Stanford Health Care Fiscal Years 2023–2025 Implementation Strategy

GENERAL INFORMATION

Contact Person: Years the Plan Refers to:	Colleen Johnson Fiscal Years 2023–2025
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I. ABOUT STANFORD HEALTH CARE

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

SHC is creating new delivery models, leveraging advanced resources to create seamless continuity of care for every patient. From its suite of virtual care services to its primary and specialty care offices throughout the Bay Area, SHC offers people from across the region and around the world comprehensive solutions to meet all of their health care needs.

At the center of the SHC health system is one of the most advanced hospitals in the world. The new Stanford Hospital, opened in late 2019, makes SHC's bold vision for compassionate, coordinated, personalized, and leading-edge care a reality for more people than ever before.

II. SHC'S SERVICE AREA

SHC is a regional referral center for an array of adult specialties, drawing patients from 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 live in San Mateo and Santa Clara counties. For the purposes of its community benefit initiatives, SHC has identified these two counties as its target community. While SHC's primary community benefit service area spans these two counties, SHC also supports community health needs across a nine-county network of care.

San Mateo County comprises 19 cities and more than two dozen unincorporated towns and areas. It is far less populous than Santa Clara County, with approximately 746,752 residents in 2019. Daly City is San Mateo County's largest city by population, with just over 106,000 people (14% of the total). The population of the county is substantially denser than the state, with 9,206 people per square mile compared to 8,486 per square mile in California. The median age in San Mateo County is 40.3 years. Over 20% of the county's residents are under the age of 18, and nearly 16% are 65 years or older. Among the population aged 75 and older, more than two in five (46%) are living with a disability.

Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2019, approximately 1.92 million people lived there, making it the sixth largest county in California by population. San José is its largest city, with over 1.02 million people (53% of the total). The population of the county is substantially denser than the state, with 9,115 people per square mile compared to

8,486 per square mile in California. The median age in Santa Clara County is 38.1 years. More than 22% of the county's residents are under the age of 18, and over 13% are 65 years or older. Among the population aged 75 and older, nearly half (48%) are living with a disability.[a]

The ethnic makeup of both counties is extremely diverse. In total, the non-white population of San Mateo County represents about 62% of its total population, while 70% of Santa Clara County's total population is non-white. About 4% of people in both counties' communities are uninsured.

More than 34% of community members in San Mateo County and more than 39% of community members in Santa Clara County are foreign-born. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[a]

Two key social determinants, income and education, are closely connected[b] and have a significant impact on health outcomes, including poor birth outcomes, functional health (hearing, vision, and speech), asthma, obesity, and mental health.[c] Both counties not only earn some of the highest annual median incomes in the U.S. but also bear some of the highest costs of living. Median household incomes are $130,820 in San Mateo County and $129,210 in Santa Clara County, both far higher than California's median of $82,053.

However, the California Self-Sufficiency Standard,[d] set by the Insight Center for Community Economic Development, suggests that at least 40% of households in San Mateo and Santa Clara counties are unable to meet their basic needs.[e] (For a family with two children, the 2021 standard was $166,257 in San Mateo County and $144,135 in Santa Clara County.) The minimum wage in San Mateo County was $14–$15.90 per hour in 2021 and in Santa Clara County was $14–$16.30 per hour, where self-sufficiency requires an estimated $34–$39 per hour.[e, f] California Self-Sufficiency Standard data show a 26% increase in the cost of living in San Mateo County and a 27% increase in Santa Clara County

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[a] Census data in prior paragraphs from https://www.census.gov/quickfacts

[b] Vilorio, D. (2016). Education matters. *Career Outlook.* U.S. Bureau of Labor Statistics, March 2016.

[c] Gupta, R.P., de Wit, M.L., & McKeown, D. (2007). The impact of poverty on the current and future health status of children. *Pediatric Child Health.* 12(8): 667–672.

[d] 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.

[e] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org/node/44

[f] **San Mateo County:** Bay City News Foundation. (2021). Several San Mateo County cities hike minimum wage for 2021. *The Daily Journal*. Retrieved from https://www.smdailyjournal.com/news/local/several-san-mateo-county-cities-hike-minimum-wage-for-2021/article_47e4717a-4f0b-11eb-ac74-6fa7c18ed062.html

Santa Clara County: Alaban, L. (2021). Minimum wage goes up in South Bay -- with mixed reaction. *San José Spotlight.* Retrieved from https://sanjosespotlight.com/minimum-wage-in-san-jose-goes-up-splitting-business-and-economic-leaders/

between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 5.4% per year average increase in wages in the San José-Sunnyvale-Santa Clara metropolitan area between 2018 and 2020.[e,g]

In 2021, the median home price was $1.6 million and the median rent was $2,451 in San Mateo County; this compares to $1.4 million and $2,374 in Santa Clara County.[h] In both counties, 26% of children are eligible for free or reduced-price lunch and close to one quarter of children live in single-parent households (22% of children in San Mateo County and 23% of children in Santa Clara County). The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30% of a household's annual income. People who spend more than that on rent or mortgage are less able to pay for other necessities, such as clothing, food, medical care, child care, and transportation.[i]

> *"The way I see it play out, both in my administrative role and also my clinical role, is that people will continue to prioritize their …ability to actually put food on the table above their health. And we see that play out in a myriad of different ways, including the negative outcomes on their health."*
>
> *– Safety Net Clinic Medical Director, focus group participant*

The Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, indicates that both counties' populations overall are healthier than the national average.[j] Although San Mateo and Santa Clara counties are quite diverse and have substantial resources, there is significant inequality in their populations' social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality,[k] is higher in certain ZIP Codes compared to others.

Certain areas also have poorer access to high-speed internet (e.g., ZIP Codes 95013, 94074), walkable neighborhoods (e.g., ZIP Codes 95002, 94060), or jobs (e.g., ZIP Codes 95020, 94044). The CHNA

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[g] U.S. Bureau of Labor Statistics. (2021). https://www.bls.gov

[h] **San Mateo County:** Redfin. (2021). *San Mateo County Housing Market.* Retrieved from https://www.redfin.com/county/343/CA/San-Mateo-County/housing-market
Santa Clara County: Redfin. (2021). *Santa Clara County Housing Market.* Retrieved from https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market

[i] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*

[j] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while both San Mateo and Santa Clara counties are scored at -0.8. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health, 83*(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

[k] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality.

focused particularly on disparities and inequities within the community rather than simply in comparison to California or the nation as a whole.

III. PURPOSE OF IMPLEMENTATION STRATEGY

This Implementation Strategy Report (IS Report) describes SHC's planned response to the needs identified through the 2022 CHNA process. It fulfills Section 1.501(r)(3) of the IRS regulations governing nonprofit hospitals. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address. Per these requirements, the IS report documents the actions (strategies) SHC intends to take, including the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

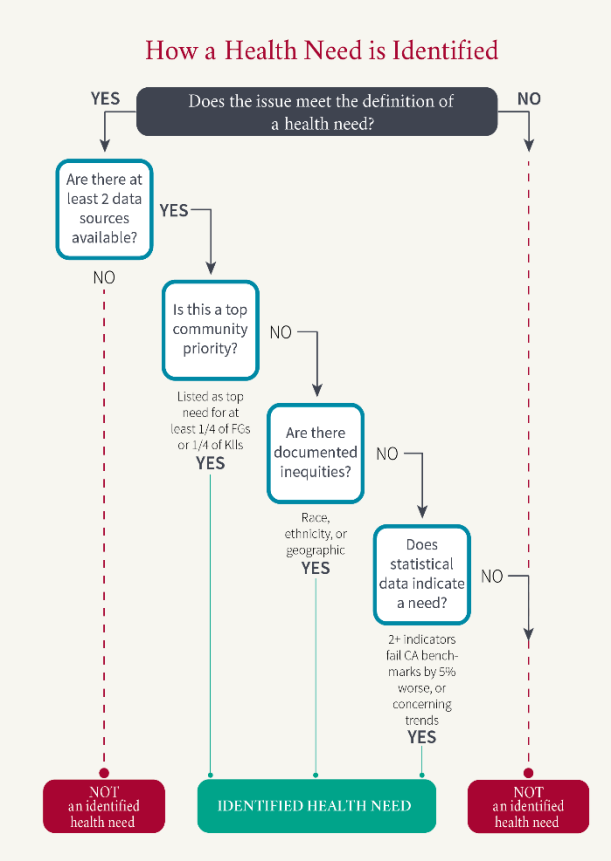
For information about SHC's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html.

IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.

To be considered a health need for the purposes of the 2022 CHNA, the need had to fit the definition of a health need (*see Definitions, next page*), be present in at least two data sources, and be prioritized by key informants or focus groups. A total of 10 health needs were identified in the 2022 CHNA.

Per IRS requirements, Stanford Health Care gathered leaders with knowledge and expertise in local community health needs and trends to prioritize (rank) the health needs list generated from the CHNA. Leaders were presented with the data that support the health needs list and agreed upon certain criteria (*see 2022 Community Health Needs Prioritization Criteria, next page*), all rated on a three-point scale, to prioritize the health needs.



DEFINITIONS

Data source: Either a statistical dataset, such as those found throughout the California Cancer Registry, or a qualitative dataset, such as the material resulting from interviews and focus groups.

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

Health need: A poor health *outcome* and its associated *risk(s)*, or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

Health indicator: A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

2022 COMMUNITY HEALTH NEEDS PRIORITIZATION CRITERIA

- **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. Scores were generated by Actionable Insights (AI) based on CHNA primary data.
- **Lacking sufficient community assets and/or resources.** The IRS requires that hospitals take into consideration whether existing assets/ resources are available to address the issue. Scores were generated by AI based on the number of assets per need in each county.
- **Disparities/inequities exist.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender identity, or others. Scores were generated by experts and leaders based on expertise and knowledge.
- **Multiplier effect.** A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down. Scores were generated by experts and leaders based on expertise and knowledge.

Community health experts and leaders used an online survey to score the needs and AI compiled the results. The needs are presented below in priority order based upon the survey results.

2022 COMMUNITY HEALTH NEEDS LIST

1. **Economic Security**
2. **Housing and Homelessness**
3. **Behavioral Health**
4. **Health Care Access and Delivery**
5. **Diabetes and Obesity**
6. **Maternal and Infant Health**
7. **Climate and Natural Environment**
8. **Community Safety**
9. **Cancer**
10. **Sexually Transmitted Infections**

COVID-19

The CHNA incorporated COVID-19 data in two ways: 1. Statistical data detailing the disease and associated health conditions and 2. Qualitative data provided by community experts and residents. As a novel virus, statistical data was limited when the CHNA was conducted; however, community experts and residents offered ample qualitative data on the economic and social impacts of COVID-19 on local vulnerable communities. SHC will continue to monitor the trends and health impacts while addressing the health care needs of COVID-19.

V. IMPLEMENTATION STRATEGY (IS) DEVELOPMENT

SHC Community Health & Partnerships (CH&P) formed a steering committee, which completed a comprehensive strategic planning process to select the health needs and strategies. The group included experts and stakeholders from across Stanford Medicine (Stanford hospitals and School of Medicine) and the local community.

Stanford Medicine Experts and Stakeholders

- Ambulatory Care
- Community Health & Partnerships
- Community-Engaged Participatory Research
- Health Education, Engagement and Promotion
- Market Development & Outreach
- Nursing Leadership & Research
- Patient Experience
- Primary Care & Population Health
- Quality
- Social Work & Case Management

Community Experts and Stakeholders

- Local Public Health Department
- Community health center, safety-net health care provider
- Social services provider

The CH&P steering committee gathered input from internal and external experts and other stakeholders, considering both the current state of assets in the service area and best practices to address the needs. The strengths and gaps of SHC's existing community benefit strategy were assessed and emerging community health trends and opportunities were considered in strategy development. The committee prioritized community voice and carefully considered the kinds of meaningful impact that SHC could make. SHC leadership will rely on this work to inform organizational planning and resourcing to enhance equity and community benefits moving forward.

Implementation Strategy Process Map

March 2022:

- Understand workgroup objectives, scope, and timeline
- Review 2022 identified health needs with particular attention to community's priorities

April 2022:

- Review 2022 assets dedicated by SHC to strategies addressing community-priority health needs
- Propose increases in/changes to focus of assets based on assessment of current strategies and emerging trends and opportunities
- Prioritize key findings from 2022 CHNA among community-priority health needs

May 2022:

- Review top-priority findings from 2022 CHNA
- Determine where existing SHC strategies are adequate/inadequate
- Discuss how to better address top-priority findings

Early June 2022:

- Further review and refine distribution of 2022 assets dedicated by SHC to strategies addressing community-priority health needs
- Learn about evidence-based and promising strategies to address top-priority findings
- Rank strategies based on committee members' community health expertise
- Select health needs to address based on community's priorities

Late June 2022:

- Review and discuss 2023-2025 draft workplan

- Review and test current SHC grantmaking and partnership guiding principles
- Determine future Community Health & Partnerships plans, including enhancing equitable grantmaking, adopting anchor institution elements, and supporting racial equity and social justice

Actionable Insights, LLC (AI) provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. AI is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. HEALTH NEEDS THAT SHC PLANS TO ADDRESS

A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In the first half of 2022, CH&P steering committee members met five times to review and discuss the information collected for the 2022 CHNA and IS process. *(See Implementation Strategy Process Map, Section V of this report.)* The committee paid special attention to the needs and desires of the community that were identified during the CHNA. Committee members participated in several prioritizing, ranking, and selection exercises to determine which needs SHC would address and what strategies SHC would pursue to address them. In June 2022, CH&P steering committee members, by consensus, selected the five health needs SHC would address as well as their associated strategies. The committee's decisions would form the basis for SHC's FY2023–2025 community benefit and implementation plans:

1. **Access & Delivery of Health Care**
2. **Behavioral Health**
3. **Housing**[l]
4. **Economic Security:**
    - **Income Security**
    - **Food Security**

B. DESCRIPTION OF HEALTH NEEDS THAT SHC PLANS TO ADDRESS

See CHNA report for statistical data tables for each health need described below.[m]

[l] In the CHNA, this need was referred to as "Housing and Homelessness." SHC plans to continue to address homelessness but has updated the title of this health need to "Housing."
[m] For a copy of the 2022 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html

Health Care Access and Delivery

Health care access and delivery, which affects various other community health needs, was identified as a top health need by more than half of the focus groups and over one third of key informants in San Mateo and Santa Clara counties. Experts and community members indicated a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Health care access may be especially problematic for youth in the community: In both counties' schools, the ratio of students to each school nurse substantially exceeds the state ratio. In San Mateo County, the ratio of other primary care providers (i.e., not primary care physicians) is also worse than the state's ratio. In addition, community members in both counties who are Black, Indigenous, or other people of color (BIPOC) experience significantly worse health than community members of other races; for example, a higher rate of preventable hospital stays may be a sign of inequitable access to high-quality care.

Many key informants and focus group participants connected health care access with economic instability. For example, some mentioned that low-income community members might be required to prioritize rent and food over health care. Some reported that low-income and undocumented community members especially have difficulty accessing insurance. Affordability, both of insurance premiums and of health care itself, especially preventive care, was a particular concern; in SHC's 2019 CHNA report, community members of Latinx and "Other" ancestries[n] in both counties were significantly less likely to have health insurance than others. In 2021, CHNA participants identified the lack of information about health care costs for patients as another barrier to accessing care.

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide (in which some have easy access to computers and the Internet, while others experience barriers, usually due to income constraints) and patients' lack of privacy. They also expressed concern about the lower reimbursement rate for telephone appointments (i.e., without video). Once in-person appointments were more common again, transportation returned as a barrier to care for those living on the Coastside.

Key informants and focus group participants expressed a common theme of the need for health care workforce training to deliver care in a sensitive manner. Training areas identified included: a) LGBTQ+ sensitivity and education about issues specific to the population, b) trauma-informed care, and c) greater respect/efforts for patients with mental health issues, who are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included the education of health care workers around public charge issues and the need for more providers who speak patients' languages. More than one

[n] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.

in ten Santa Clara County community members speak limited English, compared to fewer than one in ten in San Mateo County and in California overall. Limited English proficiency can restrict health care access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility to retain coverage were specific concerns. Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to health care among these groups.

Access issues related to oral health arose as well. An oral health expert described the lack of preventive dental care for low-income and underserved populations as a driver of poor access and suggested integrating oral health care into whole-person care to improve access. Other data from SHC's 2019 CHNA suggest that Santa Clara County's adults were more likely to experience dental decay than Californians overall and had a higher rate of emergency department visits for non-traumatic dental conditions than the state rate.

Behavioral Health

Behavioral health, which includes mental health and trauma, as well as substance use and domestic violence, ranked high as a health need, being prioritized by three quarters of focus groups and more than two thirds of key informants.

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported increased demand for services; however, children and adolescents were of particular concern. The most recent available statistics (dating pre-pandemic) suggest that youth mental health is an issue: students in Santa Clara County have lower access to psychologists at school than students statewide. Perhaps due in part to these access issues, Santa Clara County's self-harm injury hospitalization rate for youth is significantly higher than the state's rate. Experts noted the lack of mental health providers and addiction services overall, especially those providing services in non-English languages.

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data before the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic. Drug overdose deaths have been rising in both counties.

Statistics suggest disparities associated with behavioral health. For example, drug overdose deaths among San Mateo and Santa Clara counties' Black populations occur at nearly twice the rate as all Californians. Both counties' white suicide rate for all ages remains persistently higher than the state rate. Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[o] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[p] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10–17) are substantially higher for Black and Latinx youth in both counties than for California youth overall.

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services, and there are very few inpatient psychiatric beds for acute/high needs. Experts stated that services for people without health insurance can be expensive and difficult to access.

Housing

More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo and Santa Clara counties are extremely high. Both counties' median home rental costs are more than 40% higher than the median state home rental cost. The home ownership affordability indices[q] for both counties

[o] McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, *27*(2), 393–403. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

[p] Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

[q] The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median

are substantially worse than for the state overall. Moreover, while homeowners statewide are spending approximately just under one third of their income on their mortgages, homeowners in San Mateo and Santa Clara counties are exceeding that.

Most feedback about housing from key informants and focus group participants concerned housing affordability. CHNA participants reported the difficulty that individuals in poverty, described as more likely to be BIPOC, have in finding affordable housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. In both counties, homelessness rose in 2019 (the most recent homeless count). Experts noted that during COVID-19, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

Other CHNA participants said high housing costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID-19. However, housing quality is also a concern; for example, children and young adults aged 6–20 years in Santa Clara County have worse blood lead levels than California children overall.

Economic Security

Nearly all focus groups and over three quarters of all key informants identified economic security, one of the most widely recognized social determinants of health, as a top community priority. Based on the quantitative and qualitative data gathered during the 2022 CHNA, this need is comprised of income security and food security, each of which are described separately below.

Income Security

Data available on economically precarious[r] households shows that while half of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion is higher among households in both San Mateo and Santa Clara counties. Economic precariousness can force people to choose between paying rent and accessing health care; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

valued home." See Krivacsy, K. (2018). The delicate balance between housing affordability, growth, and income. *ESRI ArcGIS Blog*, December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

[r] Dimensions of economic precariousness, which include income insecurity, low occupational mobility, unemployment, part-time work, and lack of access to social welfare benefits, were first laid out by Berrington, A., Tammes, P., & Roberts, S. (2014). *Measuring economic precarity among UK youth during the recession.* ESRC Centre for Population Change, Briefing 22. Retrieved from https://eprints.soton.ac.uk/372557/1/BP22_Measuring_economic_precarity.pdf

Income inequality in Silicon Valley is 1.5 times higher than the state level. Educational attainment generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English-language arts standards compared to California 11th graders overall. Also, smaller percentages of both counties' Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of both counties' Black, Latinx, and Pacific Islander high school graduates, and San Mateo County's Filipinx high school graduates, completed college-preparatory courses than high school graduates statewide. The high school drop-out rate is particularly high among Santa Clara County's Latinx youth, about double all California youth. In SHC's 2019 CHNA report, we described similar inequities in educational attainment.

Qualitative data showed that COVID-19 created more income insecurity for those who lost work and specifically impacted low-income workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that community members often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also "overrepresented in both frontline and hardest-hit sectors" of the economy.[s] Before the pandemic, the cost of childcare may also have been a limiting factor in ability to work; the annual costs of infant childcare (ages 0–2) and pre-K childcare (ages 3–5) were substantially higher in both counties than the state average.

Food Insecurity

There is known to be a link between food insecurity and poor health.[t] The percentages of food-insecure people in San Mateo and Santa Clara counties increased between 2019 and 2020. In San Mateo County, the food-insecure population grew from 6.6% in 2019 to 7.1% in 2020, while in Santa Clara County, the figure increased from 7.3% to 7.5%.[u] Although not as high as the state percentages in either year (10.2% in 2019 and 9.1% in 2020), this trend is still of concern. According to 2022 CHNA key informants and focus group participants, food insecurity worsened in both counties during the pandemic.

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[s] Bohn, S., Cuellar Mejia, M., & Lafortune, J. (2021). *Multiple challenges for women in the COVID-19 economy.* Public Policy Institute of California. Retrieved from https://www.ppic.org/blog/multiple-challenges-for-women-in-the-covid-19-economy/

[t] Gundersen, C. & Ziliak, J.P. (2015). Food insecurity and health outcomes. *Health Affairs*, 34(11), 1830–1839.

[u] Feeding America. (2022). *Food Insecurity among Overall (all ages) Population in the United States.* Retrieved from https://map.feedingamerica.org

Data prior to the pandemic indicated that child fruit and vegetable consumption was lower in both San Mateo and Santa Clara counties than at the state level. Published studies indicate that low fruit and vegetable consumption among children is associated with food insecurity.[v]

In SHC's 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Food insecurity data for 2020 are available by race/ethnicity for Black, Latinx, and white populations. In San Mateo County, 13% of the Black and Latinx populations are food-insecure, compared with only 2% of the white population. In Santa Clara County, 15% of the Black population and 13% of the Latinx population is food-insecure, compared with 5% of the white population. These data show similar patterns to the data in the 2019 CHNA report. In the past, CHNA participants have expressed concern about undocumented immigrants' ineligibility for the Supplemental Nutrition Assistance program (SNAP) and similar federal programs.

The majority (over 80%) of SNAP redemption occurs at large grocery stores, supermarkets, and supercenters.[w] While grocery store access was better in both counties than it was statewide, access to supercenters and club stores was lower in Santa Clara County and much lower in San Mateo County than in California overall.

VII. SHC'S IMPLEMENTATION STRATEGY

> *"Hospitals are components of a larger ecosystem… as health care providers, they can be instrumental in eliminating racial disparities within clinical settings, and as anchor institutions, they can be socially impactful — using their business models to create opportunity and stimulate investments in historically marginalized communities."*[x]

SHC's annual community benefit investment focuses on improving the health of the community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, all community health investments from FY2023–FY2025 will improve access to and delivery of care, access to behavioral health care, and will

[v] See, for example, Dave, J. M., Evans, A. E., Saunders, R. P., Watkins, K. W., & Pfeiffer, K. A. (2009). Associations among food insecurity, acculturation, demographic factors, and fruit and vegetable intake at home in Hispanic children. *Journal of the American Dietetic Association*, 109(4), 697-701.

[w] U.S. Department of Agriculture, Food and Nutrition Service. (2020). *Fiscal Year 2019 Year End Summary.* See also Rhone, A., Ver Ploeg, M., Dicken, C., Williams, R. & Breneman, V. (2017). *Low-Income and Low-Supermarket-Access Census Tracts, 2010–2015, EIB-165*. U.S. Department of Agriculture, Economic Research Service. Retrieved from https://www.ers.usda.gov/webdocs/publications/82101/eib-165.pdf?v=0

[x] King, C. J., & Redwood, Y. (2016). The health care institution, population health and Black lives. *Journal of the National Medical Association*, 108(2), 131-136.

address housing, income security, and food security through community and hospital-based programs and partnerships. The efforts will inform planning and resourcing of broader organizational equity initiatives and community benefits moving forward.

The FY2023 - 2025 implementation plan is a continuation of a multi-year strategic investment in community health. SHC believes that long-term funding of proven community partners that are implementing evidence-based or promising practices improves the health and well-being of community members. Documented community health needs continue to inform the plan. Modifications to the plan are the result of new data and information collected during the 2022 CHNA process.

A. HEALTH CARE ACCESS AND DELIVERY

Key CHNA Findings:

- Fewer primary and specialty care providers than California 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	Health Care Access and Delivery Strategies	Anticipated Impact
A.1 Improve access to affordable, high-quality health care services for at-risk community members	i. Provide financial assistance to reduce health care cost barriers to care for low-income individuals.	a. Reduced health care cost barriers for vulnerable populations b. Increased use of medical home, including preventive care services c. Improved affordability of health care services
	ii. Increase health insurance coverage.[1]	a. Improved health insurance rates b. Reduced avoidable emergency department and hospital utilization c. Improved access to medical home d. Increased use of medical home, including preventive care services e. Improved affordability of health care services
	iii. Support care coordination interventions.[2, 3, 4, 5, 6]	a. Reduced avoidable emergency department and hospital utilization b. Improved access to medical home c. Improved health outcomes, particularly related to health disparities d. Improved housing and economic security by addressing physical health conditions that contribute to housing instability

Goal	Health Care Access and Delivery Strategies	Anticipated Impact
	iv. Support capacity-building opportunities.[7, 8, 9]	a. Reduced avoidable emergency department and hospital utilization b. Improved access to medical home
	v. Support initiatives that address telehealth challenges and physical and technology infrastructure improvements.[4, 10,11, 12, 13, 14, 15, 16, 17, 18, 19]	a. Improved equitable access to telehealth b. Reduced avoidable emergency department and hospital utilization c. Improved access to medical home d. Increased use of medical home, including preventive care services e. Improved health outcomes, particularly related to health disparities
	vi. Support initiatives that address culturally competent and compassionate/respectful care.[20, 21, 22, 23, 24, 25]	a. Improved health outcomes, particularly related to health disparities

B. BEHAVIORAL HEALTH

Key CHNA Findings:

- Access to mental health care and substance use treatment 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 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	Behavioral Health Strategies	Anticipated Impact
B.1 Improve access to affordable, high-quality mental/behavioral health care services	i. Support integrated mental health and substance use services/treatment for co-occurring mental illness and addiction.[26, 27]	a. Improved access to mental/behavioral health programs and services b. Increased proportion of community members served with effective mental/behavioral health services c. Improved coordination of mental/behavioral health services d. Improved mental/behavioral health among those served e. Improved housing and economic security by addressing the behavioral health conditions that contribute to housing instability
	ii. 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]	a. Improved access to mental/behavioral health programs and services b. Increased proportion of community members served with effective mental/behavioral health services
	iii. 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]	a. Increased rate of mental/behavioral health providers per 100,000 community residents

Goal	Behavioral Health Strategies	Anticipated Impact
		b. Reduced attrition of mental/behavioral health providers c. Increased diversity of mental/behavioral health providers
	iv. Support programs that assist individuals recovering from addiction to transition back into the community.[44, 45]	a. Reduced housing instability among individuals with mental illness/substance addiction
B.2 Improve outcomes of encounters between mentally ill individuals and law enforcement	i. Support programs that pair health professionals trained in mental/behavioral health crisis response with law enforcement or other security professionals.[46, 47, 48, 49]	a. Improved outcomes of encounters between mentally ill individuals and law enforcement

C. HOUSING

Key CHNA 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	Housing Strategies	Anticipated Impact
C.1 Reduce housing instability among community members to support improved health	i. Support programs that expand affordable housing opportunities (rental and ownership), including those on existing residential properties.[50, 51, 52, 53]	a. Improved access to stable housing for low-income individuals across San Mateo and Santa Clara counties b. More community members remain independent longer c. Reduced proportion of individuals who are housing insecure
	ii. 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]	a. Increased access to social services to prevent homelessness b. More community members remain independent longer c. Reduced proportion of individuals who are housing insecure
	iii. Support integrated case management programs that link high-risk individuals with housing.[57, 58, 59, 60, 61, 62]	a. Increased access to social services to prevent homelessness b. Reduced proportion of individuals who are housing insecure
	iv. Programs that assist disabled individuals and older adults with housing placement and coordinated case management to remain in their communities.[63]	a. More community members remain independent longer

Goal	Housing Strategies	Anticipated Impact
		b. Reduced proportion of individuals who are housing insecure
	v. Address affordable housing issues via investment.[64]	a. Reduced poverty rates in San Mateo and Santa Clara counties b. Improved associated health outcomes
	vi. Increase screening efforts for social determinants of health (e.g., safe housing).[65, 66, 67, 68]	a. Identification of greater proportion of housing-insecure individuals in San Mateo and Santa Clara counties b. Improved access to stable housing for low-income individuals across San Mateo and Santa Clara counties c. Reduced proportion of individuals who are housing insecure

D. INCOME SECURITY

Key CHNA 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	Income Security Strategies	Anticipated Impact
D.1 Reduce barriers to employment/careers that provide community members with a living wage	i. Support efforts to increase workforce-related educational attainment and/or job training.[69, 70, 71, 72, 73, 74, 75, 76,, 77, 78, 79, 80]	a. Reduced unemployment rates b. Improved health insurance rates c. Reduced poverty rates in San Mateo and Santa Clara counties d. Reduced California Self-Sufficiency Standard disparity e. Reduction of pay disparities
	ii. Support Guaranteed Basic Income pilots.[81, 82]	a. Reduced poverty rates in San Mateo and Santa Clara counties b. Reduced unemployment rates c. More people earning a living wage d. Reduced economic insecurity e. Improved associated health outcomes
	iii. 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]	a. Reduced unemployment rates b. More people earning a living wage c. Reduced economic insecurity

E. FOOD SECURITY

Key CHNA Findings:

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

Goal	Food Security Strategies	Anticipated Impact
E.1 Reduce food insecurity and increase healthy food access for low-income community members	i. 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]	a. Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties b. Improved associated health outcomes
	ii. Increase screening efforts for social determinants of health (e.g., food security).[65, 68, 90, 91, 92, 93, 94]	a. Identification of greater proportion of food-insecure individuals in San Mateo and Santa Clara counties b. Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties c. Reduced proportion of individuals who are food insecure
	iii. 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]	a. Improved access to healthy food for low-income individuals across San Mateo and Santa Clara counties b. Increased proportion of low-income individuals in San Mateo and Santa Clara counties who eat three meals per day c. Reduced proportion of individuals in San Mateo and Santa Clara counties experiencing poor health outcomes that are a result of food insecurity d. Reduced proportion of individuals who are food insecure e. Reduced diabetes/obesity rates

VIII. EVALUATION PLANS

Inequitable health and economic outcomes can be attributed, in part, to structural and institutional racism.[z] SHC, through its community benefit efforts, is committed to addressing such disparities that derive from racism. As part of SHC's ongoing community health improvement efforts, SHC partners with local safety net providers and community-based nonprofit organizations to invest in programs and projects that address community health needs identified through the triennial CHNA. Community grant funding supports organizations and programs with a demonstrated ability to deliver services that address the selected health need to improve the health status particularly amongst vulnerable, medically underserved, and other populations experiencing health disparities, through data-driven solutions and results. Grantees provide community-level data in the form of a health needs statement to justify the need for the grant-funded program and provide programmatic data to demonstrate the effectiveness of the proposed program strategies.

RACISM & 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.[y] This implementation strategy plan considers systemic racism as a root cause of racial and ethnic health inequities, which are detailed in the health need descriptions in Section IV of this report.

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 awarded, amount of dollars spent, and number of community members reached/served. Additionally, SHC will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees will report mid-year and year-end performance on annual outcomes metrics, which will be shared broadly with the public as well as state and federal regulatory bodies.

IX. HEALTH NEEDS THAT SHC DOES NOT PLAN TO ADDRESS

As described in Section VI(A) of this report, the CH&P steering committee recommended addressing a set of health needs that would best support the community SHC serves, considering SHC's expertise

[y] Centers for Disease Control and Prevention (CDC). (2021). *Racism and Health*. Retrieved from https://www.cdc.gov/healthequity/racism-disparities/index.html

[z] Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, 389(10077), 1453-1463. Retrieved from https://med.emory.edu/departments/human-genetics/dei/documents_images/documents/lancet_2017_structural-racism-and-health-inequities.pdf

and resources. The remaining health needs did not meet these criteria to the same extent as the selected needs; therefore, SHC does not plan to address them at this time.

Cancer: This need was of lower priority to the community than the other health needs. SHC's Stanford Medicine Cancer Center is part of the Stanford Cancer Institute, a National Cancer Institute-designated comprehensive cancer center; rather than choosing to address cancer through community benefit, SHC will continue to serve its cancer patients and conduct pioneering cancer research through the Stanford Cancer Institute.

Climate and Natural Environment: This need was of lower priority to the community than the other health needs. The CH&P steering committee determined that this area was out of SHC's core competencies and that significant impact could not be made when compared to other health needs that the community prioritized.

Community Safety: This need was of lower priority to the community than the other health needs. Although SHC lacks the expertise to address this health need, behavioral health issues such as substance use, stress, and anxiety have been shown to be drivers of bullying and violence. Thus, SHC believes that initiatives intended to address the community's behavioral health need have the potential to address community safety as well.

Diabetes and Obesity: This need was of lower priority to the community than the other health needs. SHC plans to address access and delivery to health care in addition to food security, both of which can be drivers of diabetes and obesity, through a subset of its strategies underlying food security, one of the five health needs SHC chose to address.

Maternal and Infant Health: This need was of lower priority to the community than the other health needs. In addition, this need better aligns with Lucile Packard Children's Hospital-Stanford's expertise in maternal and infant health, and was selected by that hospital.

Sexually Transmitted Infections: SHC is better positioned to address drivers of this need through initiatives related to health care access and delivery. Additionally, this need was of lower priority to the community than the other health needs.

APPENDIX 1: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST

Section §1.501(r)(3)(c) of the Internal Revenue Service code describes the requirements of the Implementation Strategy Report.

Federal Requirements Checklist	Regulation Subsection Number	Report Section
The Implementation Strategy is a written plan which includes:		
(1) Description of **how the hospital facility plans to address** the health needs selected, including:	(c)(2)	VII
Actions the hospital facility intends to take and the anticipated impact of these actions	(c)(2)(i)	VII
Resources the hospital facility plans to commit	(c)(2)(ii)	VII
Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need	(c)(2)(iii)	VII
(2) Description of why a hospital facility is **not addressing** a significant health need identified in the CHNA. *Note: A "brief explanation" is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need.*	(c)(3)	IX
(3) For those hospital facilities that adopted a joint CHNA report, a **joint implementation strategy** may be adopted which meets the requirements above. In addition, the joint implementation strategy must:	(c)(4)	N/A
Be clearly identified as applying to the hospital facility;	(c)(4)(i)	N/A
Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and	(c)(4)(ii)	N/A
Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility.	(c)(4)(iii)	N/A
(4) An authorized body **adopts the implementation** strategy on or before January 15th, 2023, which is the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.	(c)(5)	General Information
Exceptions: Our hospital does not qualify for any exception described in Section (D) for acquired, new, transferred, and terminated facilities.	(d)	N/A

APPENDIX 2: ENDNOTES

[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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[6] Health and Medicine Division of the National Academies of Sciences, Engineering, Medicine. (2011). *Report brief: Improving access to oral health care for vulnerable and underserved populations.* Retrieved from: http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations/Report-Brief.aspx

[7] Increasing community health center capacity works best when paired with efforts to increase health insurance coverage. See Hadley, J., & Cunningham, P. (2004). Availability of safety net providers and access to care of uninsured persons. *Health services research*, *39*(5), 1527-1546. See also Cunningham, P., & Hadley, J. (2004). Expanding care versus expanding coverage: how to improve access to care. *Health Affairs*, *23*(4), 234-244.

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