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2019 Community Benefits Report
2020 Community Benefits Plan

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Stanford
HEALTH CARE
STANFORD MEDICINE

Stanford HEALTH CARE

Mission Statement

For the benefit of our patients and the community we serve, our mission is

- To Care
- To Educate
- To Discover

Vision Statement

Healing humanity through science and compassion, one patient at a time

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2019 Community Benefit Report

2020 Community Benefit Plan

Stanford
HEALTH CARE
STANFORD MEDICINE

David Entwistle
President and
Chief Executive Officer

January 31, 2020

Mr. Harry Dhami
Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
400 R Street, Suite 250
Sacramento, CA 95811

Dear Mr. Dhami:

On behalf of Stanford Health Care, I am pleased to submit our Fiscal Year 2019 Community Benefit Report, which covers the period of September 1, 2018 through August 31, 2019, and our Fiscal Year 2020 Community Benefit Plan. The attached report demonstrates our commitment to making a positive difference in the health of our community. From support for our local community-based health centers to programs and services supporting indigent patients upon hospital discharge, Stanford Health Care collaborates actively with local leaders, nonprofits, health care organizations, and community members to address the most compelling health challenges facing the community.

If you have any questions, please contact Nancy Olson, Chief Government & Community Relations Officer at (650) 724-2462 or via email naolson@stanfordhealthcare.org.

Sincerely,

David Entwistle
President & Chief Executive Officer

Enclosure

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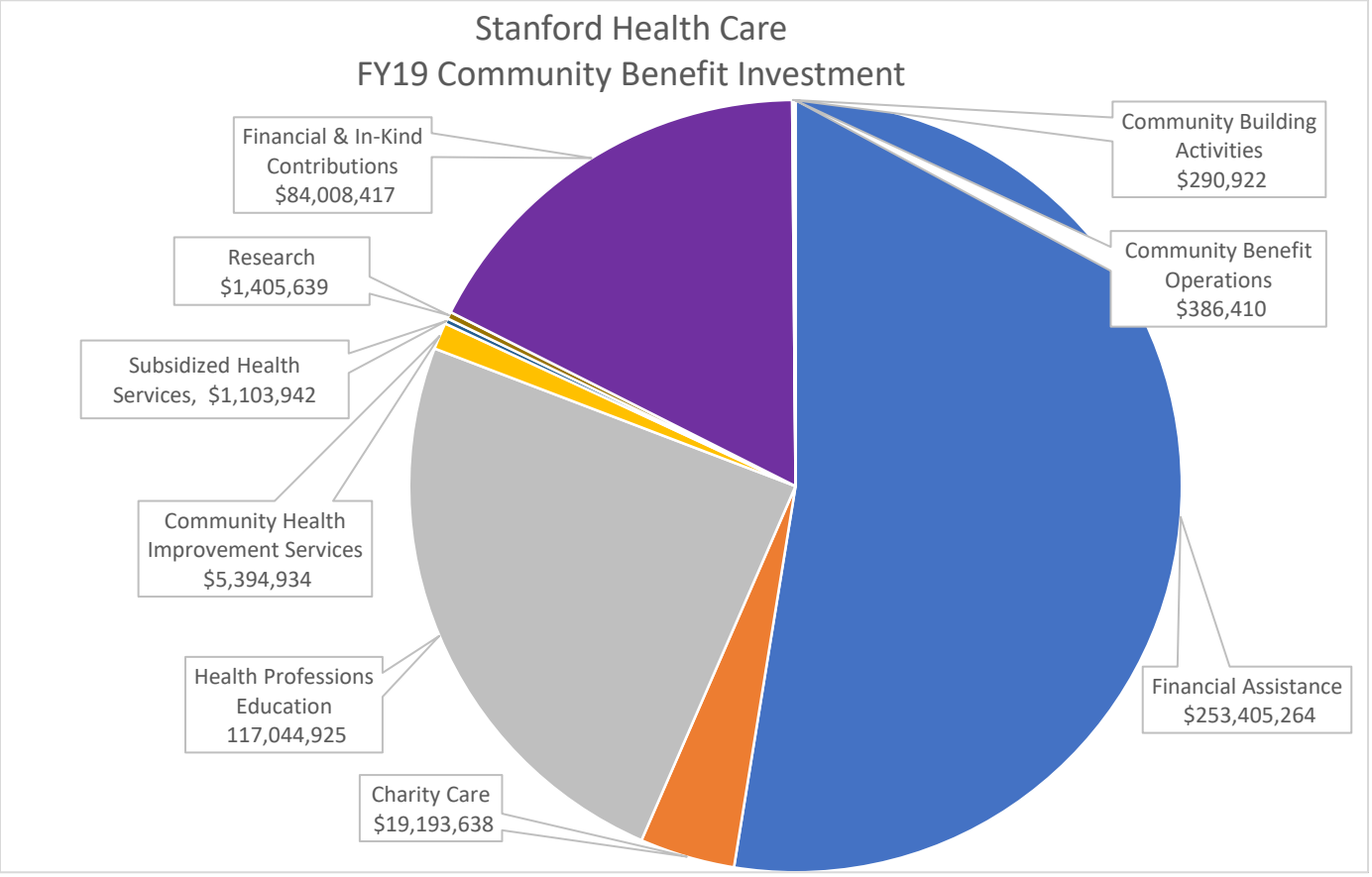
I. Introduction

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 and dedicates considerable resources to support its community benefit program.

II. Total Quantifiable Community Benefit Investment for FY2019

This report covers fiscal year (FY) 2019 beginning September 1, 2018 and ending August 31, 2019. During this time, SHC invested over **$482.2 million** in services and activities to improve the health of the communities it serves. In addition to providing details on this investment,[1] this report describes the community benefit planning process and the Community Benefit Plan for FY 2020.



[1] This figure does not include the cost of unreimbursed Medicare.

Financial Assistance and Charity Care: $272,598,902

- Uncompensated costs of medical services for patients enrolled in Medi-Cal, out-of-state Medicaid and other means-tested government programs: $253,405,264
- Charity Care: $19,193,638

Financial and In-Kind Contributions: $84,008,417

- Community clinic capacity-building and support
- Community health improvement grants
- Donations of medical equipment, supplies, furniture, and food
- Event sponsorships for nonprofit organizations
- Grants to the School of Medicine for community benefit purposes, e.g. population health, primary care delivery, and community engagement

Health Professions Education: $117,044,925

- Resident physician and fellow education costs
- Graduate medical student education costs (uncompensated costs after federal reimbursement)
- Nurse and allied health professions training

Community Health Improvement Services: $5,394,934

- Children's Health Initiative
- Community health education programs
- Patient Financial Advocacy – Health Advocates Program
- Programs to support healthy lifestyles for seniors
- Stanford Health Library
- Stanford Supportive Care Programs for Cancer and Neuroscience

Research: $1,405,639

- Research into improved care delivery and better health outcomes
- Facilitating patient access and enrollment in clinical trials

Subsidized Health Services: $1,103,942

- Stanford Life Flight

Community Building Activities: $290,922

- Advocacy for vulnerable population health issues
- Nonprofit sponsorship support
- Support for community emergency management
- Workforce development

Community Benefit Operations: $386,410

- Community Health Needs Assessment costs

- Dedicated Community Benefit staff
- Reporting and compliance costs
- Training and staff development

III. COMMUNITY SERVED

Although SHC cares for patients from throughout California, as well as nationally and internationally, more than half of its patients live in San Mateo (SMC) and Santa Clara (SCC) counties. Therefore, for the purposes of its community benefit initiatives and reporting, SHC has identified these two counties as its target community.

In 2016, approximately 1.9 million residents lived in Santa Clara County. San Mateo County is far smaller with approximately 765,000 residents in 2016. The ethnic make-up of both counties is approximately 60% White, 33% Asian, 25% Hispanic/Latino, and 3% Black/African-American. The Asian/Pacific Islander population is greater in San Mateo County (2%) than in Santa Clara County (0.5%). More than one-third of residents in both counties are foreign-born[i].

The Federal Poverty Line (FPL) is the traditional measure of poverty in a community. Unfortunately, the FPL does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. As such, the California Self-Sufficiency Standard (CASSS) is a better estimate of economic stability in both counties. CASSS cites that approximately 30% of households across SCC and SMC in 2018 were unable to meet their basic needs. For a single parent with 2 children, CASSS estimates that an annual income of $107,000 in SCC and $126,000 in SMC was necessary to meet basic needs. While minimum wage was $13.00 (SCC) and $13.50 (SMC) per hour in 2018, to meet the CASSS estimate an hourly wage of $50 (SCC) and $60 (SMC) was required. Lastly, CASSS reports a 25% increase in the cost of living across both counties between 2015 and 2018.[ii] Unfortunately, the Bureau of Labor Statistics cites only a 4% per year average increase in wages across the San Jose-San Francisco-Oakland metropolitan area during the 2015-2018 time period.[iii]

In 2018, Insight published *The Cost of Being Californian*, which cites significant income, ethnic, and gender disparities that exist across California.[iv] The key findings of The Cost of Being Californian report include:

- California (CA) households of color are twice as likely as white households to lack adequate income to meet their basic needs
- 52% of Latino CA households are struggling to get by vs. 23% of white households
- CA households of color make up 57% of all California households, but constitute 72% of households that fall below the CASSS
- Women in CA are more economically disadvantaged than men across many factors, including lower pay, taking unpaid time to care for children or family members, underemployment, and occupational segregation
- Having children nearly doubles the chance of living below CASSS

- Policy change to increase wages, institute comprehensive paid family leave, curb rising housing costs, and establish universal child care are needed

IV. Community Assessment Process and Prioritization of Community Health Needs

As required by California Senate Bill 697[v], the Santa Clara County Community Benefit Coalition and the Healthy Community Collaborative of San Mateo County each produced a community health needs assessment in 2016. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs in each county. SHC was an active participant in both collaboratives[vi] [vii] and played a leadership role as chair of the Santa Clara County Community Benefit Coalition.

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 countywide groups consisting of county coalition members and community leaders. The final health needs were selected by the SHC Community Partnership Program Steering Committee (CPPSC) after reviewing the data, countywide prioritization processes, and current SHC community health initiatives. The CPPSC then applied another set of criteria.[viii] Five significant health needs were selected using this criteria:

V. Community Grant Investment to Address Community Health Needs

SHC's annual community investment focuses on improving the health of our community's most vulnerable populations. To accomplish this goal, all community grant investment from FY17 – FY19

improved access to and delivery of care through the five prioritized community health needs: Access to Health Care, Behavioral Health, Cancer, Communicable Diseases, and Obesity & Diabetes.

A. Access to Care

Partner	Program	Program Details and FY19 Impact
Avenidas	Door-to-Door	Transportation program on the Mid-Peninsula that provides rides for older adults who no longer drive by using volunteer drivers driving their own vehicles. The service helps those with limited mobility with transportation to activities such as grocery shopping, visiting friends, and getting to their medical appointments. ♦ 100% feel more independent ♦ 92% used the service more than once per month ♦ 99% would recommend to a friend ♦ 97-98% satisfied with transportation and responsiveness Investment: $75,000 Persons served: 152
Cardinal Free Clinics (CFC)	Administrative and Technology support	This program improves access to care for the medically underserved, mainly the uninsured and LGBTQ+ populations, in San Mateo and Santa Clara counties. ♦ Expanded outreach to target populations, specifically immigrant, migrant, and visiting populations who would otherwise seek care for non-emergency care services through the hospital emergency department ♦ Replaced outdated, online volunteer workforce scheduling and reporting tool with a better solution ♦ Developed a medical home pipeline pilot program with MayView Community Health Centers ♦ Added radiology services to the SHC covered in-kind radiology diagnostic tests available to the CFCs Investment: $42,850 Persons served: 974

Partner	Program	Program Details and FY19 Impact
Cardinal Free Clinics (CFC)	Free Laboratory and Radiology services	This program provides laboratory and radiology services free of charge to uninsured and underinsured individuals. 100% of CFC clients are uninsured or underinsured. ♦ 4510 free lab tests were provided ♦ 93 free x-rays/MRIs were provided Investment: $167,798 Persons served: approximately 4,500
Ravenswood Family Health Center (RFHC) & **MayView Community Health Center (MCHC)**	Care Coordination for Complex Patients	Through a full-time social worker, this program provides community-based care coordination for high-risk, complex patients to improve health care access. ♦ Strengthened medical home engagement ♦ Provided care plans and connected with social services as needed ♦ RFHC reduced ED utilization by 55% Investment: $100,000 Persons served: 70
MayView Community Health Center (MCHC)	Palo Alto Clinic Renovations	This one-time grant allows the Palo Alto Clinic site to make renovations that will significantly increase access to health care for MayView's patients in the community by expanding from four exam rooms to eleven and allowing for three additional primary care providers (from two providers to five providers). Investment: $250,000
MayView Community Health Center	Increasing Patient Access at Palo Alto Clinic	Stanford funding supports 1 FTE Stanford physician at the clinic. This tripling of clinical capacity from FY17 enables MayView to manage patient demand and focus on clinical quality and social determinants of health. ♦ Increased the average number of medical visits by 156%, from 250 average medical visits per month to 640 ♦ Served 2,912 individual patients in FY19 ♦ Increased breast cancer screening rates by 106% (from 23% to 47%) ♦ Decreased in the proportion of patients with poor diabetic control by 21% (from 37% to 29%) ♦ Established new Diabetes Management Program

Partner	Program	Program Details and FY19 Impact
		♦ Increased Adult BMI Assessments by 155% (from 29% to 63%). Due to the improvements in workflow and EHR utilization that dramatically improved performance in assessing BMI. All providers are now required to review the BMI to complete a visit. ♦ MayView implemented a new Stanford Hospital transition pilot with the intention of improving coordination with the Stanford Emergency Department to reduce ER admissions of MayView patients at Stanford Hospital. Investment: $70,000 Persons served: 2,912 at Palo Alto Clinic
Operation Access	Care navigation and access to surgical services	This partnership with local hospitals and health systems links donated surgical preventive care to uninsured and underinsured patients in San Mateo and Santa Clara Counties at no charge to patients. ♦ 178 surgical procedures and diagnostic services completed ♦ 98% of patients reported improved health and quality of life because of services provided Investment: $10,000 Persons served: 134
Avenidas – Rose Kleiner Center	Nurse Navigator/Community-Based Home Health Program	This program provides intensive care coordination to low-income seniors with highly complex medical, cognitive, and behavioral health conditions. ♦ Reduced ED visits by 80% ♦ Reduced hospital stays by 80% ♦ No 30-day readmissions for 90% of participants Investment: $100,000 Persons served: 25

B. Behavioral Health

Based on Stanford Health Care's 2016 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve behavioral health outcomes in our community include both mental health and substance abuse interventions. For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

Partner	Program	Program Details and FY19 Impact
Asian Americans for Community Involvement (AACI)	Integrated Behavioral Health Program (IBH)	Funding supports integrated primary care and behavioral health services to all AACI patients. ♦ 88% of patients were provided depression screening and offered follow-up as needed ♦ Tracking patients who scored positive for depression but were not referred (30%) ♦ 15% increase in referrals from primary care physicians to integrated behavioral health (105) Investment: $25,000 Persons served: 105
Medical Respite Program	Behavioral health testing and therapy	Through a full-time psychologist/post-doctoral fellow and 0.5 FTE case worker, this program administers psychologic and neurologic testing, conducts 1:1 cognitive behavioral therapy sessions onsite, and increases behavioral health follow-up appointment attendance for homeless individuals. ♦ Provided respite care for 183 homeless patients ♦ Conducted psychological testing on 70% of patients ♦ Provided 1,142 individual 1:1 therapy sessions Investment: $82,140 Persons served: 183
Peninsula Healthcare Connection	Behavioral Health Outreach and Prevention Program	This program increases access to behavioral health services for homeless and at-risk individuals in north Santa Clara County. ♦ 364 behavioral health visits (psychiatry/therapy) Investment: $50,000
National Alliance on Mental Illness (NAMI)	Community-based mental health support programs	This program links patients with mental health disorders with peer mentors to aid in treatment and recovery. ♦ 3 NAMI mentors trained (exceeded goal of 2) ♦ 316 peer mentor hours spent in the unit ♦ 210 info packets distributed ♦ 29 peer matches Investment: $70,000 Persons served: 29

Partner	Program	Program Details and FY19 Impact
Mental Health America of California (MHAC)	Peer Mentoring for Dual Diagnosis Patients	This program links people with co-morbid mental health and substance use disorders with peer mentors to aid in treatment and recovery. The peer mentor provided counsel and support for patients in the community and at emergency department admission. Investment: $8,747
Kara	Subsidies for complex grief counseling services	This program provides grief counseling for low-income patients whose grief is complicated by higher degrees of trauma and/or additional relational or emotional complications. ♦ 1,633 complex grief counseling sessions provided Investment: $12,000 Persons served: 1,633

C. Cancer

Based on Stanford Health Care's 2016 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve cancer outcomes in our community are focused on cancer-related health disparities. For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

Partner	Program	Program Details and FY19 Impact
Community Health Partnership	Community Mammography Access Project (CMAP)	This program increases access to mammography services among low-income, uninsured and underinsured women age 40 years+ living in Santa Clara County. Program interventions include: 1) provider training to monitor and increase breast cancer screening rates, 2) community outreach and health education, and 3) patient navigation services. ♦ 848 women received breast health education ♦ 198 participating women received patient navigation services linking them to health coverage and a medical home for preventive breast care ♦ 116 participating women reported having mammogram Investment: $10,000 Persons served: 1,690

Partner	Program	Program Details and FY19 Impact
Asian Liver Center	Viral Hepatitis and Liver Cancer Public Awareness and Education Project	This program reduces the transmission and burden of viral hepatitis and liver cancer in the Vietnamese community in Santa Clara County. ♦ 5 outreach and health education events were held, which reached approximately 2,350 individuals ♦ 2 new community partnerships were formed to increase health education and outreach across Santa Clara County ♦ 22 new Vietnamese-speaking volunteers were recruited and trained to administer health education ♦ Public service announcements were broadcast on local Vietnamese radio and television for a 3-month period ♦ Measures indicate that 9 out of 10 participants were knowledgeable of HBV transmission routes and testing ♦ Almost 8 in 10 participants reported being tested for HBC (an increase of 12 percentage points) Investment: $10,000 Persons served: 6,000
Latinas Contra Cancer	Increasing Cervical Cancer Awareness and Screening in the Latina Community	This program increases cervical cancer screening among low-income, Spanish-Speaking Latinas aged between 16-23. ♦ 785 women received education about cervical cancer screening and HPV vaccines ♦ Identified 81 women who need screening, and helped 29 navigate the screening process. Investment: $10,000 Persons served: 458

D. Communicable Diseases

Based on Stanford Health Care's 2016 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve communicable disease outcomes in our community are focused on the following diseases: Influenza, Pneumonia, Hepatitis B (HepB), and Tuberculosis (TB). For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

Partner	Program	Program Details and FY19 Impact
Peninsula Healthcare Connection	Infectious Disease Outreach and Prevention Program	This program offers health education regarding disease transmission, treatment, and prevention practices as well as referrals to clinic-based health care services. ♦ 550 individuals received infectious disease health education through street outreach ♦ 330 patients received screening, vaccination, and/or referral services for TB, HepB, Influenza, and Pneumonia ♦ Over 100 blood draws performed Investment: $50,000
Santa Clara County Public Health Department **&** **Asian Americans for Community Involvement**	Tuberculosis Prevention and Chronic Hepatitis B Virus Screening and Management Program	This program 1) improves targeted testing and treatment for latent TB infection to prevent patients from developing TB disease in future, 2) improves screening for chronic HepB infection among at-risk persons, 3) improves management of patients with chronic HepB infection. ♦ Baseline assessment completed, and assessments analyzed to identify areas for improvement ♦ Electronic health record alerts for PCPs developed and tested ♦ Implemented health alert into clinic workflow (including staff training) Investment: $20,000 Persons served: 919
SF HepB Free – Bay Area	Program expansion into San Mateo County	This program supports Hepatitis B awareness, prevention, and treatment for at-risk populations in San Mateo County. ♦ 911 hepatitis screenings conducted in three-year period ♦ 7,393 people directly educated on risk factors, diagnosis, and treatment for Hepatitis B over 3-year period ♦ Increased proportion of Filipino residents screened (who are at higher risk for Hepatitis B) ♦ More than 224 physicians have been directly educated about hepatitis B and the importance of screening and vaccination of their at-risk patients Investment: $15,000 Persons served: 911 in 3 years

E. Obesity & Diabetes

Based on Stanford Health Care's 2016 Community Health Needs Assessment findings, Stanford Health Care's interventions to improve Obesity and Diabetes rates in our community are focused on prevention, early intervention, and treatment. For more information about Stanford Health Care's Community Health Needs Assessment, please visit: https://stanfordhealthcare.org/about-us/community-partnerships.html.

Partner	Program	Program Details and FY19 Impact
Ravenswood Family Health Center (RFHC)	Diabetes Education and Management	This program helps diabetic and pre-diabetic patients successfully manage their conditions, adopt healthy lifestyles, and achieve improved health outcomes. ♦ 72% of patients decreased their A1c level by 2% or more OR met their A1c goal in their health management plan ♦ 153 unduplicated patients participated in group visits, including blood pressure clinic and diabetes group education in a single intervention Investment: $75,000 Persons served: 271 completed program
Samaritan House Free Clinic, Redwood City	Diabetes Care Days (DCD) 2.0	This program offers monthly multi-station group visits for comprehensive diabetes care. The program also expanded in FY19 to screen patients for depression and oral health needs. ♦ 383 patient encounters in 3-yr period at Diabetes Days ♦ Additional 988 patient encounters by Advance Practice Providers in 3-yr period ♦ 99% of patients report increased engagement in self-management through increased knowledge and/or planned lifestyle changes ♦ Average improvement in Hb1A1c levels of 10% ♦ 27 patients and families participated in healthy lifestyle course (4 sessions) ♦ Obese patients (BMI >30) experienced a mean weight loss of 0.5%). 40% of obese patients lost approx. 2% in weight ♦ 27 patients and families participated in healthy lifestyle course (4 sessions) Depression: ♦ 100% of DCD+ clinic patients were screened for depression

Partner	Program	Program Details and FY19 Impact
		♦ 60% of patients showed improvement in depression symptoms (measured by PHQ-9) after treatment (average treatment lasted 7 sessions) Oral health: ♦ 124 patients screened for oral health/periodontal disease ♦ 124 patients received oral hygiene care. Investment: $125,000 Persons served: 228

VI. HOSPITAL-BASED PROGRAMS SUPPORTING COMMUNITY HEALTH IMPROVEMENT

Program	Program Details and FY19 Impact
Adult Community Health Education Programs	A variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have the resources, tools, and support needed to manage their health and live an enriched life. Investment: $58,014
Chronic Disease Self-Management Program (CDSM)	Through a six-week behavior modification workshop, this program teaches older adults how to manage their chronic conditions. Participants learn to do appropriate exercises, eat better, manage stress and pain, manage their medications, and better communicate with their families and health care providers. Two six-week programs were offered in FY19. Investment: $4,304 Persons served: 20
Community Emergency Response	As the only Level 1 Trauma Center between San Francisco and San Jose, 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.

Program	Program Details and FY19 Impact
	♦ 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 Investment: $3,059
MedData (Patient financial advocacy services)	This program assists low income, uninsured, underinsured and homeless patients in researching their healthcare options. Services, provided at no cost to the client, included helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers as needed. Investment: $1,518,388 Persons served: 2,990
Stanford Health Care Emergency Department Registration Unit	In partnership with Santa Clara and San Mateo counties, this program links uninsured pediatric patients treated in SHC's emergency department with health insurance including Medi-Cal, Healthy Kids, Healthy Families, etc. Investment: $603,610
Stanford Health Care Post-Hospital Support	For patients that have limited or no ability to pay for necessary medical and non-medical services, the Social Work and Case Management department provides funding and resources. Services include medical equipment, transportation, temporary housing, medications and meal assistance. Investment: $282,763
Stanford Health Library (SHL)	SHL provides scientifically based health information to assist in making informed decisions about health and health care. Staffed with health librarians at all five branches, including at the Ravenswood Family Health Center in East Palo Alto, culturally-competent services, resources, and health education are provided to the community free of charge. Investment: $1,472,843 Persons served: 36,506
Stanford Life Flight	Helicopter transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient's ability to pay.

Program	Program Details and FY19 Impact
	♦ 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 Investment: $1,103,942 Persons served: 409
Stanford Medical Youth Science Program (SMYSP)	SMYSP is an annual five-week science and medicine-based enrichment program for low-income and ethnically diverse high school sophomores and juniors. Students are linked with an SHC staff mentor and participate in real-life health professions education. The program goal is to promote representation of ethnic minority and low-income groups across all health professions, including orthopedics, pharmacy, Life Flight, physical therapy, and emergency. Investment: $280,915
Stanford Supportive Care Programs for Cancer and Neuroscience (SCSCP)	SSCP 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, clinical trials, caregiver workshops, exercise and yoga classes, and art therapy classes Investment: $1,087,590 Persons served: 20,143

VII. COMMUNITY-BASED PROGRAMS SUPPORTING COMMUNITY HEALTH IMPROVEMENT

Program	Program Details and FY19 Impact
Support Groups	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. Investment: $131,312

Program	Program Details and FY19 Impact
Traffic and Bicycle Safety	SHC provides several traffic and driving safety educational programs to reduce traffic-related injuries and deaths. Programs include: ♦ Bicycle rodeo and helmet fitting program (3rd graders) ♦ Bicycle safety education and helmet fitting for Stanford University freshman ♦ Impact Teen Drivers (distracted driving education for high school students) ♦ Traffic court diversion program for youth aged 13-17 (education for parents and teens who were cited for unsafe behaviors. Investment: $3,557 Persons served: 109
Stanford Lifeline	This program offers in-home medical alert services for older adults. Through the service, older adults are supported to remain independent by providing an easy way to summon help in an emergency and community-based resources for clients at-risk for falls or other emergencies. Need-based subsidies are provided. Investment: $346,238 Persons served: 349 free or reduced cost subsidies provided`
Strong for Life	This program is a free group exercise program that helps older adults increase strength, balance and mobility, and reduce isolation. Investment: $78,861 Persons served: 8,268
Farewell to Falls	This best-practice fall prevention program offers free occupational therapist home visits to assess fall risk-factors, makes recommendations for risk-factor mitigation, including exercise and home safety improvements, and provides ongoing follow-up for one year. Investment: $159,793 Persons served: 302
Stepping On	This program empowers older adults to make behavior change to reduce their risk of falling. Resources include strength and balance exercises and risk-factor education, such as home safety, footwear, medications, and vision issues. Program facilitators include physical and occupational therapists, pharmacists, and vision specialists. This program is provided free of charge. ♦ 4 eight-class sessions were conducted in FY19 (seven weeks plus a booster session each)

Program	Program Details and FY19 Impact
	Investment: $10,935 Persons served: 53
Stop the Bleed	Training on life-saving bleeding control for teachers, coaches and other residents (one-hour sessions). Investment: $32,103 Persons served: 738 (24 sessions)
Matter of Balance	This evidence-based program works with older adults to reduce the fear of falling. Through occupational therapists and volunteer lay leaders, participants learn to view falls as controllable, set goals for increasing activity, learn appropriate home modifications to reduce the risk of falling, and practice exercises to increase strength and balance. ♦ 7 two-hour sessions were conducted in FY19 plus booster sessions Investment: $20,044 Persons served: 296
Rebuilding Together Peninsula	SHC provides funding and volunteer support for housing and infrastructure improvements for low-income community members and not-for-profit organizations, including home modifications. Investment: $3,194
Aging Adult Community Health Education Programs	A variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have the resources, tools, and support needed to manage their health and live an enriched life. Investment: $58,014
Rehabilitation Community Health Education Programs	The Rehabilitation Department provides a variety of community health education programs, including a Speech Communication group therapy program that supports those recovering from a stroke with opportunities to improve their speech, language, and cognitive skills. Investment: $3,966 Persons served: 14

VIII. HEALTH EDUCATION, RESEARCH, AND TRAINING

Program	Program Details and FY19 Impact
Medical Student, Resident, and Fellow training	Student training programs included all primary and specialty care programs. Investment: $108,673,635
Allied Health Professions Education	Student training programs, including: Clinical Laboratory Clinical Nutrition Nuclear Medicine Nursing Nutrition Paramedic Pharmacy Psychology Radiology Rehabilitation Services Respiratory Care Services Investment: $6,245,448
Clinical Pastoral Education	Students, from a range of religious traditions, enroll in this program to prepare for a career in chaplaincy or receive continuing education in pastoral/spiritual care. Upon completion of this year-long program, students use their training to provide effective spiritual care to individuals and families facing health challenges, including death, dying, and bereavement. Investment: $169,612
Office of Research	This program, staffed by research scientists and coordinators, conducts research and clinical trials to improve care delivery and health outcomes across the health care field. FY19 research initiatives included Healthcare Con, a research and education symposium in collaboration with the Bay Area Magnet Consortium – a collaboration between 11 hospitals. Investment: $1,305,639
Health Professions Continuing Education	As experts in their field, SHC staff host continuing education courses for the community, including continuing education for people working with the aging adult and social work fields. Investment: $1,027,537

2019 COMMUNITY BENEFIT REPORT ENDNOTES

[i] U.S. Census Bureau QuickFacts: San Mateo County, California. (2018, July 1). Retrieved December 12, 2018, from https://www.census.gov/quickfacts/sanmateocountycalifornia and https://www.census.gov/quickfacts/santaclaracountycalifornia

[ii] Self-Sufficiency Standard. (2018, April). Retrieved December 12, 2018, from https://insightcced.org/2018-self-sufficiency-standard/

[iii] Changing Compensation Costs in the San Jose Metropolitan Area – September 2018 : Western Information Office. (2018, November 02). Retrieved December 12, 2018, from https://www.bls.gov/regions/west/news-release/employmentcostindex_sanjose.htm

[iv] Bhattachara, J., & Price, A. (2018, August 07). The Cost of Being Californian: A Look at the Economic Health of California Families. Retrieved December 12, 2018, from https://insightcced.org/2018-self-sufficiency-standard-report/

[v] SB 697: By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

[vi] Healthy Community Collaborative of San Mateo County members: County of San Mateo Human Service Agency, Hospital Consortium of San Mateo County, Kaiser Permanente San Mateo Area, Lucile Packard Children's Hospital at Stanford, Peninsula Health Care District, San Mateo County Health System, Sequoia Hospital (Dignity Health System), Seton Medical Center (Verity Health System), Stanford Health Care, and Sutter Health Mills-Peninsula Health Services

[vii] Santa Clara County Community Benefit Coalition members: El Camino Hospital (Mt View, Los Gatos), Hospital Council of Northern and Central California, Kaiser Permanente South Bay Area, Lucile Packard Children's Hospital Stanford, O'Connor Hospital, Santa Clara County Public Health Department, Stanford Health Care, Saint Louise Regional Hospital, Sutter Health

[viii] SHC selection criteria: supported by primary data (community input) and secondary data; misses a benchmark (Healthy People 2020 or California state average); cuts across both San Mateo and Santa Clara counties; affects a relatively large number of individuals; is one in which SHC has the required expertise as well as the human and financial resources to make an impact; disparities or inequalities exist

IX. 2020 COMMUNITY BENEFIT PLAN

This plan represents a continuation of a multi-year strategic investment in community health. SHC believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2019 CHNA process.

SHC's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations effected by health disparities. To accomplish this goal, all community health investment from FY20 – FY22 will improve access to and delivery of care, housing and homelessness, and economic security through community and hospital-based programs and partnerships.

A. Access to Care

Goal	Strategies	Anticipated Impact
A.1: Improve access to affordable, high-quality health care services for at-risk community members.	▪ Provide financial assistance to reduce health care cost barriers to care for low-income individuals ▪ Increase health insurance coverage[i] ▪ Support care coordination interventions[ii, iii, iv, v, vi, vii, viii, ix] ▪ Support capacity-building opportunities[x, xi, xii] ▪ Support physical and technology infrastructure improvements[v] ▪ Support initiatives to improve affordability of health care services[xiii] ▪ Support direct services related to behavioral health, diabetes and obesity, and oral health[ii, viii, ix, xiv, xv, xvi, xvii, xviii, xix, xx, xxi, xxii, xxiii, xxiv, xxv, xxvi, xxvii, xxviii]	◆ Improved health outcomes, particularly related to health disparities, behavioral health, diabetes and obesity, and oral health-related conditions ◆ Reduced avoidable emergency department and hospital utilization ◆ Improved access to medical home ◆ Increased use of medical home, including preventive care services ◆ Reduced health care cost barriers for vulnerable populations ◆ Improved health insurance rates

B. Housing and Homelessness

Goal	Strategies	Anticipated Impact
B.1: Improve the health of those at-risk of and/or experiencing homelessness.	▪ Improve access to health care for those at-risk of and/or experiencing homelessness[xxix, xxx, xxxi, xxxii] ▪ Improve access to social services to support immediate health care needs and upstream health influencers[xxxiii, xxxiv] ▪ Advocate for policy change to improve health outcomes for those at-risk of and/or experiencing homelessness	◆ Improved health outcomes for those at-risk of and/or experiencing homelessness
B.2: Improve housing stability for those at-risk of and/or experiencing homelessness.	▪ Increase in efficient and effective community-based resources ▪ Address the physical and behavioral health-conditions that contribute to housing instability among those at-risk of and/or experiencing homelessness, including mental health and substance use issues ▪ Increase affordable and/or permanent supportive housing[xxix, xxxv, xxxvi] ▪ Provide financial assistance related to housing and/or utility costs[xxxvii, xxxviii] ▪ Support displacement avoidance interventions[xxxix, xl, xli] ▪ Improve sub-standard living conditions, including overcrowding[xlii, xliii, xliv] ▪ Advocate for policy change to positively impact housing and homelessness-related issues across San Mateo and Santa Clara counties	◆ Reduced homelessness across San Mateo and Santa Clara counties ◆ Increase in social services that are co-located within affordable housing sites ◆ Reduced proportion of overcrowded, sub-standard dwellings ◆ Increase in affordable and/or permanent supportive housing units

C. Economic Security

Goal	Strategies	Anticipated Impact
C.1: Increase access to high-quality, healthy foods for vulnerable populations.	▪ Expand access to food access programs specifically addressing health care-related food access (i.e., food pharmacy, medically tailored meals, meals on wheels, etc.)[xlv] ▪ Increase food security screening programs[xlvi, xlvii xlviii, xlix, l] ▪ Expand capacity of existing food access programs[li, lii] ▪ Increase food security screening programs[liii, liv, lv, lvi, lvii] ▪ Advocate for policy change to improve local food security for those at-risk of and/or experiencing food insecurity	◆ Improved associated health outcomes ◆ 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
C.2: Reduce transportation-related barriers to good health and quality of life	▪ Increased capacity of existing transportation programs for vulnerable populations[lviii] ▪ Increase transportation options to/from health care appointments and services ▪ Increase transportation options to/from activities supporting healthy, active lifestyle ▪ Increase transportation options for daily living activities for individuals at-risk of and/or experiencing homelessness	◆ Improved associated health outcomes ◆ Decrease in health care access transportation barriers ◆ For high-risk populations, decrease in transportation barriers for daily living activities supporting good health and quality of life

Goal	Strategies	Anticipated Impact
	▪ Advocate for policy change to improve local transportation barriers for vulnerable populations	
C.3: Reduce barriers to high-quality employment.	▪ Increased workforce-related educational attainment and/or job training[lix, lx, lxi, lxii] ▪ Increased supply of high-quality, affordable child care[lxiii, lxiv] ▪ Improved financial literacy and self-sufficiency among economically insecure community members[lxv, lxvi] ▪ Advocate for policy change to improve economic security for vulnerable populations	◆ Improved associated health outcomes ◆ Improved health insurance rates ◆ Reduced poverty rates in San Mateo and Santa Clara counties ◆ Reduced unemployment rates ◆ Reduced California Self-Sufficiency Standard disparity ◆ Reduction of pay disparities

X. EVALUATION PLANS

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

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

2020 COMMUNITY BENEFIT PLAN ENDNOTES

[i] 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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