to stable housing
- 82% of clients reported having increased trust in behavioral health providers

Investment: $400,000
Persons Served: 2,700
Target: Vulnerable populations

Momentum for Health
Momentum Employment Services

This effort aims to train and support staff to become certified Work-Incentive Planners who provide benefits planning counseling to clients who are considering employment but are skeptical due to lack of understanding how employment impacts their eligibility for public benefits.

- 1 staff member was trained and certified as a Work-Incentive Planner
- 4 staff registered to become Work-Incentive Planners

Investment: $160,000
Persons Served: 2
Target: Vulnerable populations

10% of adults reported frequent mental distress for at least 14 or more days per month

Economic Stability

Based on Stanford Health Care's 2022 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve economic stability in our community are focused on food and income security.

For more information about Stanford Health Care's Community Health Needs Assessment, please visit: [https://stanfordhealthcare.org/about-us/community-partnerships.html.](https://stanfordhealthcare.org/about-us/community-partnerships.html)

26% of children are eligible for a free or reduced-price lunch

FOOD SECURITY

More than 51% of Second Harvest Food Bank clients have less than $100 in savings

Second Harvest Food Bank of Silicon Valley

Lean Proteins for Local Food Distribution Centers

The program provides lean proteins (dairy, eggs, poultry, fish, peanut butter, and almonds) for local food bank sites.

- 573,505 pounds of healthy proteins distributed
- Linked 552 new clients referred from health providers to food assistance
- Submitted 504 CalFresh applications for eligible clients

Investment: $360,000
Persons served/month: 30,034
Target Population: Vulnerable populations

The Health Trust

Food & Nutrition Services Program

Meals on Wheels

The Meals on Wheels program provides daily delivered meals and wellness checks for isolated, vulnerable, and disabled older adults.

- Provided 300,479 home-delivered meals to 1,403 unduplicated clients who are nutritionally insecure and ineligible for other meal delivery programs
- 93% of Client Survey respondents reported that they agree or strongly agree that the program helps them remain independent in their home

Investment: $350,000
Persons served: 1,403
Target: Vulnerable populations

Samaritan House

Food Pharmacy

This year-round program aims to advance health equity, food and nutrition security, as well as diabetes management, while reducing health care costs for medically underserved, uninsured individuals suffering from Type 2 diabetes. The program provides nutrient dense foods coupled with nutrition counseling and health education.

- 12,294 bags of nutrient dense food were distributed from the Food Pharmacy, including 1,420 home-delivered bags of groceries
- 187 patients received education appointments for nutritions counseling and diabetes education

Investment: $119,083
Persons Served: 743
Target: Vulnerable populations

INCOME SECURITY

Senior Coastsiders

Creating an Age Friendly Coastside Community

In partnership with the city of Half Moon Bay's age-friendly master plan, the program engages older adults in community-led planning and data gathering, analysis, and implementation to inform the process of obtaining an Age Friendly Community designation.

- 30 low-income older adults provided with home repairs and modifications to increase independence, safety, and accessibility
- 200 older adults provided with physical, mental and social-well being services, including physical fitness classes, health education and screenings, and activities to reduce social isolation

Investment: $30,200
Persons Served: 700
Target Population: Vulnerable populations

Housing

Based on Stanford Health Care's (SHC) 2022 Community Health Needs Assessment findings, SHC's interventions to housing outcomes in our community include homelessness prevention, expanded supportive care and social services for self-sufficiency, and access to care for those experiencing and/or at-risk for homelessness.

For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

Destination: Home
Supportive Housing and Innovation Fund

The program helps catalyze the building of deeply affordable and supportive housing and advances innovative solutions that accelerate the agency's progress toward ending homelessness in Silicon Valley.

- 650 affordable housing units were funded for vulnerable households
- 97% of households remained stably housed at least 12 months after receiving housing assistance
- 93% of households did not enter or re-enter emergency shelter or transitional housing withing two years after receiving assistance since inception of program

Investment: $500,000
Unduplicated households served: 5,704

Target: Vulnerable populations

Downtown Streets Team
Work Exchange Program for Chronically Homeless Individuals

Unhoused team members volunteer in work experience teams, beautifying their community in exchange for basic needs stipends, case management, and employment services.

- Team waitlists reduced from 10.9 to 4.6 weeks
- Removed 1,378 barriers to self-sufficiency for Team Members (Examples: enrolled in government programs, received personal identification and employment application)

Investment: $214,203
Persons served: 518
Target: Vulnerable populations

Medical Respite Program
Intensive Case Management and Behavioral Health Services

This program provides health care and supportive care services to address the "total health" needs of homeless patients post-hospital discharge, intensive case management, behavioral health (mental health and substance abuse) services, and linkage to community-based social services.

- 668 hospital days avoided
- 633 individual behavioral therapy sessions provided to homeless patients

Investment: $77,500
Persons served: 167
Target: Vulnerable populations

54% to 89% UNEMPLOYMENT BENEFITS pays for rent in Santa Clara and San Mateo counties, leaving little for food, healthcare, transportation, or child care

Hospital-Based Programs Supporting Community Health

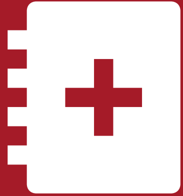
Program	Program Details and Impact
CLINICAL ADVICE SERVICES **Investment:** $16,165 **Target Population:** Vulnerable populations	This program provides nurse-run telephone triage services and aims to improve health outcomes associated with patients' unmet needs post-hospital discharge.
COMMUNITY EMERGENCY RESPONSE **Investment:** $7,094 **Target population:** Broader community	As the only Level 1 Trauma Center between San Francisco and San Jose, Stanford Health Care (SHC) plays a key role in disaster planning for the community. Through the Office of Emergency Management, SHC collaborates with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community. The goal of these activities is to minimize the impact on life, property, and the environment from catastrophic events such as pandemic flu, earthquakes, and other disasters. • Coordination with emergency management services (EMS) in joint disaster exercises, disaster planning and mitigation, and best practices • Maintains caches of emergency medical equipment and supplies for ready access and deployment in the case of a disaster or emergency • Provides regular inventory review and 24/7 security to ensure that these EMS supplies are service-ready at all times • Leader among COVID-19 emergency management and response.
HOUSING SUPPORT **Investment:** $2,159,475 **Target Population:** Vulnerable populations	To better support patients during treatment and post-discharge, the Social Work and Case Management department provides free and reduced cost housing support.
PATIENT FINANCIAL ADVOCACY SERVICES (MedData) **Investment:** $1,235,658 **Target population:** Vulnerable populations	This program assists low income, uninsured, underinsured, and homeless patients in researching their healthcare options. Services are provided at no cost to the client, and include helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow-up with county case managers as needed.

POST-HOSPITAL SUPPORT **Investment:** $3,106,214 **Target population:** Vulnerable populations	The Social Work and Case Management department provides funding and resources for patients with limited or no ability to pay for necessary medical and non-medical services. Services include skilled nursing facility and/or home health care costs, medical equipment, transportation, temporary housing, medications, and meal assistance.
SEXUAL ASSAULT RESPONSE TEAM (SART) **Investment:** $1,371,121 **Target Population:** Vulnerable populations	Stanford Hospital became the second medical center in Santa Clara County to offer a dedicated, private and confidential space co-located in the Emergency Department for survivors of sexual assault to receive care and undergo evidence collection. The county's SART team administers the Sexual Assault Forensic Exam (SAFE), working closely with hospital Emergency Department staff. Survivors receive trauma-informed care, including seamless access to medical forensic care, critical laboratory work, emergency contraception, and medications for sexually transmitted infections (STIs), all provided free of charge.
STANFORD HEALTH LIBRARY **Investment:** $2,317,865 **Persons served:** 17,974 **Target population:** Broader community	The Health Library provides scientifically-based health information to assist in making informed decisions about health and health care. Staffed with health librarians at all four branches, culturally-competent services, resources, and health education is provided to the community free of charge.
STANFORD LIFE FLIGHT **Investment:** $5,063,771 **Target population:** Broader community	Helicopter transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient's ability to pay. • 73% of flight volume transports critically ill patients from partner hospitals to major medical centers, including Stanford Health Care • 27% of flight volume is transported from accident sites or medical emergencies to trauma centers or specialty medical centers, such as stroke or burn centers
STANFORD SUPPORTIVE CARE PROGRAM (Cancer and Neuroscience) **Investment:** $899,519 **Persons served:** 12,891 **Target population:** Broader community	The Supportive Care Program provides free, non-medical support services to cancer and neuroscience patients, family members, and caregivers regardless of where patients receive treatment. • 60+ services are provided, including support groups, health education classes, caregiver workshops, exercise and yoga classes, and art therapy classes
SUSTAINABILITY PROGRAM OFFICE **Investment:** $1,004,073 **Target population:** Broader community	This program coordinates donations of medical supplies, food, furniture and equipment to local, national, and international charitable organizations.

Community Based Programs Supporting Community Health Improvement

Program	Program Details and Impact
AGING ADULT COMMUNITY HEALTH EDUCATION PROGRAMS **Investment:** $30,468 **Target population:** Vulnerable populations	Offering a variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have access to resources, tools, and the support needed to manage their health and live an enriched life.
BOARD SERVICE **Investment:** $4,773 **Target population:** Broader community	To support improved community health and access to care for vulnerable populations, Stanford Health Care leaders and staff offer expertise, advocacy, and resources to local and national professional organizations, nonprofit community service organizations, and advocacy groups.
COMMUNITY HEALTH EDUCATION PROGRAMS **Investment:** $878,354 **Target population:** Broader community	Health education has an important role in preventing disease and injury, improving health, and enhancing quality of life. As such, Stanford Health Care offers numerous community health education programs at a reduced or no cost to patients and the broad community. The following are among SHC's community health education offerings: • COVID-19 prevention and treatment • Smoking cessation • Falls and other injury prevention • Life-saving techniques • Palliative Care • Spiritual Care • Annual community health event, Health Matters • International Medicine Services: health conference and physician observership program
FINANCIAL DONATIONS **Investment:** $120,101 **Target population:** Vulnerable populations	Restricted financial contributions to organizations helps support program and service delivery to address health needs of the most vulnerable members of the community. Other community-based grant-making and financial contributions are detailed on pages 12 - 19.)
ONLINE SECOND OPINION **Investment:** $985,631 **Target population:** Broader community	Seeking to improve high quality care and access to specialty services, the Stanford Medicine Online Second Opinion program offers review of clinical diagnosis, treatment options, and care plans for community members.
REBUILDING TOGETHER **Investment:** $10,446 **Target population:** Vulnerable populations	Stanford Health Care provides funding and volunteer support for housing and infrastructure improvements for low-income community members and not-for-profit organizations.

STAFF COMMUNITY SERVICE **Investment:** $25,000 **Target Population:** Broader community	Stanford Health Care staff participate in community-based activities that support the identified community health needs.
SUBSIDIZED HEALTH SERVICES **Investment:** $1,098,074 **Target population:** Vulnerable populations	To expand access to health care for vulnerable residents, Stanford Health Care providers offer services at federally qualified health centers, county health systems, and government first responders. FY23 provider services include: • Primary Care • Psychiatry • Emergency Medicine
SUPPORT GROUPS **Investment:** $42,264 **Target population:** Broader community	The Social Work and Case Management Department facilitates support groups for patients, families, and community members. Support groups include: transplant groups for patients and caregivers; cancer-related groups; and a pulmonary hypertension group.
WORKFORCE DEVELOPMENT **Investment:** $235,179 **Target population:** Vulnerable populations	Stanford Health Care is committed to partner with community organizations on workforce development opportunities in community-based settings and at Stanford Health Care. Opportunities may include internships, hiring pipelines, mentorship, recruitment practice and support and initiatives that aim to support vulnerable communities.



Health Education, Research, and Training

Program	Program Details and Impact
ALLIED HEALTH PROFESSIONS EDUCATION **Investment:** $11,935,286	Student training programs in the field of: • Clinical Laboratory • Clinical Nutrition • Dosimetry • Nuclear Medicine • Nursing • Orthopedic Technician • Paramedic Student Training • Pharmacy • Physician Assistant • Psychology • Radiology • Rehabilitation Services • Respiratory Care Services • Social Work • Ultrasound • Wound Care
CLINICAL PASTORAL EDUCATION **Investment:** $275,326	Students from a range of religious traditions enroll in this program to prepare for a career in chaplaincy or to receive continuing education in pastoral/spiritual care. Upon completion of this year-long program, students use their training as clergy to provide effective spiritual care to individuals and families facing health challenges, including death, dying, and bereavement.
MEDICAL STUDENT, RESIDENT, AND FELLOW TRAINING **Investment:** $149,778,473	Student training programs included all primary and specialty care programs.
OFFICE OF NURSING PATIENT CARE HEALTH EQUITY AND RESEARCH **Investment:** $6,965	Stanford Health Care's Office of Nursing Patient Care Health Equity and Research, staffed by research scientists and coordinators, conducts research and clinical trials to improve care delivery and health outcomes.
SUPPORT FOR STANFORD UNIVERSITY **Investment:** $79,095,056	Grant support provided to Stanford University School of Medicine for health professions education, community health improvement and research, and community benefit activities.

2024 Community Benefit Plan

This plan represents the second year of a three-year strategic investment in community health. Stanford Health Care believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan is based on documented community health needs disclosed in the 2022 Community Health Needs Assessment.

Health Care Access and Delivery

Key Community Health Needs Assessment Findings:

- Fewer primary and specialty care providers than California's average
- Health insurance affordability for middle- and low-income community members, health insurance enrollment for low-income and undocumented community members
- Telehealth, digital health care access and use challenges for low-income older adults
- Lack of culturally competent/trauma-informed care, especially for LGBTQ+ individuals, speakers of languages other than English, individuals with mental health co-morbidities, individuals with limited technology or health literacy

Goal	Improve access to affordable, high-quality health care services for at-risk community members
Strategies	**Anticipated Impact**
Provide financial assistance to reduce health care cost barriers to care for low-income individuals.	• Reduced health care cost barriers for vulnerable populations • Increased use of medical home, including preventive care services • Improved affordability of health care services
Increase health insurance coverage.[1]	• Improved health insurance rates • Reduced avoidable emergency department and hospital utilization • Improved access to medical home • Increased use of medical home, including preventive care services • Improved affordability of health care services
Support care coordination interventions.[2, 3, 4, 5, 6]	• Reduced avoidable emergency department and hospital utilization • Improved access to medical home • Improved health outcomes, particularly related to health disparities • Improved housing and economic security by addressing physical health conditions that contribute to housing instability
Support capacity-building opportunities.[7,8,9]	• Reduced avoidable emergency department and hospital utilization • Improved access to medical home
Support initiatives that address telehealth challenges and physical and technology infrastructure improvements.[4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19]	• Improved equitable access to telehealth • Reduced avoidable emergency department and hospital utilization • Improved access to medical home • Increased use of medical home, including preventive care services • Improved health outcomes, particularly related to health disparities
Support initiatives that address culturally competent and compassionate/ respectful care.[20, 21, 22, 23, 24, 25]	• Improved health outcomes, particularly related to health disparities

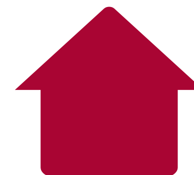
Behavioral Health

Key Community Health Needs Assessment Findings:

- Access to mental health care and substance use treatment is limited for all, worse for BIPOC and low-income individuals
- COVID-related stress: depression, anxiety, trauma, grief, economic factors
- Isolation for older adults and youth
- Suicide is higher than California's average for all age groups
- Justice system issues: BIPOC individuals experience higher rates of incarceration (drivers: racism, jail in lieu of health care services)
- Rising drug overdose deaths among community members

Goal	Improve access to affordable, high-quality mental/behavioral health care services
Strategies	**Anticipated Impact**
Support integrated mental health and substance use services/treatment for co-occurring mental illness and addiction.[26, 27]	• Improved access to mental/behavioral health programs and services • Increased proportion of community members served with effective mental/behavioral health services • Improved coordination of mental/behavioral health services • Improved mental/behavioral health among those served • Improved housing and economic security by addressing the behavioral health conditions that contribute to housing instability
Support screening and referral for mental/ behavioral health issues both at primary care visits and in emergency departments, and training for such screening when appropriate.[28, 29, 30]	• Improved access to mental/behavioral health programs and services • Increased proportion of community members served with effective mental/behavioral health services
Support initiatives aimed at increasing the supply of diverse mental/behavioral health providers in community/safety net clinics.[31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43]	• Increased rate of mental/behavioral health providers per 100,000 community residents • Reduced attrition of mental/behavioral health providers • Increased diversity of mental/behavioral health providers
Support programs that assist individuals recovering from addiction to transition back into the community.[44, 45]	• Reduced housing instability among individuals with mental illness/ substance addiction
Goal	Improve access to affordable, high-quality mental/behavioral health care services
Support programs that pair health professionals trained in mental/ behavioral health crisis response with law enforcement or other security professionals.[46, 47, 48, 49]	• Improved outcomes of encounters between mentally ill individuals and law enforcement

Housing



Key Community Health Needs Assessment Findings:

- Housing affordability worse than California average for households spending more than one third of income on housing, worse for BIPOC individuals
- Fewer housing units are available than demand
- Lower homeownership for all groups, especially BIPOC individuals
- Resulting in:
- Housing unit overcrowding as a result of unaffordability
- Poor housing quality, substandard conditions, and landlord-deferred maintenance/neglect, particularly for undocumented individuals
- Outmigration, higher among BIPOC individuals and low-wage earners (impacting employment and economic stability of the region)

Goal	Reduce housing instability among community members to support improved health
Strategies	**Anticipated Impact**
Support programs that expand affordable housing opportunities (rental and ownership), including those on existing residential properties.[50, 51, 52, 53]	• Improved access to stable housing for low-income individuals across San Mateo and Santa Clara counties • More community members remain independent longer • Reduced proportion of individuals who are housing insecure
Support local homelessness prevention organizations and collaboratives that provide temporary financial assistance, legal support, case management and/or other needed services to low-income individuals and families at risk of losing their housing.[54, 55, 56]	• Increased access to social services to prevent homelessness • More community members remain independent longer • Reduced proportion of individuals who are housing insecure
Support integrated case management programs that link high-risk individuals with housing.[57, 58, 59, 60, 61, 62]	• Increased access to social services to prevent homelessness • Reduced proportion of individuals who are housing insecure
Programs that assist disabled individuals and older adults with housing placement and coordinated case management to remain in their communities.[63]	• More community members remain independent longer • Reduced proportion of individuals who are housing insecure
Address affordable housing issues via investment.[64]	• Reduced poverty rates in San Mateo and Santa Clara counties • Improved associated health outcomes
Increase screening efforts for social drivers of health (e.g., safe housing).[65,66,67,68]	• Identification of greater proportion of housing-insecure individuals in San Mateo and Santa Clara counties • Improved access to stable housing for low-income individuals across San Mateo and Santa Clara counties • Reduced proportion of individuals who are housing insecure

Income Security

Key Community Health Needs Assessment Findings:

- Wages for frontline and essential workers rarely meet the California Self-Sufficiency Standard
- Despite low unemployment locally, annual wage increases are not meeting inflation
- Local minimum wages in each county are less than half of the California Self-Sufficiency Standard minimum wage requirements

Goal	Reduce barriers to employment/careers that provide community members with a living wage
Income Security Strategies	**Anticipated Impact**
Support efforts to increase workforce-related educational attainment and/or job training.[69, 70, 71, 72, 73, 74, 75, 76, 78, 79, 80]	• Reduced unemployment rates • Improved health insurance rates • Reduced poverty rates in San Mateo and Santa Clara counties • Reduced California Self-Sufficiency Standard disparity • Reduction of pay disparities
Support Guaranteed Basic Income pilots.[81, 82]	• Reduced poverty rates in San Mateo and Santa Clara counties • Reduced unemployment rates • More people earning a living wage • Reduced economic insecurity • Improved associated health outcomes
Support anchor institution-informed interventions to address economic security issues (e.g., targeted hiring and workforce development pipelines, incentivizing local and minority-owned procurement, policy change to improve economic security for vulnerable populations).[83, 84, 85, 86, 87, 88]	• Reduced unemployment rates • More people earning a living wage • Reduced economic insecurity

Food Security

Key Community Health Needs Assessment Findings:

- Trade-off between paying for housing, food, transportation, child care, medical care, etc.)
- Limited access to healthy foods

Goal	Reduce food insecurity and increase healthy food access for low-income community members
Strategies	**Anticipated Impact**
Expand access to food security programs specifically addressing health care-related food access (e.g., food pharmacy, medically tailored meals, Meals on Wheels, health policy advocacy).[89]	• Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties • Improved associated health outcomes
Increase screening efforts for social drivers of health (e.g., food security).[65, 68, 90, 91, 92, 93, 94]	• Identification of greater proportion of food-insecure individuals in San Mateo and Santa Clara counties • Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties • Reduced proportion of individuals who are food insecure
Expand capacity of existing food access programs and/or support new programs to increase access to nutrient-dense foods.[95, 96, 97, 98, 99, 100, 101, 102, 103, 104]	• Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties • Increased proportion of low-income individuals in San Mateo and Santa Clara counties who eat three meals per day • Reduced proportion of individuals in San Mateo and Santa Clara counties experiencing poor health outcomes that are a result of food insecurity • Reduced proportion of individuals who are food insecure • Reduced diabetes/obesity rates

End Notes

[1] Addresses strategies under U.S. Department of Health and Human Services' Strategic Goal 1, Objective A, to "extend affordable coverage to the uninsured," including identified strategies such as "Maximize the participation of…eligible individuals in affordable health insurance coverage by helping them understand insurance options" and "…provide outreach and enrollment assistance." U.S. Department of Health and Human Services. (2019). Strategic goal 1: Reform, strengthen, and modernize the nation's healthcare system. Retrieved from http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj_a

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Target Community End Notes

[1] Living Wage Calculation for Santa Clara County, California https://livingwage.mit.edu/counties/06085

[2] Living Wage Calculation for San Mateo County, California https://livingwage.mit.edu/counties/06081

[3] Defined as a household where no one aged 14 years or older speaks English "very well." U.S. Census Bureau American Community Survey, 5-Year Estimates, 2012-2016.

[4] The Cost of Being Californian Santa Clara County Fact Sheet https://insightcced.org/the-cost-of-being-californian-santa-clara-county-fact-sheet/

[5] The Cost of Being Californian San Mateo County Fact Sheet https://insightcced.org/the-cost-of-being-californian-san-mateo-county-fact-sheet/

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

[7] The Insight Center for Community Economic Development. Self-Sufficiency Standard Tool. Retrieved March 2019 from https://insightcced.org/family-needs-calculator/

[8] Zillow, data through May 31, 2018: https://www.zillow.com/home-values/3136/santa-clara-county-ca/

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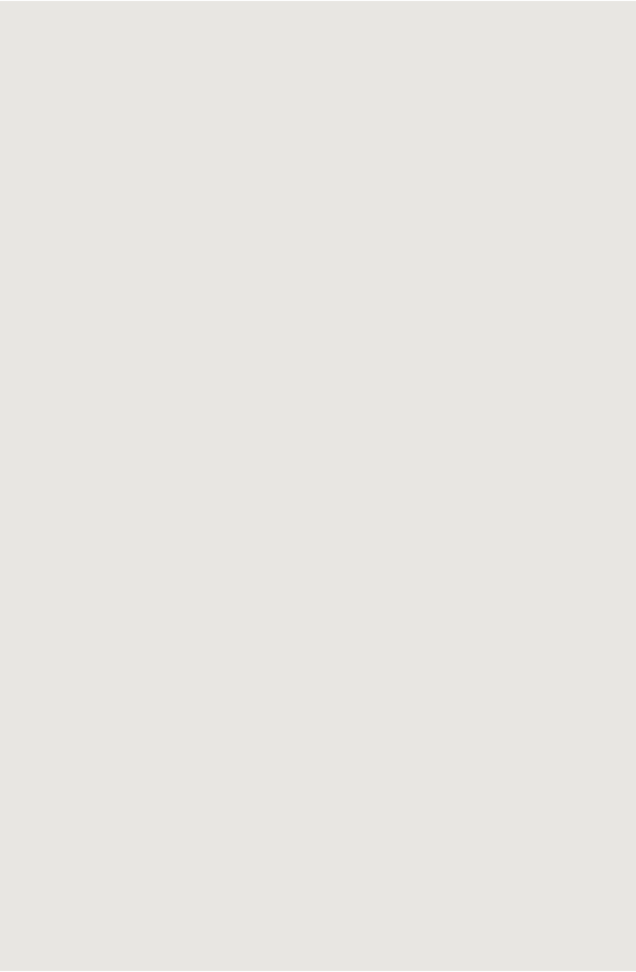
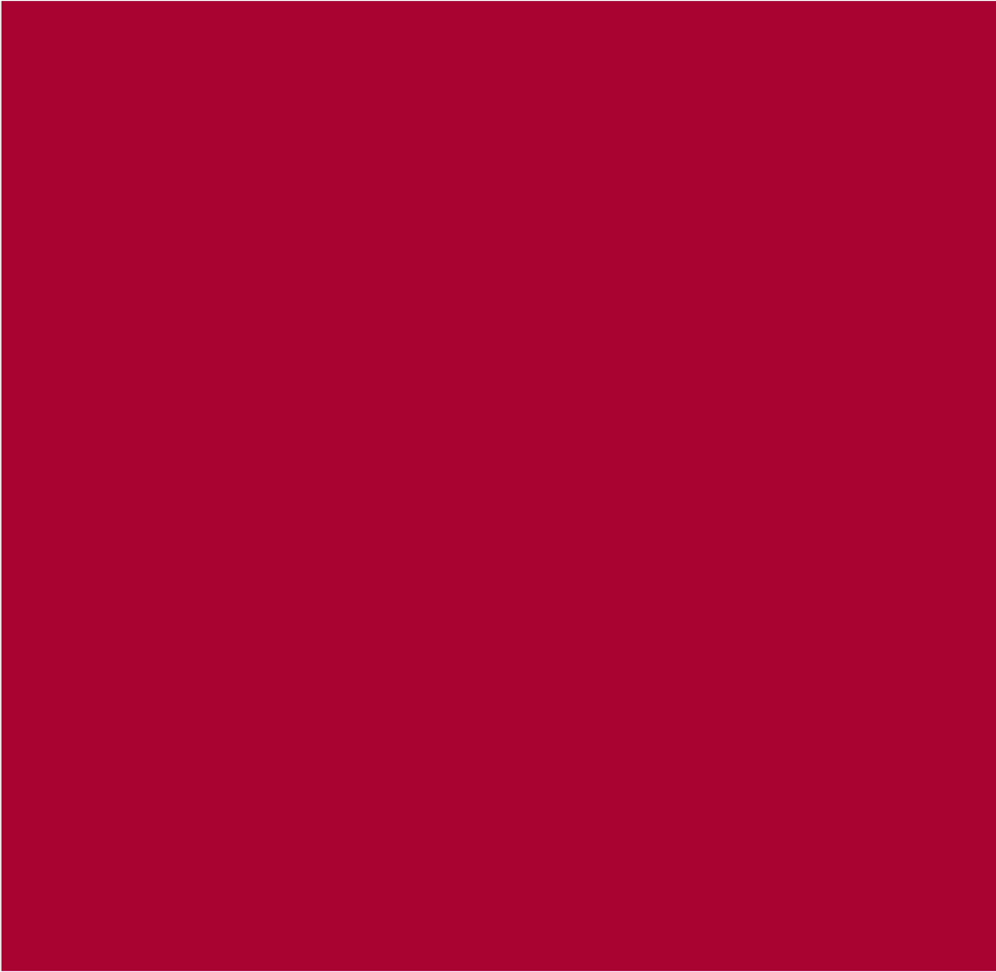
[10] U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012-2016.

[11] Measuring America's People, Places, and Economy https://www.census.gov/

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