STANFORD HEALTH CARE
COMMUNITY HEALTH AND PARTNERSHIPS PROGRAM

Fiscal Years 2026–2028 Implementation Strategy

Improving health. Advancing equity.

Stanford Health Care Implementation Strategy

Fiscal Years 2026–2028

GENERAL INFORMATION

Contact Person:	
Years the Plan Refers to:	Fiscal Years 2026–2028
Date Written Plan Was Adopted by Authorized Governing Body:	January 21, 2026
Authorized Governing Body that Adopted the Written Plan:	Stanford Health Care Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	Stanford Health Care EIN 94-6174066
Address of Hospital Organization:	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305-5547

TABLE OF CONTENTS

I. About Stanford Health Care 4
II. Community Served 6
III. Purpose of Implementation Strategy 10
IV. List of Community Health Needs Identified in the 2025 CHNA 11
V. Implementation Strategy (IS) Development 13
VI. Health Needs that SHC Plans to Address 13
A. Process and Criteria Used to Select Heath Needs 13
B. Description of Health Needs That SHC Plans to Address 14
Access to Care 15
Mental and Behavioral Health 18
Economic Stability 21
VII. SHC's Implementation Strategy 25
Access to Care 26
Mental and Behavioral Health 28
Economic Stability 30
VIII. Evaluation Plans 32
IX. Health Needs that SHC Does Not Plan to Address 32
Appendix 1: Implementation Strategy Report IRS Checklist 34
Appendix 2: Demographics by Individual County: Alameda County 36
Appendix 3: SHC's Implementation Strategies Tables 40
Appendix 4: Strategies Research Citations 42
Access to Care 42
Mental and Behavioral Health 44
Economic Stability 47

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.

Stanford Health Care in the Community: Beyond Hospital Walls

Community Health Needs Assessment

Stanford Health Care's triennial community health needs assessments guides strategy and decision-making, using primary and secondary data collection methods. Its hallmark is capturing community voice, particularly of the most vulnerable community members.

Community Partnerships

Stanford Health Care partners with community-based organizations addressing identified health needs to co-create and implement interventions that deliver long-term, sustainable, impactful solutions to improve community health and well-being.

Communication

Stanford Health Care fosters and engages in bi-directional communication with the community. This communication measures and ensures accountability and impact.

Community Health Improvement Services

- Community health education programs
- Patient financial advocacy
- Healthy lifestyles programs for seniors
- Sexual Assault Response Team
- Stanford Health Library
- Supportive care programs (e.g., for cancer)

Financial and In-Kind Contributions

- Community clinic capacity building/ support
- Community health improvement grants
- Fundraising support for nonprofits
- Community health improvement
- Charity Care and Financial Assistance

Subsidized Health Services

- Stanford Life Flight
- Community-based second opinion services

Research: Equity and Care Delivery

- Research into improved care delivery and better health outcomes

Donations of Equipment, Supplies & Food

- Donating essential equipment, supplies and food to nonprofit organizations

Staff Community Service & Volunteerism

- Community service initiatives for staff via partnerships with local nonprofits
- Employee Resource Groups' community service activities

Health Professions Education & Workforce Development

- Resident physician, fellow, and medical student education costs
- Nurse & allied health professions training
- Workforce development opportunities

Government Affairs & Public Health Advocacy

- Monitor and advocate for public health
- Mobilize expertise of the Stanford community in support of regional, state and national initiatives

II. COMMUNITY SERVED

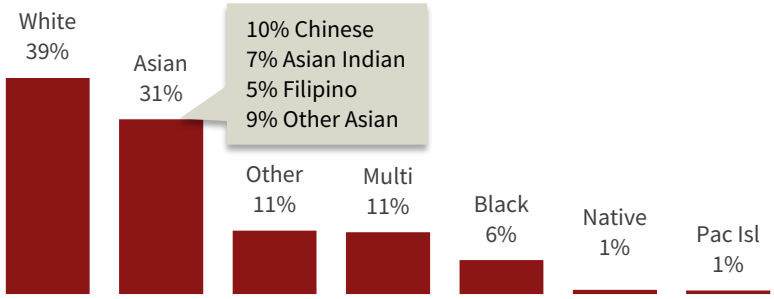
As an academic health system and leading teaching and research facility, Stanford Medicine provides primary care and highly specialized health care for adult and pediatric patients from throughout California, across the country, and around the globe. Stanford Medicine integrates a premier medical school, three world-class hospitals (Stanford Health Care, Stanford Health Care Tri-Valley, and Lucile Packard Children's Hospital), a network of community-based physician offices, virtual care offerings, and health plan programs. As the adult health care provider of Stanford Medicine, Stanford Health Care clinical locations are based in the San Francisco Bay Area and most concentrated across a four-county geographic area of Santa Clara, San Mateo, Alameda and Contra Costa counties. Based on the CHNA findings, Stanford Health Care provides targeted community benefits across this four-county geographic area.

Comprehensive community benefits and needs assessments of the pediatric and maternal populations as well as the Tri-Valley area of Alameda and Contra Costa counties are provided by Stanford Medicine's Lucile Packard Children's Hospital and Stanford Health Care Tri-Valley hospital, respectively.

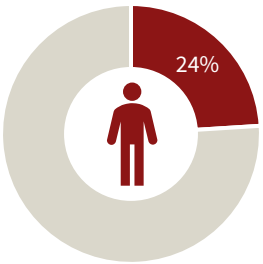
FOUR-COUNTY AREA: ALAMEDA, CONTRA COSTA, SAN MATEO, AND SANTA CLARA COUNTIES

See *Appendix 2: Demographics by Individual County* for more information.

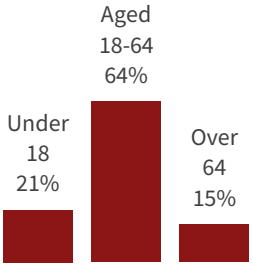
A majority of residents are non-White.



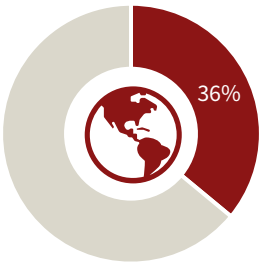
About one-quarter are Hispanic/Latino.



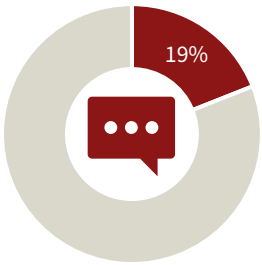
More than one in five residents are children.



Over one-third of residents are foreign-born.



About one in five over age 5 speak limited English.



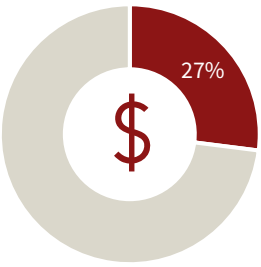
$125,241

household Real Cost Measure (RCM), 4-county average*

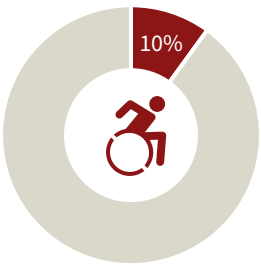
$1.2M

median home sale price, 4-county average

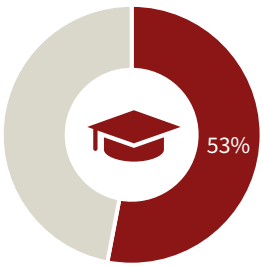
More than one in four households live below the RCM.



One in ten residents lives with a disability.



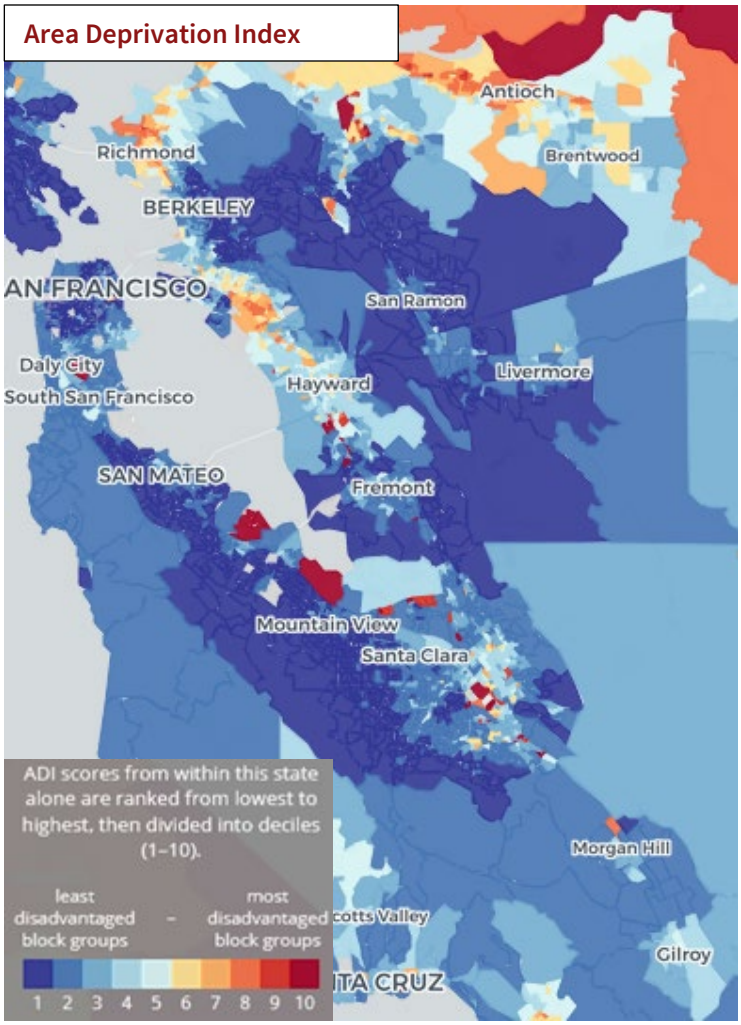
More than half aged 25+ earned at least a Bachelor's degree.



*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

COMMUNITY DISPARITIES

In this assessment of the health needs in the community, there is a focus particularly on disparities and inequities within the community rather than simply in comparison to California or the nation as a whole. The health needs descriptions in Section 6 of this report include discussions of racial, economic, and geographic disparities. As an introduction to these issues, this section reflects on the Area Deprivation Index (ADI), a composite of measures by neighborhood comprised of factors related to social determinants of health, including:[a]



- Educational attainment
- Households without a motor vehicle
- Housing costs
- Housing units without complete plumbing
- Median family income
- Overcrowded housing
- Poverty rate
- Single-parent households
- Unemployment rate

The counties that make up Stanford Health Care's community do much better than California overall. On average, the four counties' combined 5.5 million residents have higher incomes and educational attainment than much of the rest of the state. The counties themselves have substantial resources (see

[a] The Area Deprivation Index ranks each Census block group in deciles from 1 to 10, compared to all other California Census block groups; higher deciles are considered worse. For more information, see originators:

Kind, A.J.H. and Buckingham, W. Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. *New England Journal of Medicine*, 2018. 378: 2456–2458. DOI: 10.1056/NEJMp1802313. PMCID: PMC6051533 and University of Wisconsin School of Medicine and Public Health. 2022 Area Deprivation Index v4. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/ November 2024.

CHNA 2025 report)[b]. However, there are real needs, as can be seen by the notable differences in subcounty ADI metrics (see map above). For example, educational achievement and median income are lower in areas that are colored yellow, orange, and red on the map, including neighborhoods east of Palo Alto and Mountain View, parts of central and east San José, a portion of Morgan Hill, parts of Oakland and Richmond, and in the northeastern area of Contra Costa County near Concord and Antioch. This is in comparison to swaths of the four counties that are the least disadvantaged, shown in dark blue on the map.

The higher the neighborhood's Area Deprivation Index is, the poorer its residents' health outcomes are likely to be. To address these inequities, Stanford Medicine and its hospitals, Stanford Health Care, Stanford Medicine Children's Health, and Stanford Health Care Tri-Valley, are committed to supporting community health improvement through upstream (health-related social needs) and downstream (health condition) interventions.

[b] For a copy of the 2025 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html.

III. PURPOSE OF IMPLEMENTATION STRATEGY

This Implementation Strategy Report (IS Report) describes SHC's planned response to the needs identified through the 2025 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 2025 CHNA process and for a copy of the 2025 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html.

IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2025 CHNA

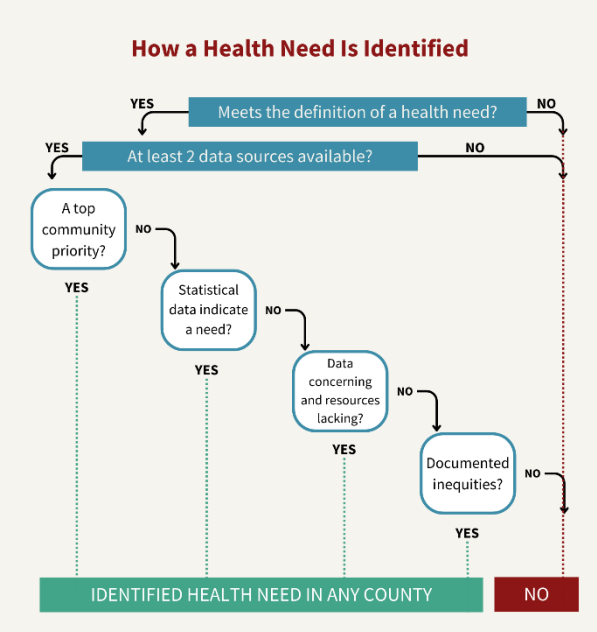
The 2025 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, disproportionalities in health, 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 2025 CHNA, the need had to fit the definition of a health need,[c] be present in at least two data sources, and either be prioritized by multiple key informants and/or focus groups or rise to the list based on statistical data, with at least two direct indicators exhibiting documented differences between groups, failing the benchmark by five percent or more, or showing worsening trends and few supporting resources. The 2025 CHNA identified a total of 14 health needs. The health need selection process is described in Section VI of this report.

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, rated on a three-point scale, to prioritize the health needs.

2025 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 based on CHNA primary data. This criterion was weighted doubly in the prioritization.
- **Disparities/inequities exist.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, economic status, sexual orientation, age, gender identity, or others. Scores were generated by experts and leaders based on expertise and knowledge.



[c] A health need was defined in the CHNA report as a poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome. For further information, see Section 5 of the 2025 CHNA report at https://stanfordhealthcare.org/about-us/community-partnerships.html.

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

2025 Community Health Needs List

1. Economic Stability
2. Behavioral Health
3. Health Care Access and Delivery
4. Health Inequities
5. Community Safety
6. Diabetes and Obesity
7. Climate and Natural Environment
8. Cancer
9. Heart Disease and Stroke
10. Built Environment
11. Sexual Health
12. Communicable Diseases
13. Maternal and Infant Health
14. Respiratory Health

V. IMPLEMENTATION STRATEGY (IS) DEVELOPMENT

SHC Community Health & Partnerships (CH&P) met with its Community Engagement & Partnerships (CE&P) committee, which completed a comprehensive strategic planning process to select the health needs and strategies. (See *Section VI-A: Process and Criteria Used to Select Health Needs* for more information.)The group included experts and stakeholders from across Stanford Medicine (Stanford hospitals and School of Medicine). Because SHC engages in such a wide range of activities in the community, it was crucial to have broad institutional representation.

Stanford Medicine Experts and Stakeholders

- Ambulatory Care
- Community Health & Partnerships
- Division of Medicine
- Emergency Medicine
- Health Equity
- Health Education, Engagement and Promotion
- Hospital Medicine
- Human Resources
- Market Development & Outreach
- Marketing & Communications
- Nursing Strategy
- Office of Government Affairs
- Patient Care Services
- Patient Experience
- Pharmacy
- Primary Care & Population Health
- Quality
- Radiology
- Social Work & Case Management
- Stanford Health Care Tri-Valley
- Stanford Medicine Partners

The CE&P committee reviewed input from internal and external experts and community members, considering both the current state of assets in the service area and best practices to address the needs, including anchor institution-informed approaches. The committee prioritized community voice and carefully considered the kinds of meaningful impact that SHC could make. 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. SHC leadership will rely on these resulting strategies to inform organizational planning and resourcing to enhance equity and community benefits moving forward.

Actionable Insights, LLC provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. Actionable Insights 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 HEATH NEEDS

In the first half of 2025, CE&P committee members met several times to review and discuss the information collected for the 2025 CHNA and IS process, paying special attention to the needs and desires of the community that were identified during the CHNA. Specifically, in February 2025, CE&P committee members were presented with the results of the 2025 CHNA, as well as criteria to rank and select the needs that the community had identified. Committee members then participated in structured exercises to evaluate the identified health needs, rank them, and select the three health needs SHC would address. Ranking criteria involved in needs selection were:

1. Community priority. The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. Scored 3 if prioritized as one of the top five needs by at least one-half (50%) of all focus groups and key informants combined, scored 1 if prioritized as one of the top five needs by 15% or fewer, and scored 2 otherwise.

2. Potential impact on need. SHC can make a meaningful contribution to addressing the need because of its relevant competencies, and/or unique expertise as a health system, and because of an organizational mission/commitment to addressing the need. Scored 3 (substantial differences/strong concern), 2 (moderate differences/some concern), or 1 (minor differences/less concern) by leaders based on expertise and knowledge.

The two scores were summed together, and the top three needs were selected.

In May of 2025, guided by a combination of information on community voice, evidence-based and promising practices, anchor institution-informed approaches, and emerging trends, the CE&P committee ranked the associated strategies. The results formed the basis for SHC's FY2026–2028 community benefit and implementation plans:

Health Care Access and Delivery

Behavioral Health

Economic Stability

It is acknowledged that Economic Stability includes income security, housing security, and food security. For the purposes of this IS, Health Care Access and Delivery will be referred to as **"Access to Care"** and Behavioral Health will be referred to as **"Mental and Behavioral Health"** to more clearly reflect the focus areas addressed in meeting these identified health needs.

The process map displayed below details the IS process described in this section and in *Section V: Implementation Strategy (IS) Development*.

Implementation Strategy Process Map

B. DESCRIPTION OF HEALTH NEEDS THAT SHC PLANS TO ADDRESS

See SHC's 2025 CHNA report for statistical data tables for each health need described below.[d]

[d] For a copy of the 2025 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html

Access to Care

See Mental and Behavioral Health need description for issues related to mental health care and substance use treatment access.

What is the issue?

Access to affordable, comprehensive, quality health care is important for improving health and increasing quality of life.[e] For most people, access to care means having insurance coverage, being able to find an available primary or specialty care provider nearby and receiving timely delivery of care. Delivery of care involves the quality, transparency, and cultural competence/humility with which services are rendered. Limited access to care and compromised delivery affect people's ability to reach their full potential, diminishing their quality of life.

Key data:

- Health care access and delivery was prioritized in more than half of all interviews and focus groups.
- In all four counties, the rates of preventable hospitalizations are highest for the Black population, followed by the Hispanic/Latino population.
- The ratio of community members to non-physician primary care providers are worse in three of the four counties compared to California overall.

How was access to care identified as a need?

Health care access and delivery was prioritized in more than half of all interviews and focus groups.[f] CHNA participants focused on barriers to health care access including economic obstacles—high costs can limit access, but even slight increases in income can disqualify individuals from receiving benefits such as Medi-Cal. Some health care providers noted that they cannot shoulder the burden of helping individuals sign up for benefits, which adds to patients' ongoing challenges.

Barriers also included geographic obstacles; rural or less-populated areas lack nearby hospitals, clinics, and specialty services like dental care, necessitating long travel distances for medical care when transportation can also be a barrier (e.g., older adults and farmworkers may not have access to a car or a driver's license).

With regard to health care delivery, some CHNA participants emphasized the need for health care services to be more culturally sensitive and respectful, noting that current practices often disregard cultural preferences and individual differences. Some expressed concerns about the quality of care, citing issues such as long wait times, lack of follow-up, and perceived disrespect from health care providers.

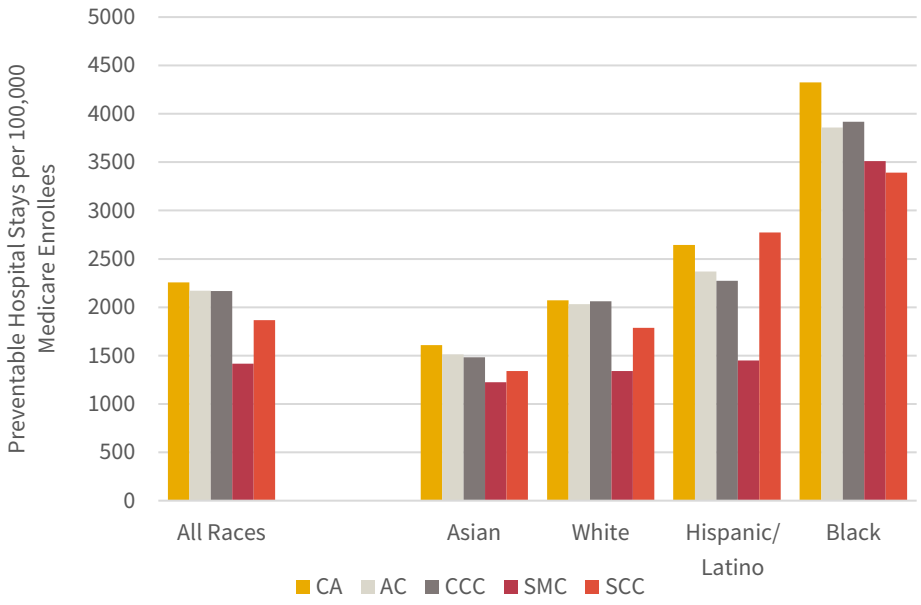
[e] County Health Rankings & Roadmaps. (2024). Access to Care.

[f] In Contra Costa County, this need did not meet the community prioritization threshold of 50%.

> *"Limited access to health care services in languages other than English and a lack of culturally sensitive providers can create challenges for diverse populations."*
>
> —Health Provider, Alameda County

In all four counties, the rates of preventable hospitalizations are highest for the Black population, followed by the Hispanic/Latino population. A higher rate of preventable hospital stays may be a sign of inequitable access to high-quality care.

In most of the service area*, Hispanic/Latino and Black older adults are hospitalized for preventable causes significantly more often than their peers of other races.



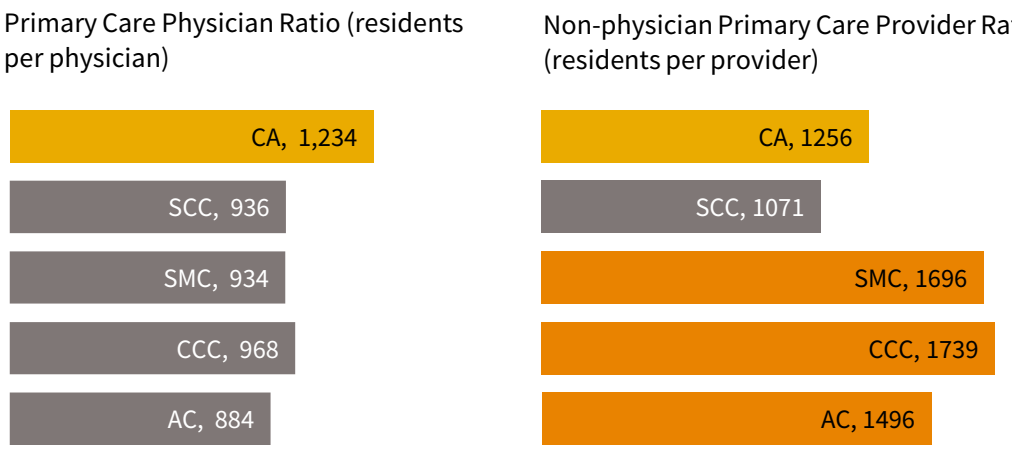
*Note: CA=California, AC=Alameda County, CCC=Contra Costa County, SMC=San Mateo County, SCC=Santa Clara County.

Definition: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Source: Mapping Medicare Disparities Tool, 2020.

What else plays into this need?

Statistics show that in all four counties, ratios of community members to primary care providers are better than the ratio among Californians overall. However, ratios of community members to other primary care professionals (e.g., physicians assistants) are worse in Alameda, Contra Costa, and San Mateo counties compared to the state and Santa Clara County (see charts below). Access among public school students to school nurses is also worse in all four counties compared to the state.

The ratios of community members to non-physician primary care providers are worse in three of the four counties compared to California overall.



Source: CMS, National Provider Identification, 2020.

What else was notable by geography?

East Bay	Silicon Valley
• In Alameda County, the Ashland/southern Castro Valley area is designated as a Dental Health Professional Shortage Area (HPSA).	• Some participants in coastal San Mateo County and East San José raised concerns about the potential closure of essential health care facilities in their area, which would exacerbate existing access issues.

Mental and Behavioral Health

What is the issue?

Mental health—defined as social, emotional, and psychological well-being—plays a key role in a person's overall wellness, ability to have healthy and maintain healthy relationships, and function in society.[g] Behavioral health, including the use of substances such as alcohol, marijuana, and other legal or illegal drugs, affects not only the individuals who use them, but also their families and communities.

Key data:

- Mental and behavioral health was one of the highest-priority health needs in interviews and focus group discussions.
- The opioid hospitalization rate in Santa Clara County (34.3 per 100,000) is notably higher than the state overall (12.8).
- In Contra Costa County, the ratio of community residents to mental health providers is notably higher (worse) (260:1) compared to the ratio in California overall (236:1).

How was mental and behavioral health identified as a need?

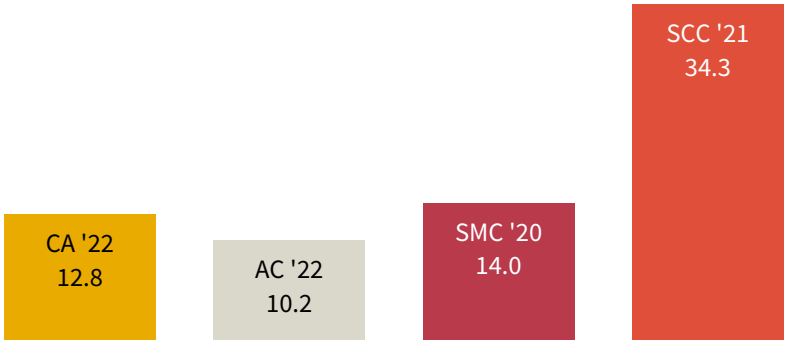
Mental and behavioral health was one of the highest-priority health needs in interviews and focus group discussions. Across all four counties, key informants and focus group participants expressed strong concern about poor mental health and substance use. Participants mentioned stress and loneliness as significant factors contributing to these issues.

> *"San Mateo County declared loneliness a public health emergency recently. And one of the supervisors said 45% of folks reported experiencing loneliness."*
>
> —Dual-County Focus Group Participant

Statistics suggest that substance use is an issue to varying degrees in all four counties. For example, in Alameda County, the drug overdose mortality rate is rising. Also, tobacco use (current smoking) is higher in both Alameda and Contra Costa counties compared to California overall. Some health experts expressed concern about the rise in fentanyl- and other opioid-related deaths in the Bay Area. Although mortality rates are lower than California's rate, the opioid hospitalization rate in Santa Clara County (34.3 per 100,000) is notably higher than the state's (12.8) (see chart on following page).

[g] Substance Abuse and Mental Health Services Administration. (2023). *What is Mental Health?*

The Santa Clara County opioid hospitalization rate (per 100,000 people) is nearly three times as high as the California rate.



Sources: California and Santa Clara County: Santa Clara County Public Health Department, personal correspondence July 1, 2024. San Mateo: Retrieved from San Mateo Health All Together Better platform. Alameda County: Alameda County Alameda County Public Health Department (ACPHD) Community Assessment, Planning, and Evaluation (CAPE). **Note:** Use caution when comparing these rates from different years. Contra Costa hospitalization rates were not available.

CHNA participants in all four counties felt there was a relative lack of mental and behavioral health care access due to the insufficient supply of mental health care practitioners and substance use treatment options. In Contra Costa County in particular, the ratio of community residents to mental health providers is notably higher (worse) (260:1) compared to the ratio in California overall (236:1).

What else plays into this need?

CHNA participants frequently identified economic insecurity, isolation, and experiences of discrimination as drivers of poor mental and behavioral health. For example, some participants noted that Black community members experience high levels of stress related to discrimination, isolation, and financial hardship, while others described LGBTQ community members as having higher rates of substance use and mental health issues due to ongoing stigma and collective trauma (negative psychological effects experienced throughout a community as the result of an act of violence against one or more members of that community).

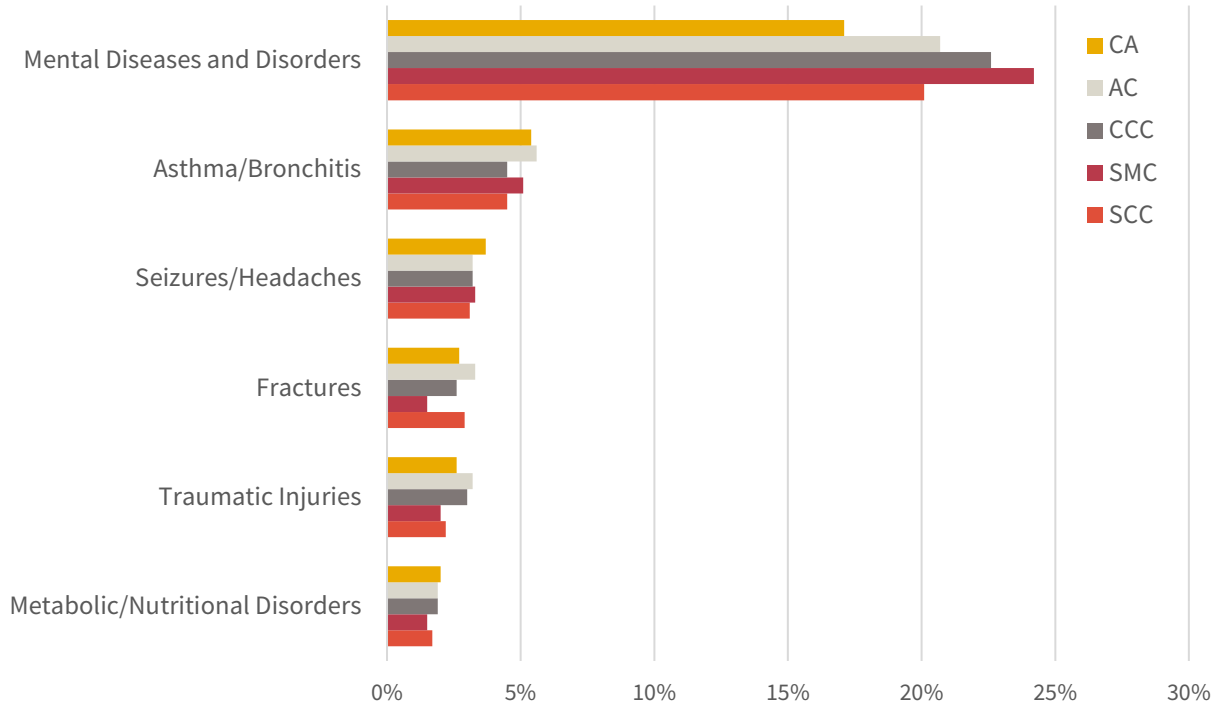
A number of experts who participated in the CHNA felt the lack of full integration of mental health and substance use services is a significant barrier to people getting treatment. Substance use service providers and experts in all counties also spoke to the barrier posed by lack of awareness and education of the harms of substance use.

CHNA participants in all areas also described issues with appropriately tailored delivery of care. They stated that mental health care services are often not adapted or modified to the specific needs of individuals, which can lead to inadequate care and support for those who seek it. Language barriers and cultural stigma were both mentioned.

Across all four counties, the common populations of concern related to mental and behavioral health needs included LGBTQ, Black and Hispanic/Latino communities, youth, unhoused individuals, and justice-involved individuals. For youth in all four counties, mental diseases and disorders represented the

highest proportions of hospital discharges, more than double the next-highest primary diagnosis in each county.

The top reason for child hospitalizations is mental diseases and disorders.



Source: California Dept. of Health Care Access and Information custom tabulation, as cited by KidsData.org. 2020.

What else was notable by geography?

East Bay		Silicon Valley	
Alameda County	**Contra Costa County**	**San Mateo County**	**Santa Clara County**
• The suicide rate is rising.	• There are three Mental Health Professional Shortage Areas (HPSAs) in the county: central Richmond, Pittsburg, and in the eastern part of Brentwood.	• The percentage of adults who are likely in serious psychological distress has been rising, as has the percentage who have ever thought seriously of committing suicide.	• There are mental health HPSAs in Gilroy and Milpitas.

Economic Stability

What is the issue?

Economic stability has been defined as the ability of people to cover their basic needs sustainably, in a manner that allows them dignity and self-respect.[h] Higher income and social status, often achieved through attainment of higher education, have each been linked to greater health. Research shows that access to economic stability programs such as SNAP (formerly called food stamps) results in better long-term health outcomes.[i] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the well-being, educational achievement, and economic success of those who live inside it.[j] Poor health can lead to homelessness, and vice versa. People experiencing homelessness suffer from preventable illnesses at a greater rate, require longer hospital stays, and have a greater risk of premature death than their peers with housing security.[k]

Key data:

- Economic stability, including education, housing and food security, was the highest-priority health need in interviews and focus group discussions.
- Economic stability statistics vary substantially by race/ethnicity; for example, in Alameda County median household income among Asian households is more than twice that of Black households.

How was economic stability identified as a need?

Economic stability, including education, housing, and food security, was the highest-priority health need in interviews and focus group discussions. The high cost of living was a key theme among CHNA participants in all four counties. Participants said wages have not kept pace with rising costs, leading to economic strain and forcing people to work multiple jobs or cut back on essentials like food and medication. Many mentioned the correlation between economic and food insecurity, with some noting a record increase in food insecurity since the 2020 pandemic.

> *"Economic security here is bad. The reason is that the salary is very low. Every time you go to Cárdenas, to any grocery store, the groceries are through the roof. You have to decide whether you eat or pay the rent."*
>
> — Community Member, Santa Clara County

[h] International Committee of the Red Cross. (2020). *Economic Security Strategy 2020–2023.*

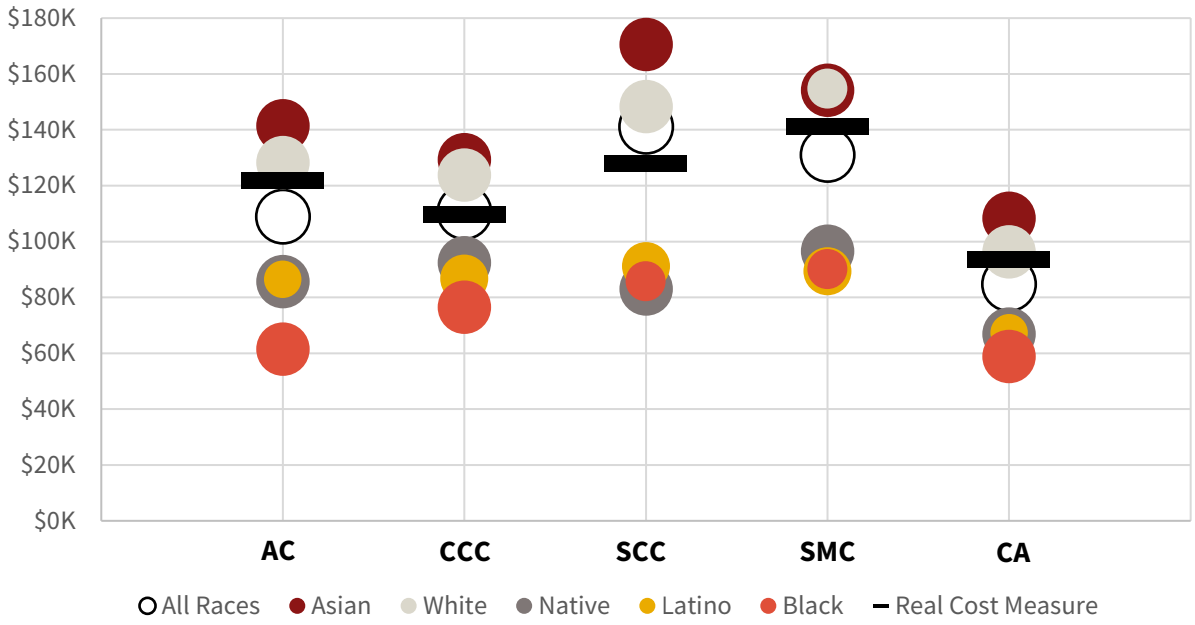
[i] Center on Budget and Policy Priorities. (2018). *Economic Security, Health Programs Reduce Poverty and Hardship, With Long-Term Benefits*.

[j] Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis.*

[k] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council.

The populations of concern included individuals on fixed incomes, such as older adults and people with disabilities. Regarding other specific populations, some participants noted that immigrants can face additional challenges, limiting their employment opportunities. Others said economic challenges, such as families needing to work multiple jobs, hinder students' ability to focus on education, effectively deterring their long-term economic prospects. A number of participants felt economic instability is linked to broader systemic issues, such as long-standing inequities and inadequate local resources. Experts in all four counties mentioned that programs which guarantee basic income have shown positive impacts but face a variety of challenges. There are substantial disparities in median income by race/ethnicity within each county.

The Real Cost Measure (the annual cost for a four-person family to make ends meet, including housing, food, health care, childcare, transportation, and other basic needs) is higher than the median household income among Black, Hispanic/Latino, and Native American households in all four counties.



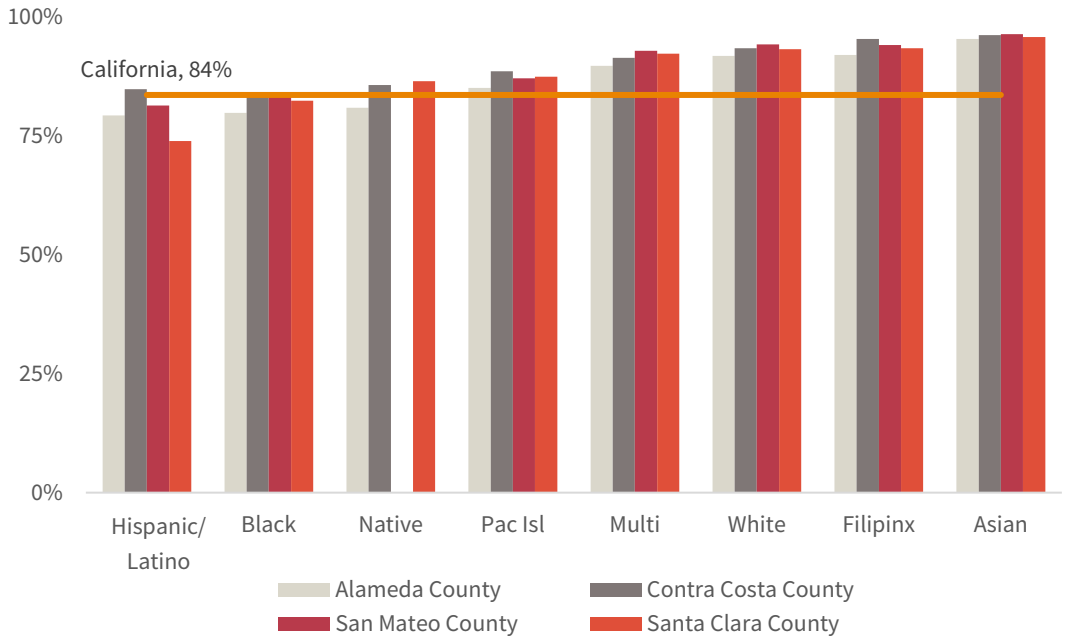
Notes: Dot size varies to show overlap. Source: Real Cost Measure: United Way, 2021. Income: U.S. Census Bureau Small Area Income and Poverty Estimates, 2021. Retrieved from County Health Rankings, June 2024.

> *"When a majority of people are economically advantaged, they have the resources to afford good food…and they're more educated, and then they know how to be more healthy, and they're more likely to pass that down to their children versus the people who are disparaged… they're not given a fair advantage."*
>
> —Community Member Focus Group Participants, Alameda County

High dropout rates and lower academic performance compared to state and national averages were highlighted by some CHNA participants. Education has generally and historically correlated directly with income, so statistics about educational status are particularly concerning to CHNA participants. In three of the four counties, Hispanic/Latino students were more likely than students of other ethnic groups not

to graduate high school with their cohort, while in Contra Costa County, Black students were the least likely to graduate on time.

Black and Hispanic/Latino students are less likely to graduate from high school with their cohort than their peers.



Definition: Percentage of public-school students who complete high school with their graduating class. Source: California Department of Education, 2021. Note: No data available for Native youth in San Mateo County.

CHNA participants in all four counties emphasized the lack of housing affordability. Some mentioned that this affects people in various economic sectors, including health care workers, teachers, and public servants. Participants said rising rent costs and lack of affordable housing options are major issues, leading to overcrowded living conditions or forcing people out of the area altogether. Some also mentioned that housing insecurity can force people to stay in unsafe situations (such as being exposed to domestic violence) or move into unsafe conditions (such as living in their car).

> *"We are seeing multi-generational families living in one home. They might not have access to a kitchen. We are seeing a lot of families living in a garage with a microwave."*
>
> *"People are cutting costs on their medication, not going to the doctor's, nothing, …and then also living in situations which [are] uninhabitable or not recommended, where there are three families, five families, people are huddled together, couch surfing and sleeping in their cars."*
>
> — Service Providers' Focus Group, Santa Clara County

Participants discussed barriers to housing, including high income requirements for rentals, complex processes for accessing low-income housing, discrimination, and a lack of tenant rights awareness. A

number of participants described the lingering effects of red-lining (residential segregation),[l] which has been shown to be related to health inequities. In all four counties, data show that vulnerable populations are disproportionately represented among those who are rent-burdened.

Participants indicated that homelessness is also increasing as a consequence of the obstacles mentioned above and the lack of affordable housing. Many noted that homelessness is often linked with other issues like mental health problems and substance abuse.

What else plays into this need?

Data show that there are greater gender pay gaps in three of the four counties compared to California overall; only in San Mateo County do women earn more per dollar than their female peers statewide, though they still earn only $0.90 for each dollar paid to their male counterparts.

What else was notable by geography?

<table>
<tr><th colspan="2">East Bay</th><th colspan="2">Silicon Valley</th></tr>
<tr><td colspan="2">• Math and reading performance are notably worse among Alameda and Contra Costa counties' Black and Hispanic/Latino children.</td><td colspan="2">• Local older adults who participated in the Community Assessment Survey of Older Adults give a "Livability Score" of 19 out of 100 for housing. [m]</td></tr>
<tr><th>Alameda County</th><th>Contra Costa County</th><th>San Mateo County</th><th>Santa Clara County</th></tr>
<tr><td>• The proportion of individuals experiencing chronic homelessness is worsening.</td><td>• Overall homelessness is rising.</td><td>• Overcrowded housing is notably worse in the county (and specifically the Daly City area) compared to California overall.</td><td>• In 2022, the high school graduation rate was lower (83%) than the state rate (88%).</td></tr>
</table>

[l] Knopov, A., Rothman, E.F., Cronin, S.W., Franklin, L., Cansever, A., Potter, F., Mesic, A., Sharma, A., Xuan, Z., Siegel, M. and Hemenway, D. (2019). The role of racial residential segregation in black-white disparities in firearm homicide at the state level in the United States, 1991–2015. *Journal of the National Medical Association*, 111(1), pp.62–75.

[m] Polco, formerly the National Research Center. (2023). *Community Assessment Survey for Older Adults: Avenidas, September 2022*. Retrieved from https://www.avenidas.org/wp-content/uploads/2023/03/2022-CASOA-report.pdf

VII. SHC'S IMPLEMENTATION STRATEGY

The federal government requires nonprofit hospitals to complete an Implementation Strategy (IS) report. The IS report is a companion to the CHNA, in that it describes how hospitals will use community benefit and other resources to address priority health needs in their service areas. Furthermore, California Senate Bill 697 (1994) mandates that nonprofit hospitals report annually on their strategies to improve community health. This IS report informs Stanford Health Care's annual Community Benefit Implementation Strategy, as well as fulfills federal requirements. Specifically, the IS report must detail:

- Which of the priority health needs will be directly addressed by the hospital as part of its implementation strategy, and which top health needs will not be addressed (and justification)
- The actions, programs, and resources the hospital intends to commit to address the selected health needs
- The anticipated impact of these actions
- Any planned collaboration between the hospital and other hospitals or organizations

OUR STRATEGIC APPROACH

SHC's annual community benefit investment centers on improving the health of the most vulnerable populations across our region, including the medically underserved, low-income, and populations affected by health disparities. In response to the 2026 Community Health Needs Assessment, we developed this Implementation Strategy to guide our investments, institutional practices, and community engagement over the next three years (FY26–FY28).

What Is an Anchor-Inspired Approach?

The anchor approach is centered on leveraging the economic, social, and human capital of "anchors"—large, place-based institutions such as universities, hospitals, and government agencies—to create lasting, positive outcomes in their local communities.

In practice, anchor-inspired strategies align institutional resources—such as hiring, purchasing, investing, and engaging in community partnerships—to support local needs.

Guided by anchor principles and frameworks, we selected strategies based on a combination of community input, data from the CHNA, existing hospital capabilities, research on evidence-based and promising practices (see *Appendix 4: Strategies Research Citations* for details), and opportunities to make a meaningful and lasting impact. Across all priority areas—Economic Stability, Mental and Behavioral Health, and Access to Care—we focus on:

- Investing in upstream solutions that address the conditions influencing health
- Listening to community voice and building collaborative relationships
- Enhancing the quality and reach of programs and services for community members
- Leveraging hospital resources and partnerships to strengthen systems of care

Our approach blends direct service, internal system improvements rooted in anchor principles, and community partnerships. Through these strategies, we aim to strengthen positive outcomes across our service area and support a healthier future for the communities we serve.

Access to Care

Why This Matters

Access to health care remains uneven across communities. Health care workforce shortages, high costs, and linguistic and cultural barriers limit care for vulnerable community members. Access to primary and specialty care is particularly strained in underserved regions.

Key Data Highlights

- Shortages of non-physician providers (e.g., NPs, PAs) in three of the four counties vs. the state
- Limited cultural and language concordance
- Chronic and infectious disease rates in all four counties suggest poor access to care
- Dental Health Professional Shortage Area in Ashland/Castro Valley
- In all four counties, rates of preventable hospitalizations for older adults are highest for the Black population, followed by the Hispanic/Latino population
- Premature death (years of potential life lost) higher in three of the four counties vs. CA

At a Glance: Barriers to Care

Long wait times

Language & literacy challenges

High cost even with insurance

Transportation gaps

Community Voice

Community members and stakeholders shared:

- Concerns about affordability and long wait times
- Rural and less-populated areas may lack nearby hospitals, clinics, and specialty services
- The potential of the closure of essential health care facilities in coastal San Mateo County and East San José
- People expressed a desire for providers who are respectful, inclusive, and speak their language

LONG-TERM GOAL

Improve access to affordable, high-quality health care services for at-risk community members.

Our Approach[n]

A. Investments & Grants

- Support capacity-building opportunities, such as health clinics near vulnerable neighborhoods

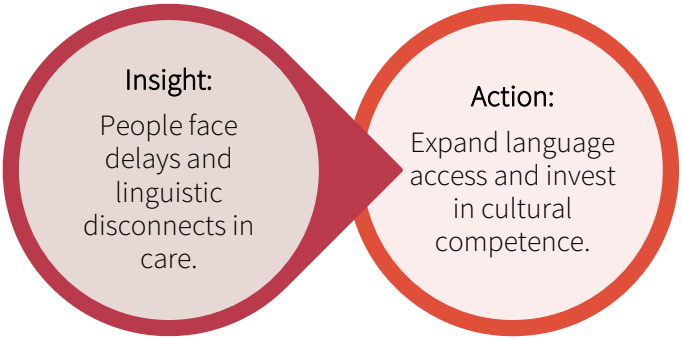
B. Institutional Systems & Practices

- Expand access via digital health initiatives
- Continue to offer financial assistance, including charity care and uncompensated care
- Support enrollment in health insurance
- Encourage care coordination interventions
- Support initiatives that address culturally responsive and compassionate/respectful care, including enhanced language access
- Advance health-related social needs screening and linkage to resources

C. Advocacy & Community Engagement

- Advocate for access-focused policies at all government levels

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

- Recognize that access to care is inseparable from the social and economic determinants of health that shape community well-being.
- Acknowledge that many people experience major barriers in accessing quality care.
- Align institutional resources with community needs to remove barriers and promote equity in compliance with state and federal law.
- Help create environments where health services are more accessible, culturally responsive, and better integrated with other forms of support.

What We Aim to Achieve

- Greater access to culturally sensitive care
- Higher preventive care and vaccination rates
- Reduced avoidable ED use and preventable hospitalizations
- Improved outcomes and reduced disparities for community members

[n] To view SHC's planned strategies in another format, see *Appendix 3: SHC's Implementation Strategies Tables.*

Mental and Behavioral Health

Why This Matters

Mental and behavioral health is a pressing concern in all four counties. Key challenges include a shortage of mental health providers, especially in outlying areas like Gilroy and Brentwood, and rising rates of psychological distress, suicide, and suicidal ideation. These challenges were amplified by the COVID-19 pandemic, which increased economic stressors, isolation, and substance use.

Key Data Highlights

- Rise in fentanyl and opioid-related deaths in Bay Area despite lower overall mortality compared to California
- In all four counties, mental diseases and disorders accounted for the highest proportion of hospital discharges among youth, more than double the next-highest primary diagnosis
- Suicide and suicidal ideation rising in Alameda and San Mateo counties
- Low supply of qualified mental health providers, especially Contra Costa County
- Higher opioid hospitalization rate in Santa Clara County compared to state

At a Glance: What Else We Heard

Long wait times

Language barriers

Culture/service match lacking

Earlier prevention efforts needed

Community Voice

CHNA participants highlighted the following:

- Growing loneliness, stress, and isolation, exacerbated by economic insecurity and experiences of discrimination
- Concerns about lack of awareness and education of the harms of substance use, especially regarding potent substances like fentanyl
- The need for more integrated mental health and substance use services across systems
- Across all four counties, common populations of concern included LGBTQ, Black and Hispanic/Latino communities, youth, unhoused individuals, and justice-involved individuals

LONG-TERM GOAL

Improve access to affordable, high-quality mental/behavioral health care services.

Our Approach

A. Investments & Grants

- Support initiatives to increase the cultural competency of mental/behavioral health providers in community/safety net clinics
- Support community-based efforts aimed at expanding access to care for mental health and substance use issues
- Support programs that assist people recovering from addiction to transition back into the community

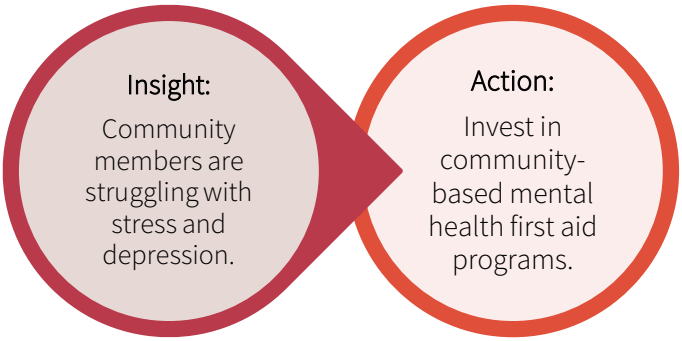
B. Institutional Systems & Practices

- Enhance screening and referral for mental/behavioral health issues in primary care and emergency care settings
- Support integrated mental health and substance use services/treatment for co-occurring mental illness and addiction
- Increase internal capacity through workforce development and partnerships

C. Advocacy & Community Engagement

- Advocate for mental health parity and policy solutions at the local and state levels

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

- Recognize that many people face significant barriers to accessing mental/behavioral health care.
- Align institutional resources with community needs to remove barriers and promote equity in compliance with state and federal law.
- Help create environments where mental/behavioral health services are more accessible, culturally relevant, and integrated with other forms of support.

What We Aim to Achieve

- Improved access to culturally sensitive or responsive mental/behavioral health services, programs, and providers
- Greater emotional coping and resilience among people served
- Reduced housing instability among people with mental health/substance use issues
- Enhanced coordination across the continuum of care

Economic Stability

Why This Matters

Financial stability plays a key role in the health and well-being of community members. Across the four counties, more than one in four households are not economically self-sufficient. The high costs of housing, food, health care, and education makes it difficult for many people to meet their basic needs.

Key Data Highlights

- Large differences in educational outcomes and income by race and ethnicity
- Greater gender pay gaps in three of the four counties vs. California
- Rising homelessness and overcrowding in the Bay Area
- Black, Hispanic/Latino, and Native American populations more likely to be rent-burdened

At a Glance: Barriers to Economic Stability

High housing costs

Limited access to financial aid, job training

Many needing food support

Overcrowded living conditions

Community Voice

CHNA participants highlighted the following:

- Wages have not kept pace with rising costs, leading to economic strain
- People feel forced to work multiple jobs or cut back on essentials
- Food insecurity seems to have stayed high since the COVID-19 pandemic
- People experiencing greater instability due to unaffordable housing
- Concern for individuals on fixed incomes
- People desire more equitable opportunities in education, jobs, and housing

LONG-TERM GOAL

Reduce economic instability among community members to support improved health.

Our Approach

A. Investments & Grants

- Support social services addressing housing, food, and financial instability
- Fund homelessness prevention and intervention approaches
- Expand capacity of and access to healthy food access programs (e.g., food banks)

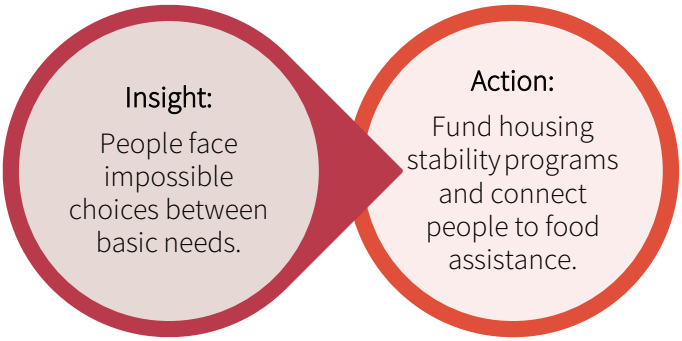
B. Institutional Systems & Practices

- Enhance case management and care coordination that connects people to housing and other support
- Promote CalFresh and WIC enrollment
- Improve hospital screening, referral, and follow-up for health-related social needs
- Foster workforce development and job training initiatives
- Support implementation of policies that prioritize purchasing locally and from small businesses

C. Advocacy & Community Engagement

- Participate in local housing and homelessness collaboratives
- Support local initiatives focused on household income support

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

- Align institutional resources to support community needs, removing barriers and promoting equity in compliance with state and federal law.
- Shift everyday business practices to foster communities' economic vitality.
- Take an integrated approach to address contributing factors to differing health outcomes in the community.

What We Aim to Achieve

- Increased use of available services and benefits
- Improved housing and food security for vulnerable people
- Greater financial stability for community members
- Reduced economic disparities and poverty

VIII. EVALUATION PLANS

SHC, through its community benefit efforts, is committed to addressing health inequities by promoting equitable access to care. 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, in compliance with state and federal law, 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.

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. SHC will use anchor-inspired principles and the anchor framework to guide how it measures and ensures 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 CE&P committee recommended addressing a set of health needs that would best support the community SHC serves, considering SHC's expertise 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.

Built Environment: While SHC will continue to serve its patients who present with unintended injuries and other health issues related to the built environment , this need was of lower priority to the community than the other health needs. Additionally, the CE&P 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..

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 CE&P committee further 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.

Communicable Diseases (other than STIs): The elements of this need described in SHC's CHNA report[o] were fully duplicative of the Respiratory Health and Sexually Transmitted Infections health needs. For an explanation of why SHC does not plan to address those needs, see their related paragraphs below.

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 three health needs SHC chose to address.

Heart Disease and Stroke: 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 heart disease and stroke, through a subset of its strategies underlying food security, one of the three 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.

Respiratory Health: This need was of lower priority to the community than the other health needs. SHC is also better positioned to address drivers of this need through initiatives related to health care access and delivery.

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.

Health Inequities: This implementation strategy plan considers health inequities to be a key issue shaped by overlapping barriers, which are detailed in this report and in SHC's CHNA report.[o] SHC addresses this need via the strategies in this report, which contribute to more equitable access and improved outcomes for vulnerable populations, in a manner that complies with federal and state nondiscrimination requirements.

---

[o] For a copy of the 2025 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html.

APPENDIX 1: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST

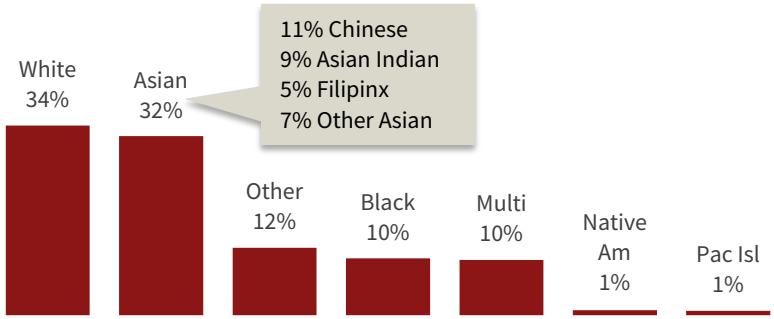
Section §1.501(r)(3)(c) of the Internal Revenue Service code describes the requirements of the Implementation Strategy Report.

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

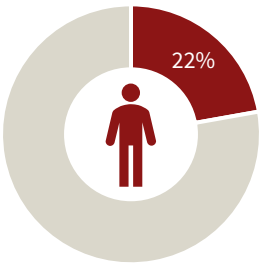
Federal Requirements Checklist	Regulation Subsection Number	Report Section
(4) An authorized body **adopts the implementation** strategy on or before January 15th, 2026, which is the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless 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: DEMOGRAPHICS BY INDIVIDUAL COUNTY: ALAMEDA COUNTY

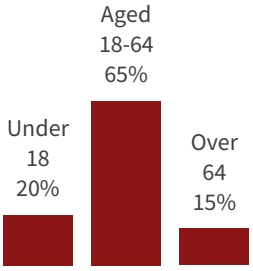
A majority of residents are non-White.



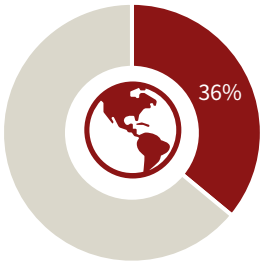
Over one in five are Hispanic/ Latino.



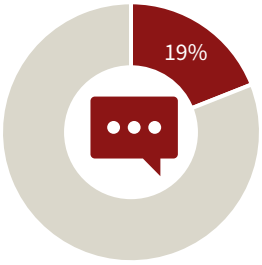
One in five residents are children.



Over one-third of residents are foreign-born.



About one in five over age 5 speak limited English.



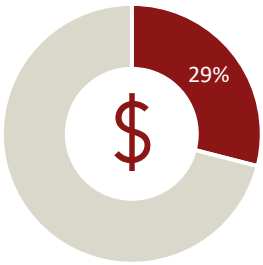
$121,703

4-person household Real Cost Measure (RCM)*

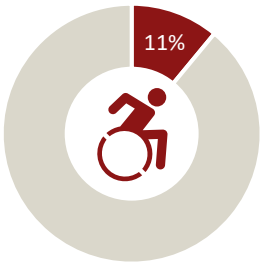
$1.0M

median home sale price

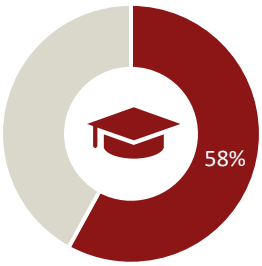
On average, close to one in three households lives below the Real Cost Measure.



Over one in ten residents lives with a disability.



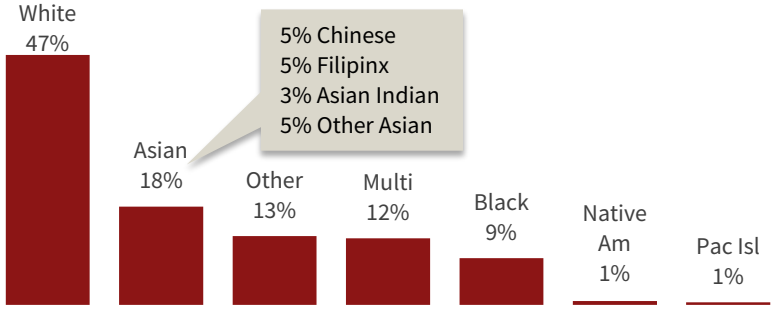
Nearly three in five residents aged 25+ have earned at least a Bachelor's degree.



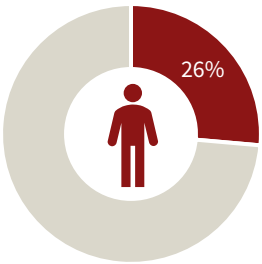
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

CONTRA COSTA COUNTY

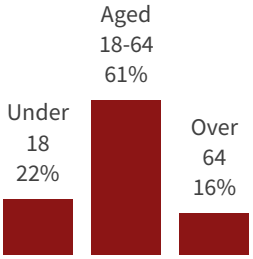
A majority of residents are non-White.



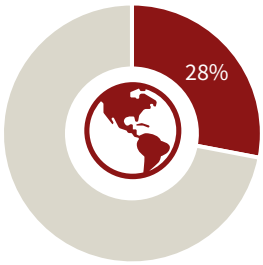
About one-quarter are Hispanic/Latino.



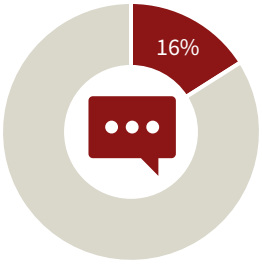
Over one in five residents are children.



More than one in four residents are foreign-born.



About one in six over age 5 speak limited English.



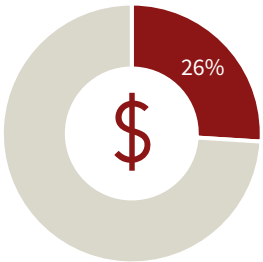
$109,770

4-person household
Real Cost Measure (RCM)*

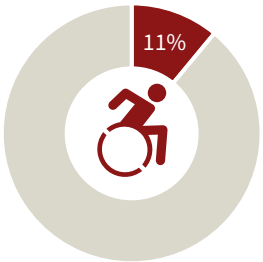
$795K

median home sale price

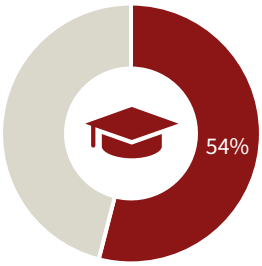
On average, more than one in four households lives below the Real Cost Measure.



More than one in ten residents lives with a disability.



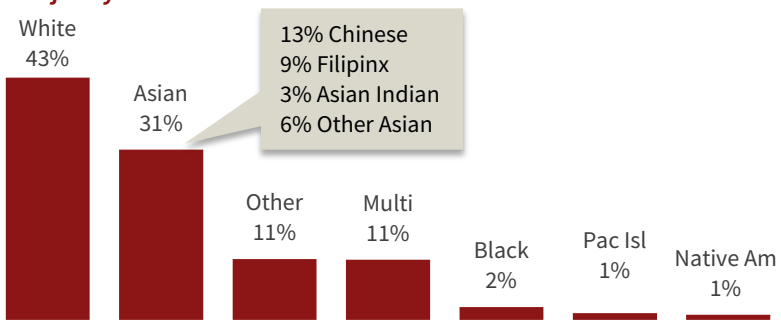
Just over half of residents aged 25+ have earned at least a Bachelor's degree.



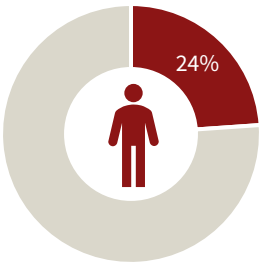
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

SAN MATEO COUNTY

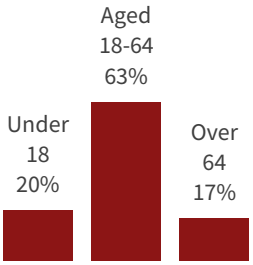
A majority of residents are non-White.



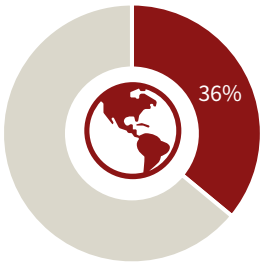
About one-quarter are Hispanic/Latino.



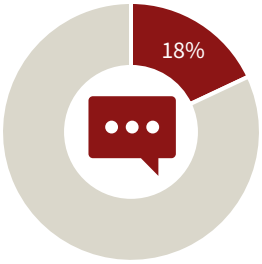
One in six residents are older adults.



More than one in three residents are foreign-born.



Close to one in five over age 5 speak limited English.



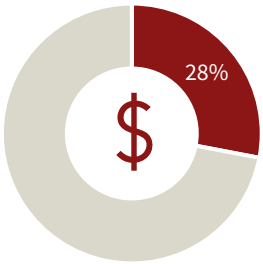
$141,316

4-person household
Real Cost Measure (RCM)*

$1.5M

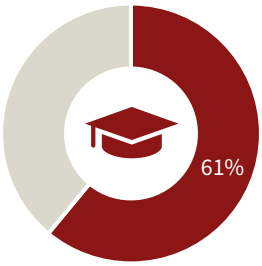
median home sale price

On average, more than one in four households lives below the Real Cost Measure.



One in ten residents lives with a disability.

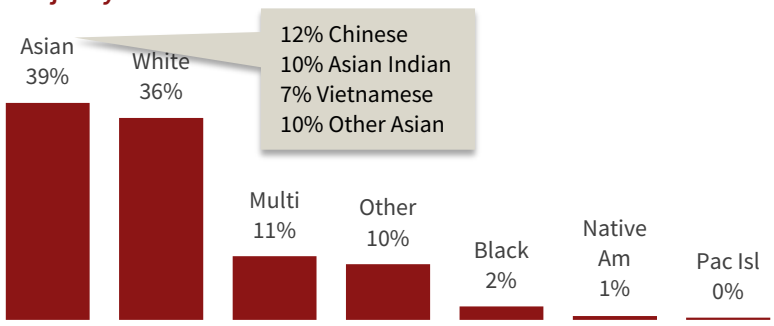
About three in five residents aged 25+ have earned at least a Bachelor's degree.



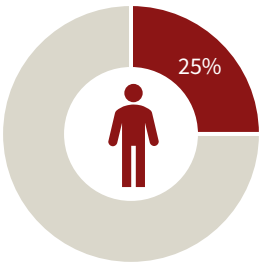
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

SANTA CLARA COUNTY

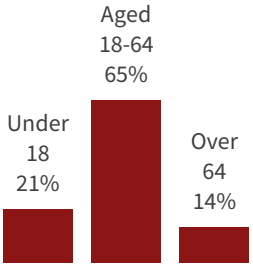
A majority of residents are non-White.



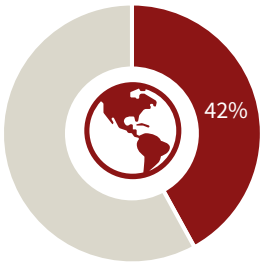
One-quarter are Hispanic/ Latino.



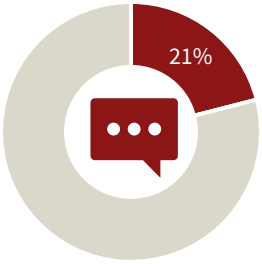
About one in five residents are children.



Over two in five residents are foreign-born.



About one in five over age 5 speak limited English.



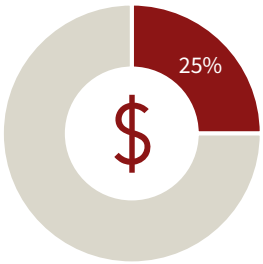
$128,176

4-person household Real Cost Measure (RCM)*

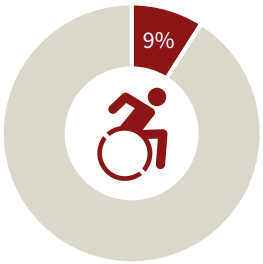
$1.7M

median home sale price

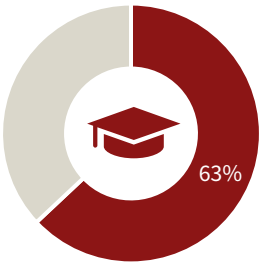
On average, one in four households lives below the Real Cost Measure.



Almost one in ten residents lives with a disability.



Over three in five residents aged 25+ have earned at least a Bachelor's degree.



*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

APPENDIX 3: SHC'S IMPLEMENTATION STRATEGIES TABLES

ACCESS TO CARE

Investments & Grants	Institutional Systems & Practices	Advocacy & Community Engagement
Support capacity-building opportunities such as health clinics near vulnerable neighborhoods	• Expand access via digital health initiatives • Continue to offer financial assistance including charity care and uncompensated care • Support enrollment in health insurance • Encourage care coordination interventions • Support initiatives that address culturally competent and compassionate, respectful care including enhanced language access • Advance health-related social needs screening and linkage to resources	Advocate for access-focused policies at all government levels

MENTAL AND BEHAVIORAL HEALTH

Investments & Grants	Institutional Systems & Practices	Advocacy & Community Engagement
• Support initiatives to increase the cultural competency of mental, behavioral health providers in community, safety net clinics • Support community-based efforts aimed at expanding access to care for mental health and substance use issues	• Enhance screening and referral for mental, behavioral health issues in primary care and emergency care settings • Support integrated mental health and substance use services, treatment for co-occurring mental illness and addiction	Advocate for mental health parity and policy solutions at the local and state levels

• Support programs that assist people recovering from addiction to transition back into the community	• Increase internal capacity through workforce development and partnerships	

ECONOMIC STABILITY

Investments & Grants	Institutional Systems & Practices	Advocacy & Community Engagement
• Support social services addressing housing, food, and financial instability • Fund homelessness prevention and intervention approaches • Expand capacity of and access to healthy food access programs (e.g., food banks)	• Enhance case management and care coordination that connect people to housing and other support • Promote CalFresh and WIC enrollment • Improve hospital screening, referral, and follow-up for health care-related social needs • Foster workforce development and job training initiatives • Support implementation of policies that prioritize purchasing locally and from small businesses	• Participate in local housing and homelessness collaboratives • Support local initiatives focused on household income support

APPENDIX 4: STRATEGIES RESEARCH CITATIONS

ACCESS TO CARE

Financial assistance:

1. Adams, A. S., Kluender, R., Mahoney, N., Wang, J., Wong, F., & Yin, W. (2021). *The impact of financial assistance programs on health care utilization* (No. w29227). National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w29227/w29227.pdf

Health insurance coverage:

2. Sommers, B. D., Gunja, M. Z., Finegold, K., & Musco, T. (2015). Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. JAMA, 314(4), 366-374. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/2411283

Care coordination interventions:

3. Unützer, J., Harbin, H, Schoenbaum, M., & Druss, B. (2013). The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. *Health Home Information Resources Center.* Retrieved from https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf
4. Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ, 2013*(347):f4913.
5. Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care, 15*(6). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/
6. Community Preventive Services Task Force. (2019). Mental health and mental illness: Collaborative care for the management of depressive disorders. *The Community Guide.* Retrieved from https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders
7. 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: https://nap.nationalacademies.org/resource/13116/oralhealthaccess2011reportbrief.pdf
8. Singer, C., & Porta, C. (2022). Improving patient well-being in the United States through care coordination interventions informed by social determinants of health. Health & social care in the community, 30(6), 2270-2281. Retrieved from https://www.connectionriversidehealthcare.com/wp-content/uploads/SDOH-Care-Coordination.pdf

Capacity building:

9. 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. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC1361082/pdf/hesr_00302.pdf See also Cunningham, P., & Hadley, J. (2004). Expanding care versus expanding coverage: how to improve access to care. *Health Affairs*, *23*(4), 234-244. Retrieved from https://d1wqtxts1xzle7.cloudfront.net/54271737/234-libre.pdf?1503958817=&response-content-disposition=inline%3B+filename%3DExpanding_Care_Versus_Expanding_Coverage.pdf&Expires=1746570621&Signature=fszrCtQNwztllkOVPKQBE74XxKjHIL78cU0Aj0~Egw2Gm6qodnmRAva296rMM-JFGSygkreIi3YyFOKXisFslTYMAhRbS8uoFbCtu5DGKnSDSrAgQA9qNMuWiNmvhaVMmO7An-9kRojHwqvcIsPUgydoeQqx84kI-JyFh8EwVkr1cT6Aayj4rahI2FnnAiKLGTomrXnOgF9ZT-nc4uFlUKRxAAR5ahxkuZ4wptkYY5ql~NSqbjzSiIhE~2SRhTDYO5F54WHvND5AOzzql-4S8ZkTj6~x-vAja1Fw40iLzgXOgTz-fCIts1KMC59Ns~s5-0kHoJCEqvs~y55Pb927yA__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

10. Lowe R.A., Localio A.R., Schwarz D.F., Williams S., Wolf Tuton L., Maroney S., Nicklin D., Goldfarb N., Vojta D.D., Feldman H.I. (2005). Association between Primary Care Practice Characteristics and Emergency Department Use in a Medicaid Managed Care Organization. *Medical Care*, 43:792–800. See also: Buckley, D. J., Curtis, P. W., & McGirr, J. G. (2010). The effect of a general practice after‐hours clinic on emergency department presentations: a regression time series analysis. *Medical Journal of Australia*, *192*(8), 448-451. Retrieved from: https://www.mja.com.au/system/files/issues/192_08_190410/buc10644_fm.pdf
11. Bhatt, J, Bathija, P. *Ensuring Access to Quality Health Care in Vulnerable Communities* (2018). Academic Medicine (93) 1271-1275.

Digital health initiatives:

See citation 5.

12. Hoffman, D. A. (2020). Increasing access to care: telehealth during COVID-19. *Journal of Law and the Biosciences*, *7*(1), 1-15. Retrieved from https://academic.oup.com/jlb/article/7/1/lsaa043/5857698
13. Pourrazavi, S., Kouzekanani, K., Bazargan-Hejazi, S., Shaghaghi, A., Hashemiparast, M., Fathifar, Z., & Allahverdipour, H. (2020). Theory-based E-health literacy interventions in older adults: a systematic review. *Archives of Public Health*, 78(1), 1-8. Retrieved from https://link.springer.com/article/10.1186/s13690-020-00455-6

    See also: Akhtyan, A. G., Anikeeva, O. A., Sizikova, V. V., Shimanovskaya, Y. V., Starovoitova, L. I., Medvedeva, G. P., & Kozlovskaya, S. N. (2018). Information literacy of older people: social aspects of the problem. *International Journal of civil engineering and technology*, *9*(11), 1789-1799.

14. Kindig, D. A., Panzer, A. M., & Nielsen-Bohlman, L. (Eds.). (2004). *Health literacy: a prescription to end confusion*. Retrieved from https://www.jabfm.org/content/34/Supplement/S225.full

    See, for example, suggested strategies in: Wang, L. Y., Low, T. T., & Yeo, T. J. (2020). Telehealth in COVID-19 and cardiovascular disease-Ensuring equitable care. *Annals, Academy of Medicine, Singapore*, 49, 902-4. Retrieved from https://annals.edu.sg/pdf/49VolNo11Nov2020/V49N11p902.pdf

15. Tomer, A., Fishbane, L, Siefer, A., & Callahan, B. (2020). Digital prosperity: How broadband can deliver health and equity to all communities. *Brookings Institute.* Retrieved from https://www.brookings.edu/research/digital-prosperity-how-broadband-can-deliver-health-and-equity-to-

all-communities/ See also: Zuo, G. W. (2021). Wired and Hired: Employment Effects of Subsidized Broadband Internet for Low-Income Americans. *American Economic Journal: Economic Policy.* 13(3): 447-82. Retrieved from https://www.aeaweb.org/articles?id=10.1257/pol.20190648

16. Kim, J. H., Desai, E., & Cole, M. B. (2020). How the rapid shift to telehealth leaves many community health centers behind during the COVID-19 pandemic. *Health Affairs Blog*, 10. Retrieved from https://www.healthaffairs.org/do/10.1377/forefront.20200529.449762/full/
17. U.S. Department of Health & Human Services. (2022). *Improving access to telehealth*. Retrieved from https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth/
18. Choi, K., Gitelman, Y., Leri, D., Deleener, M.E., Hahn, L., O'Malley, C., Lang, E., Patel, N., Jones, T., Emperado, K. and Erickson, C. (2021). Insourcing and scaling a telemedicine solution in under 2 weeks: Lessons for the digital transformation of health care. *Healthcare*, 9(3), 100568.
19. Lindsay, J. A., Kauth, M. R., Hudson, S., Martin, L. A., Ramsey, D. J., Daily, L., & Rader, J. (2015). Implementation of video telehealth to improve access to evidence-based psychotherapy for posttraumatic stress disorder. *Telemedicine and e-Health*, *21*(6), 467-472. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4458738/
20. Julien, H. M., Eberly, L. A., & Adusumalli, S. (2020). Telemedicine and the forgotten America. *Circulation*, *142*(4), 312-314. Retrieved from https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.120.048535
21. Cruz-Oliver DM, Malmstrom TK, Roegner M, Yeo G. Evaluation of a video-based seminar to raise health care professionals' awareness of culturally sensitive end-of-life care. Journal of Pain and Symptom Management. 2017;54(4):546-554. Retrieved from https://www.sciencedirect.com/science/article/pii/S0885392417302865?via%3Dihub=

Compassion and respect:

22. Bridges, C., Duenas, D. M., Lewis, H., Anderson, K., Opel, D. J., Wilfond, B. S., & Kraft, S. A. (2021). Patient perspectives on how to demonstrate respect: Implications for clinicians and healthcare organizations. *PloS one*, *16*(4). Retrieved from https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0250999&type=printable
23. Blandford, A. & Osher, F. (2012). A checklist for implementing evidence-based practices and programs (EBPs) for justice-involved adults with behavioral health disorders. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2020/01/SAMHSA-GAINS.pdf. For more information on Integrated Mental Health and Substance Abuse Services, visit https://library.samhsa.gov/sites/default/files/ebp-kit-getting-started-with-ebps-10242019.pdf.

MENTAL AND BEHAVIORAL HEALTH

Integrated services/treatment:

24. Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health, 88*(11): 1610-1615. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610
25. Watkins, L. E., Patton, S. C., Drexler, K., Rauch, S. A., & Rothbaum, B. O. (2023). Clinical effectiveness of an intensive outpatient program for integrated treatment of comorbid substance abuse and mental health

disorders. Cognitive and behavioral practice, 30(3), 354-366. Retrieved from https://www.researchgate.net/publication/362301815_Clinical_Effectiveness_of_an_Intensive_Outpatient_Program_for_Integrated_Treatment_of_Comorbid_Substance_Abuse_and_Mental_Health_Disorders

26. SAMHSA-HRSA Center for Integrated Health Solutions. (Undated). *Education & Training.* Retrieved from https://www.integration.samhsa.gov/workforce/education-training

BH screening and referral:

27. SAMHSA-HRSA Center for Integrated Health Solutions. (2011). *SBIRT: Screening, Brief Intervention, and Referral to Treatment*. Retrieved from https://www.samhsa.gov/substance-use/treatment/sbirt; and see Emergency Nurses Association. (2008). *Reducing Patient At-Risk Drinking: A SBIRT Implementation Toolkit for the Emergency Department Setting.*
28. Although it appears that no comprehensive evidence-based program of ED screening and referral for mental health issues currently exists [However, see this theoretical adaptation of the SBIRT model, expanded for triaging and intervening in suicidal behavior, especially Figure 1 and Table 1: Larkin, G. L., Beautrais, A. L., Spirito, A., Kirrane, B. M., Lippmann, M. J., & Milzman, D. P. (2009). Mental health and emergency medicine: a research agenda. *Academic Emergency Medicine*, *16*(11), 1110-1119. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3679662/], there is evidence that brief screening tools do well in detecting suicidal ideation among pediatric and young adult ED patients [National Institute of Mental Health. (2013). *Emergency department suicide screening tool accurately predicts at risk youth*. Retrieved from www.nimh.nih.gov/news/science-news/2013/emergency-department-suicide-screening-tool-accurately-predicts-at-risk-youth.shtml], and PTSD among pediatric ED patients and their parents [Ward-Begnoche, W. L., Aitken, M. E., Liggin, R., Mullins, S. H., Kassam-Adams, N., Marks, A., & Winston, F. K. (2006). Emergency department screening for risk for post-traumatic stress disorder among injured children. *Injury Prevention, 12*(5), 323-326. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2563451/].
29. Barata, I.A., Shandro, J.R., Montgomery, M., Polansky, R., Sachs, C.J., Duber, H.C., Weaver, L.M., Heins, A., Owen, H.S., Josephson, E.B. and Macias-Konstantopoulos, W. (2017). Effectiveness of SBIRT for alcohol use disorders in the emergency department: a systematic review. *Western journal of emergency medicine*, *18*(6):1143-1152. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC5654886/pdf/wjem-18-1143.pdf

BH providers:

30. McGee, E. O. (2020). Interrogating structural racism in STEM higher education. Educational Researcher, 49(9), 633-644. Retrieved from https://journals.sagepub.com/doi/pdf/10.3102/0013189X20972718 See also: Tilghman, S., Alberts, B., Colón-Ramos, D., Dzirasa, K., Kimble, J., & Varmus, H. (2021). Concrete steps to diversify the scientific workforce. Science, 372(6538), 133-135. Retrieved from https://brucealberts.ucsf.edu/wp-content/uploads/2022/02/Tilghman-et-al-Diversifying-2021-Science.pdf
31. Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.
32. Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.
33. See, for example, Sieck, L., Chatterjee, T., & Birch, A. (2022). Priming the pipeline: inspiring diverse young scholars in the radiologic sciences begins during early childhood education. *Journal of the American*

College of Radiology, *19*(2), 384-388. Retrieved from https://www.jacr.org/article/S1546-1440(21)00852-8/fulltext

34. Weaver, A., & Lapidos, A. (2018). Mental health interventions with community health workers in the United States: a systematic review. Journal of Health Care for the Poor and Underserved, 29(1), 159-180. Retrieved from https://web.archive.org/web/20190429000716id_/https://muse.jhu.edu/article/686958/pdf
35. Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: a systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 195-211. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803443/
36. Hosek, J., Nataraj, S., Mattock, M. G., & Asch, B. J. (2017). *The Role of Special and Incentive Pays in Retaining Military Mental Health Care Providers*. RAND Corporation. Retrieved from https://apps.dtic.mil/sti/pdfs/AD1085233.pdf
37. Renner, D. M., Westfall, J. M., Wilroy, L. A., & Ginde, A. A. (2010). The influence of loan repayment on rural healthcare provider recruitment and retention in Colorado. *Rural and remote health*, 10(4), 220-233. Retrieved from https://search.informit.org/doi/pdf/10.3316/informit.396789141569821
38. Humphreys, J., Wakerman, J., Pashen, D., & Buykx, P. (2017). *Retention strategies and incentives for health workers in rural and remote areas: what works?* Retrieved from https://openresearch-repository.anu.edu.au/items/dafc0372-8683-48ec-8b10-832835062fb2
39. Moon, K. J., Montiel, G. I., Cantero, P. J., & Nawaz, S. (2021). Addressing Emotional Wellness During the COVID-19 Pandemic: the Role of Promotores in Delivering Integrated Mental Health Care and Social Services. Preventing Chronic Disease, 18. Retrieved from https://www.cdc.gov/pcd/Issues/2021/20_0656.htm
40. Fernandez, J. S., Guzman, B. L., Bernal, I., & Flores, Y. G. (2020). Muxeres en Acción: The power of community cultural wealth in Latinas organizing for health equity. American Journal of Community Psychology, 66(3-4), 314-324. Retrieved from https://www.researchgate.net/profile/Bianca-Guzman/publication/342680802_Muxeres_en_Accion_The_Power_of_Community_Cultural_Wealth_in_Latinas_Organizing_for_Health_Equity/links/5f0311eea6fdcc4ca44ea49a/Muxeres-en-Accion-The-Power-of-Community-Cultural-Wealth-in-Latinas-Organizing-for-Health-Equity.pdf
41. Hoffmann, J. A., Attridge, M. M., Carroll, M. S., Simon, N. J. E., Beck, A. F., & Alpern, E. R. (2023). Association of youth suicides and county-level mental health professional shortage areas in the US. JAMA Pediatrics, 177(1), 71-80. Retrieved from https://jamanetwork.com/journals/jamapediatrics/fullarticle/2798887 See also Ku, B. S., Li, J., Lally, C., Compton, M. T., & Druss, B. G. (2021). Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018. *General hospital psychiatry*, *70*, 44-50. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC8127358/pdf/nihms-1683040.pdf

Recovery transitions:

42. Reif, S., George, P., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Recovery housing: Assessing the evidence. *Psychiatric Services*, *65*(3), 295-300. Retrieved from https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300243
43. Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, 96(10), 1727-1729. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2005.070839. See also: Jason, L. A., Davis, M.

I., & Ferrari, J. R. (2007). The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive behaviors*, *32*(4), 803-818.

44. National Academies of Sciences, Medicine, Medicine Division, Board on Population Health, Public Health Practice, Global Affairs, Technology for Sustainability Program and Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals. (2018). Permanent supportive housing: Evaluating the evidence for improving health outcomes among people experiencing chronic homelessness. National Academies Press: Washington, DC. Retrieved from https://pubmed.ncbi.nlm.nih.gov/30148580/

ECONOMIC STABILITY

Expand affordable housing opportunities:

45. Hope, H. (2022). Accessory dwelling units promoted as a strategy to increase affordable housing stock at White House event. *Smart Growth America*. Retrieved from https://smartgrowthamerica.org/white-house-adus-event/ See also: California Department of Housing and Community Development. (2021). *Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs).* Retrieved from https://www.hcd.ca.gov/policy-research/accessorydwellingunits.shtml
46. Benton. A. L. (2014). *Creating a Shared Home: Promising Approaches for Using Shared Housing to Prevent and End Homelessness in Massachusetts.* Retrieved from https://ash.harvard.edu/files/ash/files/3308562.pdf?m=1637364880
47. ChangeLab Solutions. (2015). *Up to Code: Code Enforcement Strategies for Healthy Housing*. Retrieved from https://changelabsolutions.org/sites/default/files/Up-tp-Code_Enforcement_Guide_FINAL-20150527.pdf

Homelessness prevention and intervention:

48. Identified as a "best practice" in community service: Institute for Local Government, League of California Cities, and California State Association of Counties. (2018). *Homelessness task force report: Tools and resources for cities and counties.* Retrieved from: http://www.ca-ilg.org/sites/main/files/htf_homeless_3.8.18.pdf.
49. Schapiro, R., Blankenship, K., Rosenberg, A., & Keene, D. (2022). The Effects of Rental Assistance on Housing Stability, Quality, Autonomy, and Affordability. *Housing Policy Debate*, 32(3), 456-472. Retrieved from https://www.nlihc.org/sites/default/files/Effects_of_Rental_Assistance.pdf and see Pfeiffer, D. (2018). Rental housing assistance and health: Evidence from the survey of income and program participation. *Housing Policy Debate*, 28(4), 515-533. Retrieved from http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence_Survey-of-Income-Program-Participation.pdf. See also Liu, L. (2022). *Early Effects of the COVID Emergency Rental Assistance Programs: A Case Study.* Available at https://europepmc.org/article/ppr/ppr602197
50. Holl, M., Van Den Dries, L., & Wolf, J. R. (2016). Interventions to prevent tenant evictions: a systematic review. *Health & Social Care in the Community,* 24(5), 532-546. Retrieved from https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12257. See also Cassidy, M. T., & Currie, J. (2022). The Effects of Legal Representation on Tenant Outcomes in Housing Court: Evidence from New York City's Universal Access Program (No. w29836). *National Bureau of Economic Research*. Retrieved from https://www.nber.org/system/files/working_papers/w29836/w29836.pdf
51. Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27(4), 334. See also Raven, M.C., Niedzwiecki, M.J., and Kushel, M. (2020). A randomized trial of permanent supportive housing

for chronically homeless persons with high use of publicly funded services. *Health Services Research*. 2020 Oct: 55 Suppl 2:797-806. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC7518819/

52. Phillips, D. C., & Sullivan, J. X. (2023). Do homelessness prevention programs prevent homelessness? Evidence from a randomized controlled trial. Review of Economics and Statistics, 1-30. Retrieved from https://destinationhomesv.org/documents/2023/06/santa-clara-county-homelessness-prevention-system-study.pdf/

Integrated case management programs for housing:

53. McHugo, G.J., Bebout, R.R., Harris, M., Cleghorn, S., Herring, G., Xie, H., Becker, D. and Drake, R.E. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, 30(4), 969-982. Retrieved from https://www.researchgate.net/profile/Gregory-Mchugo/publication/7786047_A_Randomized_Controlled_Trial_of_Integrated_Versus_Parallel_Housing_Services_for_Homeless_Adults_With_Severe_Mental_Illness/links/004635190e3121c6e9000000/A-Randomized-Controlled-Trial-of-Integrated-Versus-Parallel-Housing-Services-for-Homeless-Adults-With-Severe-Mental-Illness.pdf
54. Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A.H., Arya, N., & Hannigan, T. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PloS One*, 15(4), p.e0230896. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230896
55. Cheng, T., Wood, E., Nguyen, P., Kerr, T., & DeBeck, K. (2014). Increases and decreases in drug use attributed to housing status among street-involved youth in a Canadian setting. *Harm Reduction Journal*, *11*, 12. Retrieved from https://doi.org/10.1186/1477-7517-11-12 and see Smith, T., Hawke, L., Chaim, G., & Henderson, J. (2017). Housing Instability and Concurrent Substance use and Mental Health Concerns: An Examination of Canadian Youth. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 26(3), 214–223. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5642461/ .
56. Appel, P. W., Tsemberis, S., Joseph, H., Stefancic, A., & Lambert-Wacey, D. (2012). Housing First for severely mentally ill homeless methadone patients. Journal of Addictive Diseases, 31(3), 270-277. See also Davidson, C., Neighbors, C., Hall, G., Hogue, A., Cho, R., Kutner, B., & Morgenstern, J. (2014). Association of Housing First implementation and key outcomes among homeless persons with problematic substance use. Psychiatric Services, 65(11), 1318-1324. Retrieved from https://psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300195
57. Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: a meta-analysis. *American Journal of Psychiatry*, 164(3), 393-399. Retrieved from https://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.2007.164.3.393
58. O'Connell, J., Oppenheimer, S., Judge, D., Taube, R., Blanchfield, B., Swain, S., & Koh, H. (2010). The Boston health care for the homeless program: A public health framework. *American Journal of Public Health*, 100(8), 1400–1408. Retrieved from https://doi.org/10.2105/AJPH.2009.173609 See also Howe, E. C., Buck, D. S., & Withers, J. (2009). Delivering health care on the streets: Challenges and opportunities for quality management. *Quality Management In Health Care*, 18(4), 239–246.

Coordinated case management:

59. Campbell-Enns, H. J., Campbell, M., Rieger, K. L., Thompson, G. N., & Doupe, M. B. (2020). No other safe care option: nursing home admission as a last resort strategy. *The Gerontologist*, 60(8), 1504-1514. Retrieved from https://academic.oup.com/gerontologist/article/60/8/1504/5863160. See also Fabius, C. D., & Robison, J. (2019). Differences in living arrangements among older adults transitioning into the community: Examining the impact of race and choice. *Journal of Applied Gerontology*, *38*(4), 454-478.
60. Center for Active Design. (2019). *Healthcare: A Cure for Housing.* The Kresge Foundation. Retrieved from https://www.fitwel.org/resources/p/healthcare-a-cure-for-housing-1

Screening and linkage for social determinants of health:

61. Krist, A., Davidson, K. W., & Ngo-Metzger, Q. (2019). What evidence do we need before recommending routine screening for social determinants of health?. *American family physician*, 99(10), 602-605. Retrieved from https://www.aafp.org/pubs/afp/issues/2019/0515/p602.html
62. Andermann, A. (2018). Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public health reviews*, 39(1), 1-17. Retrieved from https://link.springer.com/article/10.1186/s40985-018-0094-7
63. O'Gurek, D. T., & Henke, C. (2018). A practical approach to screening for social determinants of health. *Family Practice Management*, 25(3), 7-12. Retrieved from https://www.aafp.org/pubs/fpm/issues/2018/0500/p7.html?cmpid=em_FPM_20180516 and see American Academy of Family Physicians. (Undated). *Social Needs Screening Tool*. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf
64. Diop, M. S., Taylor, C. N., Murillo, S. N., Zeidman, J. A., James, A. K., & Burnett-Bowie, S. A. M. (2021). This is our lane: talking with patients about racism. Women's Midlife Health, 7(1), 1-8. Retrieved from https://womensmidlifehealthjournal.biomedcentral.com/articles/10.1186/s40695-021-00066-3 . See also: Southern Jamaica Plain Health Center. (2017.) Liberation in the exam room: racial justice and equity in healthcare. Massachusetts: Southern Jamaica Plain Health Center.

Workforce-related educational attainment and job training:

65. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2006). *The rationale for diversity in the health professions: A review of the evidence.* Retrieved from https://anyflip.com/vhdl/blku/basic; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, and U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health. (2009). *Pipeline programs to improve racial and ethnic diversity in the health professions: An inventory of federal programs, assessment of evaluation approaches, and critical review of the research literature.* Retrieved from https://www.aapcho.org/wp/wp-content/uploads/2012/11/PipelineToImproveDiversityInHealthProfessions.pdf
66. Zafft, C. K. (2008). Bridging the great divide: Approaches that help adults navigate from adult education to college. *Adult Learning*, *19*(1-2), 6-11. See also: Kossoudji, S. A. (1988). English language ability and the labor market opportunities of Hispanic and East Asian immigrant men. *Journal of Labor Economics, 6*(2), 205-228.
67. Tsui, L. (2007). Effective strategies to increase diversity in STEM fields: A review of the research literature. *The Journal of Negro Education*, *76*(4): 555-581. Retrieved from

https://fieldworkfuture.ucsc.edu/assets/files/Effective-StrategiestoIncreaseDiversityinSTEMFields-AReviewoftheResearchLiterature.pdf

68. Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.
69. Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.
70. See, for example, Sieck, L., Chatterjee, T., & Birch, A. (2022). Priming the pipeline: inspiring diverse young scholars in the radiologic sciences begins during early childhood education. *Journal of the American College of Radiology*, *19*(2), 384-388. Retrieved from https://www.jacr.org/article/S1546-1440(21)00852-8/fulltext
71. Poremski, D., Rabouin, D., & Latimer, E. (2017). A randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(2), 217-224.
72. Bretherton, J., & Pleace, N. (2019). Is work an answer to homelessness?: Evaluating an employment programme for homeless adults. *European Journal of Homelessness*, 59-83. Retrieved from https://eprints.whiterose.ac.uk/145311/1/13_1_A3_Bretherton_v02.pdf
73. Johnsen, S., & Watts, B. (2014). Homelessness and Poverty: reviewing the links. In Paper presented at the *European Network for Housing Research (ENHR) conference* (Vol. 1, p. 4). Retrieved from https://pure.hw.ac.uk/ws/portalfiles/portal/6831437/ENHRfullpaper_H_P.pdf
74. Duwe, G. (2015). The benefits of keeping idle hands busy: An outcome evaluation of a prisoner reentry employment program. *Crime & Delinquency*, 61(4), 559-586.
75. Listwan, S. J., Cullen, F. T., & Latessa, E. J. (2006). How to prevent prisoners re-entry programs from failing: Insights from evidence-based corrections. *Fed. Probation*, 70, 19. Retrieved from https://www.uc.edu/content/dam/uc/ics/docs/ListwanCullenLatessaHowToPrevent.pdf
76. Bushnell, L. (2021). Educational disparities among racial and ethnic minority youth in the United States. Ballard Brief, 2021(2):9. Retrieved from https://scholarsarchive.byu.edu/cgi/viewcontent.cgi?article=1033&context=ballardbrief
77. Reynolds, A. J., Temple, J. A., Robertson, D. L., & Mann, E. A. (2001). Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *Jama*, *285*(18), 2339-2346. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/193816

Guaranteed/universal basic income:

78. Robins, P. K., Spiegelman, R. G., & Weiner, S. (Eds.). (2013). *A guaranteed annual income: Evidence from a social experiment.* Elsevier. See also: Standing, G. (2008). How cash transfers promote the case for basic income. *Basic Income Studies*, 3(1). Retrieved from https://eprints.soas.ac.uk/15656/1/How%20Cash%20Transfers%20Promote%20the%20Case%20for%20Basic%20Income,%20published%20BIS.pdf
79. Levine, R. A., Watts, H., Hollister, R., Williams, W., O'Connor, A., & Widerquist, K. (2017). A retrospective on the negative income tax experiments: Looking back at the most innovate field studies in social policy. In The ethics and economics of the basic income guarantee (pp. 95-106). Routledge. Retrieved from https://works.swarthmore.edu/cgi/viewcontent.cgi?article=1346&context=fac-economics See also: Yearby, R., & Mohapatra, S. (2020). Law, structural racism, and the COVID-19 pandemic. Journal of Law and the

Biosciences, 7(1), lsaa036. Retrieved from https://hanson.lafayette.edu/wp-content/uploads/sites/457/2020/09/lsaa036.pdf

80. Silver, D., & Zhang, J. (2022). *Impacts of basic income on health and economic well-being: Evidence from the VA's disability compensation program* (Working Paper 29877). National Bureau of Economic Research. Retrieved from https://www.ehealthecon.org/pdfs/Zhang.pdf
81. Rong, Maxwell and Lowenstein, Christopher and Rehkopf, David H. (2024 pre-print). Effects of the 2015 California EITC Expansion on Colorectal Cancer Risk Factors. SSRN (Social Science Research Network). Retrieved from https://ssrn.com/abstract=4931575

Anchor institution-informed interventions:

82. Koh, H. K., Bantham, A., Geller, A. C., Rukavina, M. A., Emmons, K. M., Yatsko, P., & Restuccia, R. (2020). Anchor Institutions: Best Practices to Address Social Needs and Social Determinants of Health. *American Journal of Public Health*, *110*(3), 309–316. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7002960/
83. Ubhayakar, S., Capeless, M., Owens, R., Snorrason, K., & Zuckerman, D. (2017). *Anchor Mission Playbook*. Chicago, IL: Rush University Medical Center and the Democracy Collaborative.
84. Zuckerman, D. & Parker, K. (2016). Inclusive, Local Hiring: Building the Pipeline to a Health Community. The Democracy Collaborative, part of the Hospitals Aligned for Healthy Communities toolkit series. Retrieved from https://healthcareanchor.network/wp-content/uploads/2021/09/Hospital-Toolkits-Inclusive-Local-Hiring.pdf
85. Schildt, C., & Rubin, V. (2015). Leveraging anchor institutions for economic inclusion. Oakland: PolicyLink. Retrieved from https://nationalequityatlas.org/sites/default/files/pl_brief_anchor_012315_a.pdf
86. Dill, J., & Duffy, M. (2022). Structural Racism And Black Women's Employment In The US Health Care Sector: Study examines structural racism and black women's employment in the US health care sector. Health Affairs, 41(2), 265-272. Retrieved from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2021.01400
87. Lucey, C. R., & Saguil, A. (2020). The consequences of structural racism on MCAT scores and medical school admissions: the past is prologue. Academic Medicine, 95(3), 351-356. Retrieved from https://www.aamc.org/system/files/2020-03/services-mcat-article-collection-academic-medicine-03212020.pdf#page=36

Screening and linkage for social determinants of health:

88. Palakshappa, D., Doupnik, S., Vasan, A., Khan, S., Seifu, L., Feudtner, C., & Fiks, A. G. (2017). Suburban families' experience with food insecurity screening in primary care practices. *Pediatrics*, 140(1). Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/140/1/e20170320.full.pdf
89. Palakshappa, D., Vasan, A., Khan, S., Seifu, L., Feudtner, C., & Fiks, A. G. (2017). Clinicians' perceptions of screening for food insecurity in suburban pediatric practice. Pediatrics, 140(1). Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/140/1/e20170319.full.pdf
90. Klein, M. D., Kahn, R. S., Baker, R. C., Fink, E. E., Parrish, D. S., & White, D. C. (2011). Training in social determinants of health in primary care: does it change resident behavior?. *Academic Pediatrics*, 11(5), 387-393. Retrieved from: https://www.pediatrics.emory.edu/documents/uhi/Klein%202011.pdf
91. Gundersen, C., Engelhard, E. E., Crumbaugh, A. S., & Seligman, H. K. (2017). Brief assessment of food insecurity accurately identifies high-risk US adults. Public health nutrition, 20(8), 1367-1371. Retrieved from: https://escholarship.org/content/qt0wz9499m/qt0wz9499m.pdf

92. Smith, S., Malinak, D., Chang, J., Perez, M., Perez, S., Settlecowski, E., Rodriggs, T., Hsu, M., Abrew, A. and Aedo, S., 2017. Implementation of a food insecurity screening and referral program in student-run free clinics in San Diego, California. *Preventive Medicine Reports*, 5:134-139. Retrieved from: https://www.sciencedirect.com/science/article/pii/S2211335516301541

Increasing healthy food access:

93. Gittelsohn, J., Laska, M. N., Karpyn, A., Klingler, K., & Ayala, G. X. (2014). Lessons learned from small store programs to increase healthy food access. *American Journal of Health Behavior*, 38(2), 307-315. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3960288/
94. Kantor, L. S. (2001). Community food security programs improve food access. *Food Review/National Food Review*, 24(1482-2017-3447), 20-26. Retrieved from https://ageconsearch.umn.edu/record/266234/files/FoodReview-237.pdf
95. Oldroyd, L., Eskandari, F., Pratt, C., & Lake, A. A. (2022). The nutritional quality of food parcels provided by food banks and the effectiveness of food banks at reducing food insecurity in developed countries: a mixed‐method systematic review. Journal of Human Nutrition and Dietetics, 35(6), 1202-1229. Retrieved from https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jhn.12994
96. Centers for Disease Control and Prevention. (2011). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables. Atlanta: U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/nutrition/media/pdfs/strategies-fruits-and-vegetables-508.pdf
97. Minkler, M., Estrada, J., Dyer, S., Hennessey-Lavery, S., Wakimoto, P., & Falbe, J. (2019). Healthy retail as a strategy for improving food security and the built environment in San Francisco. *American journal of public health*, 109(S2), S137-S140. Retrieved from https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305000
98. Promising, but still building evidence base. Garibaldi, L. A., Gemmill-Herren, B., D'Annolfo, R., Graeub, B. E., Cunningham, S. A., & Breeze, T. D. (2017). Farming approaches for greater biodiversity, livelihoods, and food security. *Trends in ecology & evolution*, *32*(1), 68-80. Retrieved from http://rid.unrn.edu.ar:8080/bitstream/20.500.12049/7182/1/Garibaldi%20%282017%29%20Farming%20Approaches%20for%20Greater%20Biodiversity%2C%20Livelihoods%2C%20and%20Food%20Security.pdf. But see: Fung, K. M., Tai, A. P., Yong, T., Liu, X., & Lam, H. M. (2019). Co-benefits of intercropping as a sustainable farming method for safeguarding both food security and air quality. *Environmental Research Letters*, 14(4), 044011. Retrieved from https://iopscience.iop.org/article/10.1088/1748-9326/aafc8b/pdf.
99. Dombrowski, R.D., Hill, A.B., Bode, B., Knoff, K.A., Dastgerdizad, H., Kulik, N., Mallare, J., Blount-Dorn, K. and Bynum, W. (2022). Assessing the Influence of Food Insecurity and Retail Environments as a Proxy for Structural Racism on the COVID-19 Pandemic in an Urban Setting. Nutrients, 14(10):2130. Retrieved from https://mdpi-res.com/d_attachment/nutrients/nutrients-14-02130/article_deploy/nutrients-14-02130-v2.pdf?version=1653281948
100. Bell, C. N., Kerr, J., & Young, J. L. (2019). Associations between obesity, obesogenic environments, and structural racism vary by county-level racial composition. International Journal of Environmental Research and Public Health, 16(5), 861. Retrieved from https://mdpi-res.com/d_attachment/ijerph/ijerph-16-00861/article_deploy/ijerph-16-00861.pdf?version=1552109441
101. Bowen, S., Elliott, S., & Hardison‐Moody, A. (2021). The structural roots of food insecurity: How racism is a fundamental cause of food insecurity. Sociology Compass, 15(7), e12846. See also: Burke, M. P., Jones, S. J., Frongillo, E. A., Fram, M. S., Blake, C. E., & Freedman, D. A. (2018). Severity of household food insecurity and

lifetime racial discrimination among African-American households in South Carolina. Ethnicity & health, 23(3), 276-292. Retrieved from https://www.tandfonline.com/doi/abs/10.1080/13557858.2016.1263286

102. Meckel, K., Rossin-Slater, M., & Uniat, L. (2021). Efficiency versus equity in the provision of in-kind benefits: Evidence from cost containment in the California WIC program. Journal of Human Resources, 0120-10677R1. Retrieved from https://www.nber.org/system/files/working_papers/w26718/w26718.pdf Key finding: "within-ZIP-code access to small vendors raises the likelihood of WIC take-up among first-time mothers, and that this effect is stronger for foreign-born than U.S.-born women and exists even for mothers who also have access to a larger WIC vendor. Our findings suggest that small vendors are uniquely effective at lowering barriers to take-up among subgroups of women with high program learning costs, and that cost containment reforms, which frequently target these vendors, may have unintended consequences of inequitably reducing program access."