PARTNERING TO IMPROVE

2016 Community Benefits Report
2017 Community Benefits Plan

To Care • To Educate • To Discover
January 31, 2017

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

Dear Mr. Nelson:

On behalf of Stanford Health Care, I am pleased to submit our Fiscal Year 2016 Community Benefit Report, which covers the period of September 1, 2015 through August 31, 2016, and our Fiscal Year 2017 Community Benefit Plan. The attached report demonstrates our commitment to making a positive difference in the health of our community. From providing programs to keep older adults healthy and independent to supporting community-based health clinics, Stanford Health Care collaborates actively with local leaders, nonprofits, health care organizations, and community members to address the most compelling health challenges facing the community.

If you have any questions, please contact Colleen Johnson, Director of Community Partnerships at (650) 736-3620 or via email colleenjohnson@stanfordhealthcare.org

Sincerely,

[Signature]

David Entwistle
President & Chief Executive Officer

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

- To Care
- To Educate
- To Discover

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

2016 Community Benefit Report

2017 Community Benefit Plan
Introduction

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

This report covers fiscal year (FY) 2016 beginning September 1, 2015, and ending August 31, 2016. During this time, SHC invested nearly $362 million in services and activities to improve the health of the communities it serves. In addition to providing details on this investment, this report describes the planning process and the Community Benefit Plan for FY 2017.

Community Served

Although SHC cares for patients from throughout California, as well as nationally and internationally, a majority of its patients, nearly 65 percent, live in San Mateo and Santa Clara counties. Therefore, for the purposes of its community benefit initiatives and reporting, SHC has identified these two counties as its target community.

Santa Clara County

In 2015, Santa Clara County had approximately 1.9 million residents with more than half of those individuals living in San Jose. The county population was 56 percent White, 36 percent Asian, 27 percent Latino/Hispanic and 3 percent African-American and 0.5 percent Pacific Islander. Foreign-born individuals make up 37 percent of county residents. The largest groups are from Mexico and China (27 percent), followed by Vietnam and India (22 percent), and the Philippines (15 percent).

In 2014, Santa Clara County’s median income was nearly $94,000; the highest in the state. Despite the high median income level, 14 percent of the county’s general population and one in ten children were living below 100% of the Federal Poverty Level (FPL), which for a family of four was $24,250 per year. Unfortunately, the FPL does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. As such, The Family Economic Self-Sufficiency Standard (FESSS) is a better estimate of economic stability in Santa Clara County. FESSS estimates that an annual income of $85,039 is necessary for a single parent with 2 children living in SCC to meet their most basic expenses. While the California minimum wage increased to $10 per hour in January 2016, the FESSS estimate is equivalent to more than four full-time minimum wage jobs.

By 2030, one in four Santa Clara County residents will be over the age of 60. The fastest growing segment of this population is 85 years and older. The increase of individuals over the age of 60 will have a significant impact on the county’s ability to provide services to meet the needs of this burgeoning population. Additionally, according to the Elder Economic Security Index (Elder Index), nearly half of SCC older adults are economically insecure, with incomes too low to meet their basic needs without additional assistance. 67 percent of Latino seniors and 76 percent of Asian seniors are living in impoverished conditions, compared with 32 percent of White (non-Latino) seniors. Additionally, female seniors and seniors ages 75 and older (any gender) are more likely to experience poverty compared to male seniors and those between the ages of 65 and 74.
The majority of the 6,556 people counted in the 2015 Santa Clara County Homeless Census were single individuals over the age of 25 years (73 percent). Thirteen percent of this population was unaccompanied children and transition-age youth under the age of 25 (children and youth living on their own without the presence of a parent or adult family member). The survey also found that 68 percent of those individuals cited inability to afford rent as the reason for being unsheltered and more than half reported they had no work or income. In comparison to the general population of Santa Clara County, a higher percentage of survey respondents identified as Hispanic or Latino (38 percent compared to 27 percent) and Black or African American (18 percent compared to 3 percent). Only three percent of homeless respondents identified as Asian, compared to 35 percent of the general population.

San Mateo County

San Mateo County (SMC), located on the San Francisco Peninsula, is made up of 20 cities and towns. In 2015, the county’s population was estimated over 765,000 with 62 percent White, 25 percent Hispanic/Latino, 28 percent Asian, 3 percent African-American and 2 percent Native Hawaiian/Pacific Islander. In 2014, the U.S. Census Bureau estimated that the median income for SMC residents was $91,421. While this median income was the third highest in California, 8 percent of all of SMC individuals lived below the Federal Poverty Line (FPL), one in ten children lived below FPL, and 27 percent of SMC female head of household families with children under age 5 live below FPL. As with Santa Clara County, the FPL does not take into consideration local conditions when setting FPL. As such the Family Economic Self-Sufficiency Standard (FESSS) is also a better measure of poverty in San Mateo County. According to the 2014 FESSS, a single parent with two children living in SMC must earn approximately $91,934 annually to meet the family’s basic needs; the equivalent of four full-time minimum-wage jobs in SMC.

According to the Elder Index, older adults are the fastest growing population segment in SMC. By 2040, it is expected that the senior population will nearly double; growing from 11 percent in 2010 to 21 percent. Older adults will also experience a shift in racial and ethnic diversity in the coming years. The percentage of White older adults is projected to decline from 66 percent in 2009 to 48 percent by 2030, while the percent of Asian and Hispanic older adults with grow by 12 percent and 5 percent during that same timeframe. African Americans are estimated to experience a small decrease of approximately one percent. Also, per the Elder Index, 36 percent of seniors struggle to cover their basic expenses because their annual income exceeds federal poverty guidelines and; therefore, they may not qualify for public assistance programs. Additionally, of those who live alone, 47 percent of senior women and 36 percent of senior men as well as 30 percent of senior couples are economically insecure.

Community Assessment Process and Prioritization of Community Health Needs

As required by Senate Bill 697, the Santa Clara County Community Benefit Coalition and the Healthy Community Collaborative of San Mateo County each produced a community health needs assessment in 2016. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs in each county. SHC was an active participant in both collaboratives and played a leadership role as chair of the Santa Clara County Community Benefit Coalition.
Health needs were identified by synthesizing primary qualitative research and secondary data, and filtering those needs against a set of criteria. Needs were then prioritized by countywide groups consisting of county coalition members and community leaders. The final health needs were selected by the SHC Community Partnership Program Steering Committee. The committee reviewed the data, the countywide prioritization processes and current SHC community health initiatives. They then applied another set of criteria from which five significant health needs were selected: access to health care, behavioral health, infectious disease, obesity/diabetes, and cancer.

Summary of Community Benefit Investments

For the purposes of this report, SHC community benefit activities fall into three major categories:

- Benefits for vulnerable populations
- Benefits for the community at large
- Health research, education, and training programs

The table and chart below summarize SHC’s FY 2016 investment in community benefit.

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits for Vulnerable Populations *</td>
<td>$281,454,441</td>
</tr>
<tr>
<td>Medicare (uncompensated expense)</td>
<td>$512,219,096</td>
</tr>
<tr>
<td>Benefits for the Larger Community</td>
<td>$4,148,779</td>
</tr>
<tr>
<td>Health Research, Education and Training</td>
<td>$76,393,241</td>
</tr>
<tr>
<td><strong>Total Excluding Uncompensated Expense of Medicare</strong></td>
<td><strong>$361,996,461</strong></td>
</tr>
<tr>
<td>Total Including Uncompensated Expense of Medicare</td>
<td><strong>$874,215,557</strong></td>
</tr>
</tbody>
</table>

* Includes uncompensated cost of Medi-Cal, Charity Care, and SHC community benefit programs whose target audience is Category 1: Benefits for Vulnerable Populations, and excludes the non-reimbursed cost of Medicare.
Category 1: Benefits for Vulnerable Populations

Investments in Vulnerable Populations

SHC’s largest community benefit investment was in improving access to health care for vulnerable community members. In FY 2016, SHC contributed nearly $281.5 million, 78 percent of its community benefit expenditures, to activities supporting vulnerable populations (excluding uncompensated Medicare). SHC’s uncompensated expense (cost less reimbursement) for Medi-Cal was over $257 million. Charity care for uninsured and underinsured patients totaled nearly $18 million.

Activities for Vulnerable Populations

In addition to the investments in charity care and uncompensated Medi-Cal, SHC’s contribution to other community benefit activities for vulnerable populations was $6.5 million in FY 2016. These activities provide essential services for those most in need in our communities.

SHC supported seven community clinics and a transitional medical unit in a homeless shelter as part of its Improve Access to Care health initiative. Community partners include Cardinal Free Clinics (Arbor and Pacific), Ravenswood Family Health Center, MayView Community Health Center, Samaritan House Redwood City Free Clinic, Peninsula HealthCare Connection, Asian Americans for Community Involvement (AACI) Health Center, and the Medical Respite Center at Home First’s Boccardo Regional Center in San Jose. The goal of this initiative is to build community capacity to deliver quality primary and preventive health care.

Cardinal Free Clinics (CFC), located in east Menlo Park and East San Jose, provides quality, free medical care to low-income uninsured populations, while offering a hands-on learning environment for Stanford students in community health, culturally competent medicine, and leadership development.

In FY 2016, SHC provided more than 2,700 free lab and pathology tests, including chemistry, hematology, microbiology and virology, as well as screening for diseases such as Hepatitis B.

In addition to the lab tests, SHC provided funding to support the Cardinal Free Clinics’ technology infrastructure to build capacity for services and to support improved operational efficiencies and patient care. With earlier SHC funding, CFC implemented an electronic medical record (EMR) system in FY 2011 and in 2016 continued to refine it, as well as to train student and physician volunteers on the new system, with more than 175 volunteers trained. Building on this work, in FY 2016, CFC worked to maintain internet connectivity to ensure access to the EMR system. The system has facilitated and enhanced lab orders, referrals to primary and specialty care, clinic flow, and charting. The EMR system also provides easy access to necessary information during the week when the clinics are not operating.

Arbor Free Clinic, located in Menlo Park, provided 407 patient visits to 534 patients in FY 2016. Most of Arbor’s clients (93 percent) are uninsured; 38 percent are unemployed; and 34 percent require language interpretation services. The clinic serves a diverse population; primarily Asian/Pacific Islander, Hispanic and White.
Pacific Free Clinic (PFC), located in East San Jose, provided 999 patient visits to 407 patients in FY 2016. Over 65% of PFC patients are Vietnamese, and the remaining are mostly Latino or other Asian/Pacific Islander patients. Most PFC patients are 45-64 years old and have at least one chronic illness such as diabetes, hypertension, dyslipidemia, or chronic Hepatitis B.

Ravenswood Family Health Center (RFHC) is an important community partner. Located in East Palo Alto, the health center provides primary care to a diverse, multi-ethnic, low-income population. During SHC’s fiscal year 2016, RFHC provided 15,218 unduplicated low income patients with 87,303 medical, dental, optometry, and behavioral health visits. RFHC’s population included 914 unduplicated homeless patients through 2,422 medical and 649 dental visits. RFHC collaborates with SHC on residency education for Pediatrics, child and adult Psychiatry, Care Coordination with RFHC patients who are seen in the ED and/or are hospitalized, and dental care for special needs children.

In 2010, SHC established a branch of the Stanford Health Library at RFHC to serve the East Palo Alto community. In addition to computers, books and a myriad of other resources, the library has a bilingual medical librarian. The librarian not only staffs the library but conducts research on condition-specific health topics for RFHC patients and staff, as well as for community members. In FY 2016, the librarian assisted in over 2300 interactions with library patrons.

In its partnership with MayView Community Health Center, SHC continued its funding for increased provider hours and for the Quality Improvement Outcomes project for MayView patients with chronic diseases, particularly diabetes. The additional provider hours contributed toward the provision of 10,546 encounter services for 2,571 patients at MayView’s Palo Alto Clinic in FY2016, an increase of 7.4 percent from FY2015 (2,393 patients). Of the diabetic patients who were seen twice in the measurement year, 84% had blood glucose levels under control (HbA1c<7). Over 34 percent of MayView's clients seen at this clinic are uninsured, nearly 95 percent are low-income (below 200 percent of the FPL); 45 percent are Hispanic or Latino White, 17 percent are Asian/Pacific Islander, and 26 percent are Non-Hispanic White.

SHC committed multi-year funding for the Medical Respite Program (MRP). The program, located in a multipurpose homeless facility in San Jose, is a 20-bed transitional unit for homeless patients. It provides a safe, supportive environment where homeless patients can be discharged from acute care settings. The center provides social services, such as housing assistance, health insurance enrollment assistance, food and clothing, and job training, in addition to continued medical care. In FY 2016, 447 homeless patients were referred to the MRP. Of those 447, 256 were accepted. The most frequent reason for not accepting patients was "acuity too high (patient too sick)." A total of 118 patients completed the program. Of those patients, 92% were enrolled in a medical home, 98% were enrolled in some type of healthcare coverage upon discharge, and 71% were placed in some type of housing.

In FY 2016 SHC continued its support of Samaritan House Free Clinic of Redwood City. The clinic provided over 5,200 patient visits serving nearly 1,000 unduplicated clients in fiscal year 2016. The patient population is largely Hispanic (92 percent) and 99 percent are uninsured. The patients served have very low incomes, face language and cultural barriers, and are likely to suffer from multiple chronic conditions due to lack of preventive care. All medical providers at the clinic donate their time and expertise providing services such as primary care, dentistry, gynecology, breast cancer
screenings, dermatology, diabetic care, endocrinology, internal medicine, neurology, nephrology, orthopedics, ophthalmology, optometry, podiatry, pulmonology, nutritional counseling and rheumatology.

**Peninsula Healthcare Connection (PHC).** Peninsula Healthcare Connection (PHC) is a nonprofit organization that provides comprehensive health, mental health and case management services to homeless and low-income community members, free of charge, at their state licensed medical clinic in Palo Alto. PHC is the only provider in northern Santa Clara County focused on health services for individuals experiencing homelessness. The goal of PHC is to promote the overall health and wellness of our patients and to provide advocacy for community members who are homeless or at risk of becoming homeless.

PHC provided over 1800 medical and psychiatric visits to our patients in 2016. The clinic serves a diverse population: 24 percent are African-American, 13 percent are Asian/Pacific Islander, 15 percent are Hispanic, 44 percent are White, 4 percent are “other” and the majority of patients (65 percent) are homeless.

**Asian Americans for Community Involvement (AACI)** provides underserved individuals and families in Santa Clara County with culturally competent high quality health, mental health and wellness programs and services. AACI serves predominantly low-income, first-generation immigrant, and limited English proficient patients, and AACI’s staff members speak more than 40 languages and dialects. Providing primary care services since 2000, AACI Health Center became a Federally Qualified Health Center in 2013. In addition to AACI’s medical and mental health services, its Senior Wellness Center, youth programs, and domestic violence shelter help provide a seamless spectrum of services for patients who need them. In FY15-16, AACI Health Center served 2,569 unduplicated patients through 8,396 patient visits. Among AACI’s patients, 82.7 percent were enrolled in public health coverage programs for low income individuals and families such as Medicare and Medi-Cal. These patients were largely Asian (73.5 percent) and White (8.4 percent), and 62 percent were 60 years of age or older. Over 71 percent were limited-English speakers with Mandarin and Vietnamese being the languages most frequently spoken. AACI has received funding from SHC to expand access to health care services for underserved populations; support AACI’s progress toward recognition as a Level 3 Patient Centered Medical Home (PCMH) from the National Committee for Quality Assurance (NCQA); and to increase access to much-needed integrated behavioral health services.

SHC’s **Emergency Department Registration Unit** partnered with the counties of San Mateo and Santa Clara in a program designed to link uninsured pediatric patients treated in the emergency department with assistance programs such as Medi-Cal, Healthy Families and Healthy Kids. This program resulted from studies by Ewen Wang, MD, associate director of Pediatric Emergency Medicine, Stanford School of Medicine, which showed that uninsured children are less likely to receive routine care due to the fear of financial hardship on their families. In FY 2016, a total of 361 referrals were made to county staff. Other those referrals, 128 children were enrolled in some type of health insurance program.

SHC also assisted uninsured, low-income patients in researching their healthcare options. Services provided by **Health Advocates and Diversified Health Resources**, at no cost to the client, included helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers.
For individuals eligible for the various programs, this service assists patients in obtaining coverage for medical necessities such as hospital care, prescription drugs, and home health care.

In cases where a patient is discharged but has limited or no ability to pay for necessary medical items and certain non-medical services, departments such as the Social Work and Case Management department provided funding to defray the costs. Medical equipment, transportation, temporary housing, medications and meal assistance, among other items and services, are funded and/or coordinated by these hospital departments.

Minority Populations
An important goal of SHC’s community benefit program is to reduce cancer health disparities. It is a goal SHC shares with the Stanford Cancer Institute. In FY 2016, SHC funded the following projects that provided access to community-appropriate cancer education and supportive services for minorities, women, and underserved populations:

St. James Community Foundation: Culturally competent, hands-on education regarding preparing healthy foods for at-risk communities, primarily African-American, Hispanic and Pacific Islander
Latinas Contra Cancer: Psychosocial support for Spanish-speaking cancer patients
Hep B Free Santa Clara: Cancer education and Hepatitis B screening education and promotion for the Chinese and Vietnamese communities of Santa Clara County

The Stanford Medical Youth Science Program is a five-week science- and medicine-based enrichment program that takes place annually and is open to low-income and ethnically diverse high school sophomores and juniors. The goal of the program is to promote the representation of ethnic minority and low-income groups in the health professions. SHC staff mentor students in a variety of departments, including orthopedics, pharmacy, Life Flight, physical therapy, emergency and others mentor the students.

Older Adults
According to one report, nearly one in four San Mateo County residents will be over the age of 65 by 2030. The situation is much the same in Santa Clara County. By 2030, more than one in four county residents will be age 60 or older. SHC prepared for this demographic shift by expanding its Aging Adult Services Program (AAS) and offering components of that program to the community.

Stanford Home Technology Lifeline, a program of AAS, is an in-home medical alert service that helps older adults remain independent by providing an easy way to summon help in an emergency. Stanford Lifeline is one of the few emergency response services that offer reduced or subsidized rates to those in need. In FY16, 400 free or reduced-cost Lifeline subscriptions were provided to low-income older adults.

SHC’s 2016 Community Benefit Plan focuses on three health initiatives: Improve the Health and Well-being of Older Adults, Improve Access to Care, and Reduce Cancer Health Disparities. In support of the first initiative, SHC implemented five evidence-based programs, free of charge, at local senior centers and in low-income communities. Those programs are Strong for Life, Farewell to Falls, Matter of Balance, Stepping On, and Chronic Disease Self-Management.
AAS’s *Strong for Life* is a group exercise program whose goals are to help older adults increase strength, balance and mobility, and reduce isolation. In FY 2016, this program served more than 195 individuals at eight senior centers. Of the eight senior centers, five serve primarily low-income older adults.

AAS also provides a program called *Chronic Disease Self-Management*, a behaviorally oriented program that teaches older adults how to manage their chronic conditions. Participants learn to do appropriate exercises, eat better, manage stress and pain, manage their medications, and better communicate with their families and health care providers. SHC conducted three, six-week workshops in FY 2016.

SHC’s Trauma Services Community Outreach and Injury Prevention staff continued to offer *Farewell to Falls*, a best-practice fall prevention program, to residents in San Mateo and Santa Clara counties. Occupational therapists provide home visits and review multiple risk factors for falls. Additionally, regular follow-up phone calls encourage compliance with exercise and other recommendations. One year after the initial home visit, therapists evaluate participants’ progress. The program enrolled 314 older adults into the program in FY 2016.

SHC’s Trauma Services Community Outreach and Injury Prevention staff provided several no-cost, evidence-based programs to help older adults in San Mateo and Santa Clara. In FY 2016, four seven-session *Stepping On* programs were provided in Santa Clara County. The goal of this program is to empower older adults to change behaviors that can help reduce the risk of falling. Participants work with a physical therapist on strength and balance exercises, hear lectures from a pharmacist and vision specialist, and participate in discussions facilitated by an occupational therapist. Over 67 older adults participated at six sites and completed the Stepping On program.

*Matter of Balance*, another free, evidence-based program, is also provided by Trauma Services. Staff work with older adults in a group setting to help reduce the fear of falling. In eight, two-hour sessions, participants learn to view falls as controllable, set goals for increasing activity, learn tips to make home modifications, and practice exercises to increase strength and balance. Lay leaders coach the sessions, supervised and mentored by an occupational therapist. Trauma Services provided 13 eight-session MOB classes in FY 2016 at sites in Menlo Park, Mountain View, Sunnyvale and Belmont, Redwood City, and San Carlos.

In addition to those participating in in-home and center-based fall prevention programs, an estimated 1442 older adults were reached through educational presentations and health fairs by Trauma Services Community Outreach and Injury Prevention staff.

SHC also supports the work of two countywide collaboratives engaged in improving the health and well-being of older adults with fall prevention education: the *San Mateo County Fall Prevention Task Force* and the *Santa Clara County Fall Prevention Task Force*.

Concerned with the growing incidence of falls among older adults in San Mateo County, a task force of 50 organizations representing community provider agencies, hospitals, nonprofit organizations, senior centers and private service providers came together to form the *San Mateo County Fall Prevention Task Force*. The mission of this group is to decrease falls among older adults through advocacy, resource development, and community education. SHC supports the work of the task force with staff representation and grant funding. This past year’s activities have included conducting
needs assessments with medical providers and home-bound older adults through Meals on Wheels as well as focus groups in English, Spanish and Chinese with community-dwelling older adults.

As a founding member of the \textbf{Falls Prevention Task Force in Santa Clara County}, SHC works in collaboration with the Silicon Valley Healthy Aging Partnership, Santa Clarita County Public Health Department, Emergency Medical System, Valley Medical Center, The Health Trust, and San José State University to reduce the risks of falls for Santa Clara County’s older adults through advocacy, resource development, and community and provider education. FY 2016 activities included the development of a strategic plan, which directs future efforts to outreach to medical providers and expanded community outreach during Fall Prevention Awareness month each September.

\textbf{Category 2: Benefits for the Larger Community}

In FY 2016, SHC contributed $4.1 million to support a wide range of activities to benefit the broader community.

\textbf{The Stanford Health Library}

The Stanford Health Library provides scientifically based health information to assist people in making informed decisions about their health and health care. The health library has five branches located in Palo Alto, East Palo Alto and a new branch at the Stanford Cancer Center South Bay. All health library services are provided to community members free of charge at a cost of nearly $1.28 million annually. The library has an extensive collection of online health and wellness resources including vetted medical websites, 1000 e-books, 70 health lectures available on YouTube and thousands of full text articles. It also has more traditional health and wellness resources such as books, medical journals, periodicals and videos. Other services include health and condition-specific research for individuals conducted by specially trained volunteers.

In FY16, approximately 21,000 community members visited health library branches. An additional 800 individuals were provided services by library staff and volunteers via e-mail and phone and 3500 more were reached by other library programs such as the lecture series. In addition, there were over 300,000 website visits and 20 programs bringing SHC physicians and researchers into the community to discuss a variety of health topics. At Ravenswood Clinic, the library supports not only the community population and patients of the clinic, but the health navigators at the clinic who deal directly in patient education. The health library’s medical librarian conducts research on their behalf and provides them with salient information that assists them as they work with patients. For patients and community members, the librarian provides information that is in alignment with their language needs and health literacy level.

\textbf{Stanford Supportive Care Programs for Cancer and Neuroscience}

The Stanford Supportive Care Programs provide FREE non-medical support services to cancer and neuroscience patients, family members and caregivers regardless of where patients receive their treatment. The programs offer over 60 different services including support groups for many types of cancer and neurological conditions, classes on topics related to the effects of treatment, clinical trials, caregiver workshops, exercise and yoga classes, art and writing workshops, Healing Touch classes, Healing Partners, spiritual workshops, and guided imagery workshops. All programs are provided free of charge to ensure that those in need of services receive them, regardless of their economic
circumstances. In FY 2016, over 35,000 encounters were provided to individuals whose lives were affected by cancer. The neuroscience program began in May 2016. Since May, over 945 encounters have been provided to individuals whose lives were affected by neurologic and neuromuscular disorders.

Support Groups
The Social Work and Case Management Department facilitates support groups for patients, families and community members. Support groups include adult liver transplant; heart transplant; caregiver training for families of patients receiving bone marrow or solid organ transplants; gynecological oncology; pulmonary hypertension; brain tumor; heart/lung and lung transplant; and head and neck cancer.

Traffic and Bicycle Safety
Trauma Service Community Outreach and Injury Prevention staff worked collaboratively with many community groups and coalitions in San Mateo and Santa Clara counties on issues related to traffic safety. A partnership with the City of Palo Alto and Palo Alto Unified School District helped to boost student understanding of bike safety skills and fitted third graders with bicycle helmets. A partnership with the Santa Clara County Public Health Department and a coalition of traffic safety experts, taught 100 kindergarten students proper pedestrian safety practices and developed a data report on pedestrian safety, which was published in December 2016. Additionally, staff partnered with Impact Teen Drivers to educate 228 San Mateo County high school students on the perils of distracted driving.

Cancer Clinical Trials Information and Referral Website and Phone Line
SHC is a significant information resource for the community. In addition to the Stanford Health Library and community health education and outreach activities, SHC provides important information regarding cancer clinical trials. In order to make this information readily available to the broadest possible audience, SHC funds the cancer clinical trials information website, phone line, email query service, information kiosk, and clinical trial search application. Staffed by a clinical trials team, the goal of this program is to increase awareness of cancer clinical trials and link cancer patients to appropriate trials. In FY2016, the patient/community outreach information pages received 2,205 hits, the information kiosk report 9,324 user sessions, the mobile clinical trial search application has a total of 477 users, 640 phone call/email queries from the public were serviced, and 1,975 learners attended a community/patient cancer clinical trials class or visited the clinical trials education table at a community event. 50 Spanish-speaking speaking patient inquiries served through phone/email.

Stanford Life Flight a Stanford operated helicopter air medical and critical care ground transport program available 365 days/year, 24 hours/day, serving Northern CA in the transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient’s ability to pay. Life Flight transports 73% of the program’s flight volume from partner hospitals to Stanford or other major medical centers, and the remaining patients are transported directly from accident scenes or medical emergencies to Trauma Centers or specialty medical centers (stroke, burns, etc). In FY 16, Life Flight transported 416 adult and pediatric patients to Stanford Hospital, Lucile Packard Children’s Hospital, and other Bay Area major medical centers.
Community Emergency Response

SHC plays a key role in disaster planning for the community. Through the Office of Emergency Management (OEM), SHC collaborates with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community. The goal of these activities is to minimize the impact on life, property, and the environment from catastrophic events such as pandemic flu, earthquakes, and other disasters. OEM works with Emergency Medical Services (EMS) in both San Mateo and Santa Clara counties on joint disaster exercises, disaster planning and mitigation, and best practices. OEM provides a critical service for San Mateo and Santa Clara counties’ EMS and other agencies, as well as the Centers for Disease Control and Prevention and other hospitals by maintaining caches of emergency medical equipment and supplies for ready access and deployment in the case of disaster or emergencies. OEM provides regular inventory review and 24/7 security to ensure that these EMS supplies are service-ready at all times.

Category 3: Health Research, Education, and Training

Research, education, and training are core to SHC’s mission. SHC is the setting for training medical students, residents and fellows from the Stanford School of Medicine and, as such, makes a significant contribution to training the next generation of healthcare providers. In FY 2016, SHC contributed over $76.4 million to support health research, education, and training. Of this amount, $68 million was spent to train medical residents and interns.

In addition to training physicians, SHC supports the training of other health professionals. In FY 2016, SHC invested more than $8.4 million in this training. Hospital departments such as Rehabilitation Services, Respiratory Care Services, Radiology, Nuclear Medicine, Nursing, Clinical Laboratory, and Clinical Nutrition provided preceptors and clinical rotations for students from local colleges and universities. SHC also provided a training ground for pharmacy residents and students and psychology graduate students.

The Community Health Advocacy Program provides Stanford undergraduate students weekly coursework focused on addressing the structural determinants of health and field study focused on capacity-building at local health clinics and non-profit organizations. In the 2015-16 academic year, seven students dedicated 900 hours to the following sites and projects: senior health (Avenidas), health careers program for middle school children (Boys and Girls Club), health education for intimate partner violence survivors (Next Door Solutions for Domestic Violence & HomeFirst), and mobile technology management of diabetes (Samaritan House).

Stanford Life Flight conducts helicopter landing-zone training classes for local fire departments and law enforcement. The goal of these trainings is to ensure safety for all involved in emergency air transports — the patient, air and ground personnel, and the community. LifeFlight participated in an estimated 325 hours of landing zone training in FY2016.

Students enrolled in Clinical Pastoral Education come from a wide range of religious traditions, the majority of whom are preparing for a career in chaplaincy or seeking continuing education in the field of pastoral/spiritual care. Upon completion of the year-long program, most students use their training as clergy (pastors, priests, rabbis, chaplains, etc.) to provide effective spiritual care to
individuals and families facing health challenges and other hardships such as death, dying and bereavement. This program served approximately 7,500 individuals in FY 2016.

As part of its support for its community partners and other community-based agencies, SHC hosted two training workshops in FY 2016 for clinical and non-clinical staff. The workshops, titled “Making the Most of Your Community Service – Foundations for Community Engagement,” were taught by faculty from the Stanford School of Medicine Office of Community Health and funded by SHC. Open to staff at SHC as well as staff from other hospitals in the community, these workshops prepared individuals for effectively working in community-based settings. The workshops were also useful for recruiting volunteers to work in the community.

The Office of Research, staffed by research scientists and research coordinators, conducts and facilitates research studies and clinical trials to improve the health and treatment of patients, wherever they receive their care. One such study, conducted with Santa Clara County Emergency Medical Services and major county stroke centers, focused on improving stroke identification and appropriate treatment referrals.

---

i This figure does not include the cost of unreimbursed Medicare.

ii Where available, data were updated for this report

iii SCC Public Health Department, 2014 Santa Clara County Community Health Assessment

iv 2015 population estimates Santa Clara County; U.S. Census Bureau State and County QuickFacts (online, accessed October, 2016)

v Only major ethnic/race categories are included so percentages may not equal 100

vi Developed by the Insight Center for Community Economic Development, the FESSS is a comprehensive measure of how much it costs for working families to live, adjusted for regional differences in prices and the ages of the children in the household; 2014

vii Seniors’ Agenda – 2015 Annual Report; Social Services Agency, Department of Aging & Adult Services


ix 2015 population estimates San Mateo; U.S. Census Bureau State and County QuickFacts (online, accessed October, 2016)

x [www.sustainablesanmateo.org](http://www.sustainablesanmateo.org); Senior Health in San Mateo County – Current Status and Future Trends (2012) (online, accessed October, 2016)

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

xii Healthy Community Collaborative of San Mateo County members: Hospital Consortium of San Mateo County, Kaiser Permanente Redwood City and South San Francisco, Lucile Packard Children’s Hospital Stanford, Peninsula Health Care District, Health Department, Mills-Peninsula Health Services, San Mateo County Human Services Agency, San Mateo Medical Center, Sequoia Healthcare District, Sequoia Hospital, Seton Medical Center, Stanford Health Care, Sutter Health Peninsula and Coastal Region
xiii Santa Clara County Community Benefit Coalition members: El Camino Hospital (Mt View, Los Gatos), Kaiser Permanente (San Jose, Santa Clara), Lucile Packard Children’s Hospital Stanford, Hospital Council of Northern & Central California, O’Connor Hospital, Santa Clara County Public Health Department, Saint Louise Regional Hospital, Santa Clara Valley Health & Hospital System, Stanford Health Care, United Way Silicon Valley

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

xv Vulnerable populations as defined by SB 697: Any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children’s Services Program, or county indigent programs

xvi Maintaining the Health of an Aging San Mateo County, fall 2010

xvii Council on Aging Silicon Valley Area Plan 2012-2016; 2012
2017 COMMUNITY BENEFIT PLAN

This plan represents the first year of a three-year strategic investment in community health. SHC believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan is based on documented community health needs disclosed in the 2016 Community Health Needs Assessment.

A. Behavioral Health

Long-Term Goal: Improve behavioral health among San Mateo and Santa Clara Counties community members, including mental health, substance abuse, and well-being (such as stress, depression, and anxiety).

Intermediate Goal A.1: Improve community members’ access to coordinated behavioral health care.

Goal A.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or Federally Qualified Health Centers (FQHCs) for efforts such as:

- Supporting coordination of behavioral health care and physical health care at MayView Clinic and Asian Americans for Community Involvement (AACI). Supposed practices could include the following:
  - Collaborative care for the management of depression using case managers to connect primary care providers, patients, and mental health specialists.
  - Clinic-based depression care management, including active screening for depression, measurement-based outcomes, trained depression care managers, case management, a primary care provider and patient education, antidepressant treatment and psychotherapy, and a supervising psychiatrist.
  - Staff-assisted depression care supports to ensure increased screening, accurate diagnosis, effective treatment, and follow-up.
- Supporting local programs that provide appropriate medical care and supportive, social services for homeless individuals transitioning out of acute care hospitals, such as funding the Medical Respite Program (MRP).
Goal A.1 Anticipated impact:
- Improved access to behavioral health services among community members.
- Improved access to coordinated care among underserved populations.
- Improved clinical and community support for active patient engagement in treatment goal-setting and self-management.
- Among providers, increased knowledge of the importance of and approaches for routine screening and diagnosis of depression and related disorders.

Intermediate Goal A.2: Expand access to behavioral health services for vulnerable community members in both counties.

Goal A.2 Strategies:
Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Integrated mental health and substance abuse services, treatment, and service provision to support recovery from co-occurring mental illness and substance abuse through a single agency or entity.\(^\text{vii}\)

Participate in collaboration and partnerships to address mental health in the community such as:

- Partnering with San Mateo Santa Clara Counties’ Behavioral Health Departments on efforts to address behavioral health in the community.

Goal A.2 Anticipated impact:
- Improved access to behavioral health services among community members.

B. Cancer

Long-Term Goal: Increase community knowledge about cancer and support of those who are affected by cancer.

Intermediate Goal B.1: Increase access to cancer education, services, clinical trials, and programs, especially among minority and underserved populations.

Goal B.1 Strategies:
Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Partnering with the Stanford Cancer Institute, a National Cancer Institute-designated cancer center, to identify and support community-appropriate cancer education programs and supportive services for minorities, women, and underserved populations that raise awareness, increase knowledge, and encourage positive attitudes and behavioral changes regarding cancer.viii
- Supporting the Stanford Cancer Supportive Care Program (SCSCP) to provide non-medical services (e.g., support groups, classes, and workshops) to cancer patients, family members, and caregivers regardless of where patients receive treatment.8
- Partnering with the Stanford University School of Medicine to provide a cancer clinical trials information website, phone line, email query service, information kiosk, and clinical trial search app in support of community outreach/education on cancer clinical trials.ix

Goal B.1 Anticipated impact:

- Increased opportunity for the community to become aware of cancer clinical trials.
- Increased opportunity for community members, particularly minority community members, with cancer to be linked to appropriate clinical trials.
- Increased access to cancer education and services.
- Increased knowledge about cancer.

C. Diabetes/Obesity

**Long-Term Goal**: Reduce obesity and diabetes incidence among adults in both counties.

**Intermediate Goal C.1**: Increase healthy behaviors among adults in both counties.

**Goal C.1 Strategies**:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Intensive behavioral counseling interventions with adults to promote a healthful diet and physical activity.x

Participate in collaboration and partnerships to promote healthy behaviors such as:

- Get Healthy San Mateo County.
- The Bay Area Nutrition and Physical Activity Collaborative (BANPAC) policy or program initiatives focused on nutrition and physical activity.
Center for Chronic Disease and Injury Prevention of Santa Clara County.

**Goal C.1 Anticipated impact:**

- Increased physical activity.
- Increased consumption of healthy foods.
- Reduced time spent on sedentary activities.
- Reduced consumption of unhealthy foods.
- More policies/practices that support increased physical activity and improved access to healthy foods.

**Intermediate Goal C.2:** Improve diabetes management and weight control among adults in both counties.

**Goal C.2 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Samaritan House’s Diabetes Care Day program or similar activities to improve diabetes self-management.

**Goal C.2 Anticipated impact:**

- Improved diabetes self-management.
- Increased physical activity.
- Increased consumption of healthy foods.
- Reduced time spent on sedentary activities.
- Reduced consumption of unhealthy foods.

**D. Health Care Access and Delivery**

**Long-Term Goal:** Increase the number of people who have access to appropriate health care services.

**Intermediate Goal D.1:** Improve access to quality health care services for at-risk community members.

**Goal D.1 Strategies:**

Allocate resources to support:
Participation in government-sponsored programs for low-income individuals.
Providing Charity Care to ensure low-income individuals obtain medical services needed.
Partnership among SHC’s Emergency Department Registration Unit, Santa Clara County, and San Mateo County to deliver a program designed to link uninsured pediatric patients treated in the emergency department with assistance programs such as Medi-Cal, Healthy Families and Healthy Kids.xi
Partnership between SHC’s Office of Research and Stanford University’s School of Medicine in conducting and facilitating research studies and clinical trials to improve the health and treatment of patients, wherever they receive their care.
Professional health advocates in assisting uninsured, low-income patients to research health care options, including helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers.xiii
Ensuring that all branches of the Stanford Health Library (including library’s collection and health lecture series) are accessible to all community members free of charge.xiv
Partnership with the Stanford University School of Medicine to support summer youth programs that promote the representation of ethnic minority and low-income groups in the health professions, such as the Stanford Medical Youth Science Program (SMYSP).xv
Providing the setting (hospital and clinics) and partial funding for Stanford University’s School of Medicine medical residents, interns, and other health professionals to be trained to provide health care.xvi
LifeFlight, a helicopter air medical and critical care ground transport program available 365 days/year, 24 hours/day, serving Northern CA in the transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient’s ability to pay.xvii

Provide grants, sponsorships, or in-kind support to community health centers, clinics, or FQHCs (e.g., AACI) for efforts such as:

Partnering with the Stanford University School of Medicine to provide free lab and pathology tests to Cardinal Free Clinics, including chemistry, hematology, microbiology, and virology, as well as imaging services and screening for diseases such as hepatitis B.xviii
Collaborating with Ravenswood Family Health Center (RFHC), Lucile Packard Children’s Hospital Stanford, and the Stanford University School of Medicine to identify RFHC patients who frequently use Stanford’s emergency department (ED) and develop appropriate interventions to address these patients’ needs (such as improved chronic disease care and management) while reducing unnecessary ED visits.xix

Goal D.1 Anticipated impact:

◆ Increased access to health insurance and health care services.
- Improved access to appropriate care.
- Improved care coordination among underserved populations.
- Increased pipeline of diverse health care providers.

### E. Infectious Diseases

**Long-Term Goal:** Prevent infectious diseases such as hepatitis B, tuberculosis, influenza and pneumonia among community members in San Mateo and Santa Clara Counties.

**Intermediate Goal E.1:** Improve detection of cases of hepatitis B among community members.

**Goal E.1 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Partnering with the Stanford University School of Medicine to provide free lab and pathology tests to Cardinal Free Clinics, including chemistry, hematology, microbiology, and virology, as well as imaging services and screening for diseases such as hepatitis B.xx
- Partnering with the Stanford University School of Medicine Asian Liver Center on community-oriented programs related to hepatitis B.

**Goal E.1 Anticipated impact:**

- Reduced transmission rates of hepatitis B due to timelier detection.

**Intermediate Goal E.2:** Increase the number of residents vaccinated against hepatitis B.

**Goal E.2 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:

- Universal hepatitis B vaccination in settings in which a high proportion of adults have risk factors for hepatitis B virus (HBV) infection.xx
- Education of primary and specialty care physicians regarding implementation of standing orders to identify adults recommended for hepatitis B vaccination and administer vaccination as part of routine services.23
- Vaccination against hepatitis B of all previously unvaccinated adults aged 19 through 59 years with diabetes mellitus (type 1 and type 2).xxii

Participate in collaboration and partnerships to address hepatitis B in the community such as:
Hep B Free Santa Clara County.

Other partnership opportunities with San Mateo and Santa Clara Counties’ Departments of Public Health, including potential collaboration around improved case management/follow-up for community members diagnosed with hepatitis B.

Goal E.2 Anticipated impact:

- Increased knowledge among providers regarding hepatitis B vaccination.
- Increased community knowledge regarding hepatitis B vaccination.
- Increased hepatitis B vaccination rates.

Intermediate Goal E.3: Improve rates of completion of treatment for those with active TB infections in San Mateo and Santa Clara Counties.

Goal E.3 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, local public health departments, or FQHCs for efforts such as:

- Improving case management for community members diagnosed with active TB, especially—but not exclusively—for homeless community members.xxiii

Participate in collaboration and partnerships to address TB in the community such as:

- Working with county/local jurisdictions to explore leveraging funds from the California Department of Health and U.S. Department of Housing & Urban Development earmarked for temporary housing of persons with TB to provide more temporary housing for TB patients while they complete treatment (as patients must be “noninfectious before discharge to a congregate living setting”).25

Goal E.3 Anticipated impact:

- Increased efforts among case managers to link TB patients (especially, but not exclusively, homeless TB patients) with behavioral health services and social services.
- Increased amount of temporary housing for TB patients during treatment.


Goal E.4 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:
Supporting case detection among foreign-born persons, including:\textsuperscript{25}
  o Appropriate, “targeted public education for foreign-born populations at high risk to explain that TB is a treatable, curable disease.”
  o “[B]etter access to medical services, especially for recently arrived immigrants and refugees.”

Improving case management for those whose primary language is not English by supporting:\textsuperscript{25}
  o Adequate access to “reliable and competent medical translation.”
  o Improved understanding among healthcare providers of “cultural attitudes towards TB.”

Participate in collaboration and partnerships to address TB in the community such as:

- Working with Breathe California of the Bay Area (located in Santa Clara County) and Breathe California Golden Gate Public Health Partnership.
- Partnering with San Mateo and Santa Clara Counties’ Departments of Public Health TB Control Programs.

**Goal E.4 Anticipated impact:**

- Increased knowledge among foreign-born residents about TB and local services and approaches related to TB.
- Increased access to medical services for foreign-born residents.
- Increased knowledge among providers about diagnosis and management of TB and various cultural attitudes towards TB.
- Increased access among foreign-born residents to reliable and competent medical translation in more languages.

**Intermediate Goal E.5:** Reduce incidence of influenza and pneumonia in San Mateo and Santa Clara counties.

**Goal E.5 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:

- Implementing or expanding patient and/or provider vaccination reminder system.\textsuperscript{xxiv}
- Reducing physical barriers to vaccination such as “inconvenient clinic hours for working patients or parents, long waits at the clinic, or the distance patients must travel” by offering pneumonia vaccinations at senior centers and/or senior health fairs and/or via home visits.\textsuperscript{26}
- Conducting educational sessions (e.g., on the importance of pneumococcal and influenza vaccinations and the effectiveness of strategies to improve documentation of vaccination
status and increase vaccination rates) with medical staff and/or nursing/quality improvement staff. xxv

Participate in collaborations and partnerships to address influenza in the community such as:

- Working with Breathe California.
- Partnering with San Mateo and Santa Clara Counties’ Departments of Public Health on influenza prevention and control efforts.

**Goal E.5 Anticipated impact:**

- Increased knowledge of the importance of and access to influenza and pneumonia vaccinations, among community members.
- Increased knowledge of the importance of and approaches to increasing pneumococcal and influenza vaccination rates, among medical staff and/or nursing/quality improvement staff.

**Intermediate Goal E.6:** Improve response to adult infectious disease in rural San Mateo County southern coastside communities.

**Goal E.6 Strategies:**

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Building the capacity of local community-based clinics such as Puente to focus on adult infectious disease prevention, detection, and treatment. xxvi

**Goal E.6 Anticipated impact:**

- Increased adult vaccination rates for infectious diseases.
- Reduced incidence rates of infectious disease in rural San Mateo County southern coastside communities.

**F. Community Emergency Response**¹

**Long-Term Goal:** Improve the community’s ability to “prevent, prepare for, respond to, and recover from a major health incident.” xxvii

---

¹ While not rising to the threshold of a significant health need as documented in the 2016 CHNA, SHC added Community Emergency Response as a need to be addressed based on its knowledge of the community it serves.
Intermediate Goal F.1: “Strengthen and sustain health and emergency response systems” in San Mateo and Santa Clara Counties.10

Goal F.1 Strategies:

Participate in collaboration and partnerships to address community emergency response such as:xxviii

- Collaborating, through the Office of Emergency Management (OEM), with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community.
- Through OEM, working with Emergency Medical Services (EMS) in both San Mateo and Santa Clara Counties on joint disaster exercises, disaster planning and mitigation, and best practices.
- Through OEM, maintaining caches of emergency medical equipment and supplies for ready access and deployment in San Mateo and Santa Clara Counties in the case of disaster or emergencies. OEM also provides regular inventory review and 24/7 security to ensure that these EMS supplies are service-ready at all times.

Goal F.1 Anticipated impact:

♦ Sustained community disaster preparedness.

G. Older Adult Healthviii

Long-Term Goal: Improve the health and well-being of older adults in San Mateo and Santa Clara Counties.

Intermediate Goal G.1: Improve older adults’ access to critical prevention and health-promotion services.

Goal G.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

viii While not rising to the threshold of a significant health need as documented in the 2016 CHNA, SHC added Older Adult Health as a need to be addressed based on its knowledge of the community it serves.
- Exercise and educational programs that help older adults increase strength, balance, and mobility, and reduce their risk of falling, such as A Matter of Balance (MOB), Stepping On, Healthy Moves for Aging Well, or Strong for Life.\textsuperscript{xxix}
- The Chronic Disease Self-Management Program (CDSMP), a behaviorally-oriented program that teaches participants how to manage their chronic conditions and helps them develop confidence in managing their health.\textsuperscript{29}
- A falls prevention program such as Farewell to Falls, including medication review, home visits, review and remediation of in-home falls risk factors, home modifications, in-home exercise program, and regular follow-up.\textsuperscript{xxx}
- Reduced-rate or subsidized in-home medical alert service, Stanford Lifeline, for low-income older adults.\textsuperscript{xxxi}

\textbf{Goal G.1 Anticipated impact:}

- Increased physical activity.
- Reduced time spent on sedentary activities.
- Increased awareness of risk factors related to falls.
- Reduced age-adjusted falls hospitalization and mortality rates.

\textbf{ENDNOTES}


vi Medical Respite Program: 20 bed respite unit located in a homeless shelter in San Jose that provides a safe, supportive environment for homeless patients discharged from acute care hospitals.


xiii Addresses strategies under U.S. Department of Health and Human Services’ Strategic Goal 1, Objective A, to “extend affordable coverage to the uninsured,” including identified strategies such as “Maximize the participation of...eligible individuals in affordable health insurance coverage by helping them understand insurance options” and “...provide outreach and enrollment assistance...”,
http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj_a


xi Addresses Healthy People 2020 emerging health issue of “increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities.” https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

xii Used as primary transport:


Used as secondary transport:


— Provide information to all adults regarding the health benefits of hepatitis B vaccination, including risk factors for HBV infection and persons for whom vaccination is recommended.

— Help all adults assess their need for vaccination.

— Vaccinate adults who report risks for HBV infection.

— Vaccinate adults requesting protection from HBV infection.

xxii Centers for Disease Control and Prevention. (2011). Use of Hepatitis B Vaccination for Adults with Diabetes Mellitus: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011; 60 (No. RR-50):1709-1711. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a4.htm; the recommendation is to vaccinate as soon as possible after a diagnosis of diabetes is made, and to vaccinate all previously unvaccinated adults aged ≥60 years with diabetes at the discretion of the treating clinician after assessing their risk and the likelihood of an adequate immune response to vaccination.


“Case management for homeless persons with TB should be structured to encourage adherence to treatment regimens by making TB treatment a major priority for the patient. It should include provision of housing, at least on a temporary basis; an increasing number of models have demonstrated the importance of a housing incentive in successful treatment of TB in homeless persons. Case management should also include establishing linkages with providers of alcohol and substance treatment services, mental health services, and social services.”

“Targeted education of populations at high risk might be particularly effective in neutralizing the stigma associated with TB among foreign-born populations on the basis of cultural beliefs in their country of origin. Programs for patient education should always be designed with input from the targeted community.”

“...education campaigns for foreign-born persons at high risk...should communicate the importance of TB as a personal and public health threat, the symptoms to look for, how to access diagnostic and targeted testing services in the community, and the concept of LTBI. The purpose of this education is to destigmatize the infection, acquaint the population with available medical and public health services, and explain the approaches used to treat, prevent, and control TB.”

“Culturally appropriate case management should be instituted, including readily available professional translation and interpretation services, for all foreign-born persons. If possible, outreach workers should be from the patient’s own cultural background.”


xxvi Addresses Healthy People 2020 emerging health issue of “increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities.” https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.


