PARTNERING TO IMPROVE

2018 Community Benefits Report
2019 Community Benefits Plan

To Care • To Educate • To Discover

Stanford
HEALTH CARE
STANFORD MEDICINE

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

---

2018 Community Benefit Report

2019 Community Benefit Plan

Stanford
HEALTH CARE
STANFORD MEDICINE

January 31, 2019

Mr. Kyle Rowert
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. Rowert:

On behalf of Stanford Health Care, I am pleased to submit our Fiscal Year 2018 Community Benefit Report, which covers the period of September 1, 2017 through August 31, 2018, and our Fiscal Year 2019 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,

David Entwistle
President and Chief Executive Officer

Enclosure

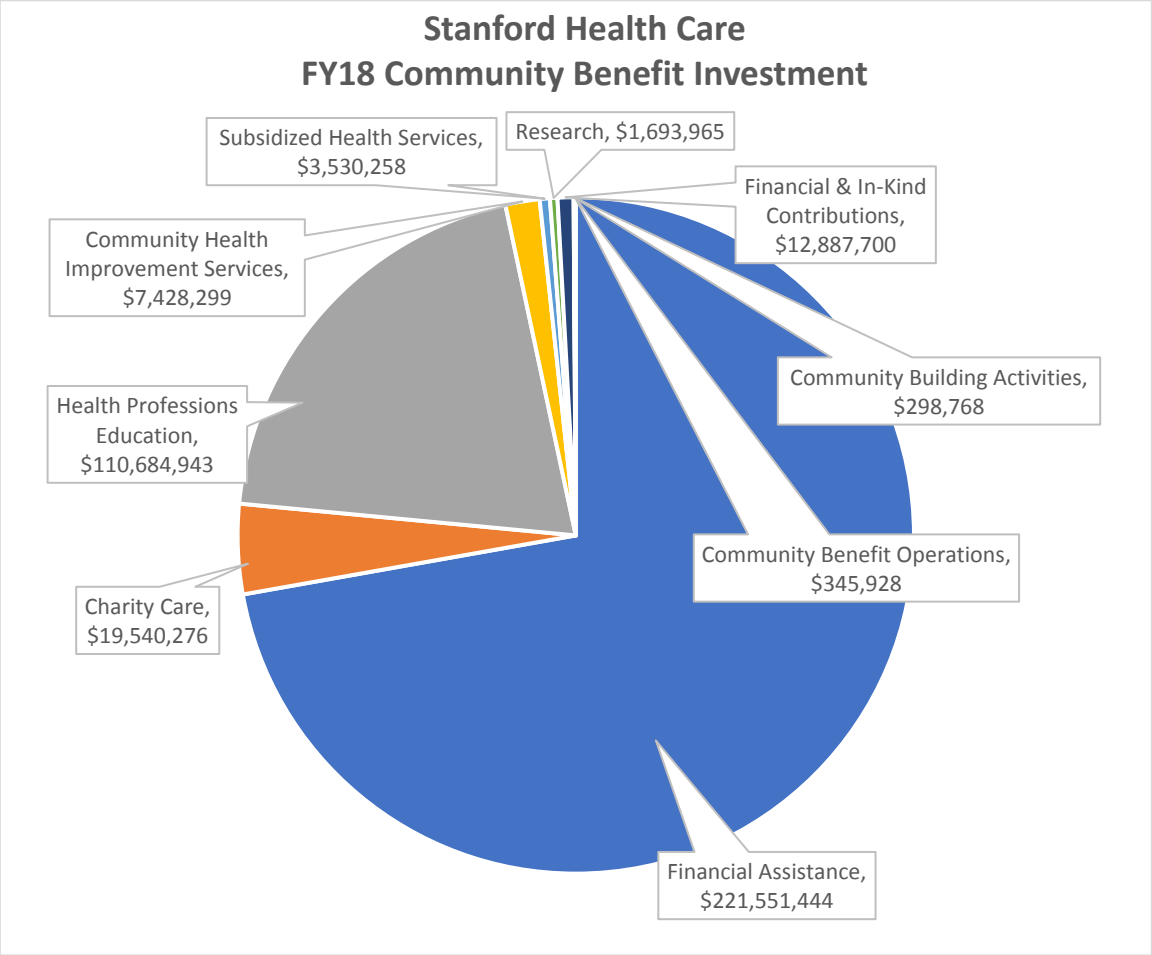
Contents

I. Introduction

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

II. Total Quantifiable Community Benefit Investment for FY2018

This report covers fiscal year (FY)2018 beginning September 1, 2017, and ending August 31, 2018. During this time, SHC invested over **$378 million**[i] in services and activities to improve the health of the communities it serves. In addition to providing details on this investment, this report describes the community benefit planning process and the Community Benefit Plan for FY 2019.



Financial Assistance and Charity Care: $241,091,720

- Uncompensated costs of medical services for patients enrolled in Medi-Cal, out-of-state Medicaid and other means-tested government programs: $221,551,444
- Charity Care: $ 19,540,276

Health Professions Education: $110,684,943

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

Community Health Improvement Services: $7,428,299

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

Subsidized Health Services: $3,530,258

- Stanford Life Flight

Research: $1,693,965

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

Financial and In-Kind Contributions: $12,887,700

- Community clinic capacity building and support
- Community health improvement grants
- Donations of medical equipment, supplies, and food
- Event sponsorships for nonprofit organizations

Community Building Activities: $298,768

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

Community Benefit Operations: $345,928

- Community Health Needs Assessment costs
- Dedicated Community Benefit staff
- Reporting and compliance costs
- Training and staff development

III. COMMUNITY SERVED

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

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

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

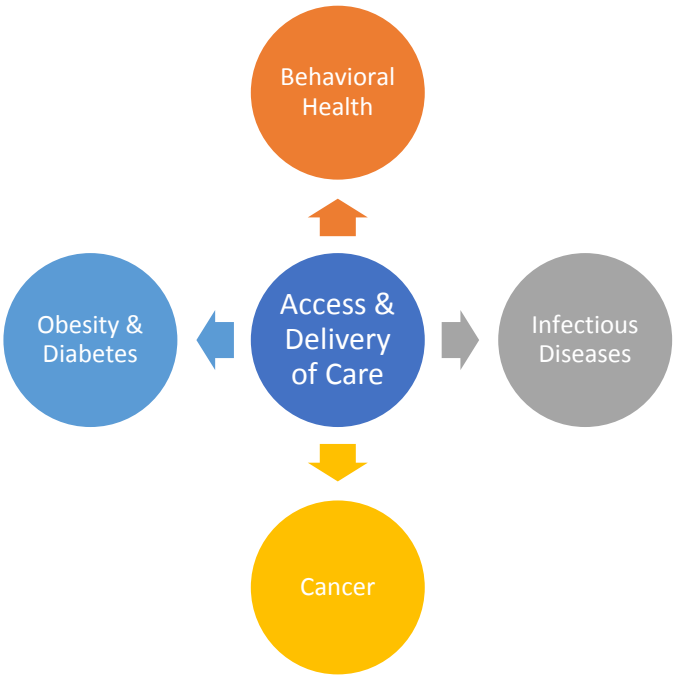
In 2018, Insight published *The Cost of Being Californian*, which cites significant income, ethnic, and gender disparities exist across California[v]. The key findings of The Cost of Being California report, include:

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

IV. Community Assessment Process and Prioritization of Community Health Needs

As required by California Senate Bill 697[vi], 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[vii] [viii] and played a leadership role as chair of the Santa Clara County Community Benefit Coalition.

Health needs were identified by synthesizing primary qualitative research and secondary data, and filtering those needs against a set of criteria. Needs were then prioritized by countywide groups consisting of county coalition members and community leaders. The final health needs were selected by the SHC Community Partnership Program Steering Committee (CPPSC) after reviewing the data, countywide prioritization processes, and current SHC community health initiatives. The CPPSC then applied another set of criteria[ix] from which five significant health needs were selected:



V. Community Investment to Address Community Health Needs

SHC's annual community investment focuses on improving the health of our community's most vulnerable populations. To accomplish this goal, all community grant investment from FY17 – FY19 will improve access to and delivery of care through the five prioritized community health needs: Access to Health Care, Behavioral Health, Cancer, Communicable Diseases, and Obesity & Diabetes.

A. Access to Care

Partner	Program	Program Details and FY18 Impact
Cardinal Free Clinics (CFC)	Administrative and Technology support	This program will access to care for the medically underserved, mainly the uninsured and LGBTQ+ populations, in San Mateo and Santa Clara counties. · Developed a culturally competent health screening tool for LQBTG+ population at the SMC Pride Center · Reduced patient wait times from 60 to 30 minutes by adopting a new online patient scheduling tool. · Developed a food insecurity screening and referral tool for patients Investment: $42,850 Persons served: 1129
Cardinal Free Clinics (CFC)	Free Laboratory and Radiology services	This program provides laboratory and radiology services free of charge to uninsured and underinsured individuals. In 2017, approximately 93% of CFC clients are uninsured. · 2989 free lab tests were provided · 35 free xrays were provided Investment: $69,291 Persons served: 3024
Ravenswood Family Health Center (RFHC) & **MayView Community Health Center (MCHC)**	Care Coordination for Complex Patients	Through a full-time social worker, this program provides community-based care coordination for high-risk, complex patients. · Improve health care access · Strengthen medical home engagement · Provide care plans and connect with social services as needed · Reduced ED utilization by 55% Investment: $100,000 Persons served: 45

Medical Respite Program (MRP)	Purchase of wheelchair accessible vehicle	One-time grant funding for MRP to purchase a vehicle to support all transportation needs of MRP clients, including from hospital (upon discharge) to MRP, pick up medications, attend follow-up medical and mental health appointments, register and/or collect payments from the General Assistance/Social Security office/Food Stamps, apply for housing and employment, evaluate Board and Care options, etc. Investment: $70,000
Operation Access	Care navigation and access to specialty care and outpatient surgical services for the uninsured and underinsured	Program partners with local hospitals and health systems to link donated surgical preventive care to uninsured and underinsured patients in San Mateo and Santa Clara Counties at no charge to patients. · 134 surgical procedures and diagnostic services completed · 90% of patients reported improved health and quality of life as a result of services provided Investment: $10,000 Persons served: 103
Avenidas – Rose Kleiner Center	Nurse Navigator/Community-Based Home Health Program	Program provides intensive care coordination for low-income seniors with highly complex medical, cognitive, and behavioral health conditions. · Reduced ED visits by 80% · Reduced hospital stays by 80% · No 30-day readmissions for 90% of participants Investment: $100,000 Persons served: 16

B. Behavioral Health

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

Partner	Program	Program Details and FY18 Impact
Asian Americans for Community Involvement (AACI)	Integrated Behavioral Health Program (IBH)	This program provides integrated primary care and behavioral health services to all AACI patients. · 44% of patients received depression screening at their primary care physician (PCP) visit and follow-up services were offered for patients with positive screening results · 90% of patients that participated in the "Better Choices, Better Health" (chronic disease self-management curriculum) program reported "improved a lot" in their confidence and ability to self-manage their chronic health condition(s) · 175 behavioral health referrals from PCPs (a 20% increase from the previous year) Investment: $25,000 Persons served: 51
MayView Community Health Center	Integrated Behavioral Health Program (IBH)	This program supports the design and implementation of an evidence-based IBH program, which offers behavioral health services in tandem with primary care. · 100% of providers participated in IBH training · 94% of patients received depression screenings · 513 patients received 1+ IBH visit · 217 diabetic patients received 1+ IBH visit · 386 patients with moderate to severe mental health conditions received referral to community provider for treatment Investment: $70,000 Persons served: 7450

Medical Respite Program	Behavioral health testing and therapy	Through a full-time psychologist/post-doctoral fellow and 0.5 FTE case worker, this program administers psychologic and neurologic testing, conducts 1:1 cognitive behavioral therapy sessions onsite, and increases behavioral health follow-up appointment attendance. · 97% of patients received MoCA testing within days of admission · 96% of patients received neuropsychiatric testing as indicated by MoCA score · 597 individual cognitive behavioral therapy sessions conducted · Reduced appointment no-show rate by 90% Investment: $82,140 Persons served: 256
Peninsula Healthcare Connection	Behavioral Health Outreach and Prevention Program	This program increases access to behavioral health services for homeless and at-risk individuals in north Santa Clara County. · 344 behavioral health visits provided · 195 previously uninsured individuals were enrolled in health insurance through Covered California Investment: $25,000 Persons served: 398
National Alliance on Mental Illness (NAMI)	Community-based mental health support programs	This program links patients with mental health disorders with peer mentors to aid in treatment and recovery. · 89 hours of mentoring provided · 134 community resource and health education packets distributed Investment: $23,050 Persons served: 165
Mental Health America of California (MHAC)	Peer Mentoring for Dual Diagnosis Patients (Mental Health & Substance Abuse diagnosis)	This program links people with co-morbid mental health and substance use disorders with peer mentors to aid in treatment and recovery. · Established referral mechanism for local health care providers · Peer mentors provide council and support for patients in the community and at emergency department admission Investment: $95,905

Kara	Subsidies for complex grief counseling services	This program provides grief counseling for low-income patients whose grief is complicated by higher degrees of trauma and/or additional relational or emotional complications. · 1322 complex grief counseling sessions provided Investment: $12,000 Persons served: 67

C. Cancer

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

Partner	Program	Program Details and FY18 Impact
Community Health Partnership	Community Mammography Access Project (CMAP)	This program increases access to mammography services among low-income, uninsured and underinsured women age 40 years+ living in Santa Clara County. Program interventions include 1) provider training to monitor and increase breast cancer screening rates, 2) community outreach and health education, 3) patient navigation services. · 1690 women received breast health education · 154 women received patient navigation services linking them to health coverage and a medical home for preventive breast care · 101 women reported receiving preventive breast care services at their medical home Investment: $10,000 Persons served: 1690

Asian Liver Center	Viral Hepatitis and Liver Cancer Public Awareness and Education Project	This program reduces the transmission and burden of viral hepatitis and liver cancer in the Vietnamese community in Santa Clara County. · Five outreach and health education events were held, which reached approx. 2350 individuals · Four new community partnerships were formed to increase health education and outreach across Santa Clara County · 12 Vietnamese-speaking volunteers were recruited and trained to administer health education · Public service announcements were broadcast on local Vietnamese radio and television for a 6-month period · New culturally and linguistically-appropriate health education brochure developed Investment: $10,000 Persons served: 3550
St. James Foundation	Eat Well, Be Well	This program is a nutrition and cooking education program geared to help survivors of cancer, especially colorectal cancer, maximize recovery during and post treatment and prevent recurrence. The program provides hands-on, culturally competent cooking classes. As a result of program participation, · Educated the African American community on the link between cancer and poor nutrition, including education on plant-based diets Investment: $10,000 Persons served: 118
Latinas Contra Cancer	Increasing Cervical Cancer Awareness and Screening in the Latina Community	This program increases cervical cancer screening among low-income, Spanish-Speaking Latinas ages 16-23. ·174 women received education about cervical cancer screening and HPV vaccines Investment: $10,000 Persons served: 174

D. Communicable Diseases

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

Partner	Program	Program Details and FY18 Impact
Peninsula Healthcare Connection	Infectious Disease Outreach and Prevention Program	This program offers health education regarding disease transmission, treatment, and prevention practices as well as referrals to clinic-based health care services. ·300 patients received screening, vaccination, and referral services for TB, HepB, Influenza, and Pneumonia ·515 individuals received health education and referrals to follow-up care as needed ·195 previously uninsured individuals were enrolled in health insurance through Covered California Investment: $25,000 Persons Served: 398
Santa Clara County Public Health Department **&** **Asian Americans for Community Involvement**	Tuberculosis Prevention and Chronic Hepatitis B Virus Screening and Management Program	This program 1) improves targeted testing and treatment for latent TB infection to prevent patients from developing TB disease in future, 2) improves screening for chronic HepB infection among at-risk persons, 3) improves management of patients with chronic HepB infection. · Baseline assessment in progress · Electronic health record alerts for PCPs developed and tested Investment: $20,000
SF HepB Free – Bay Area	Program expansion into San Mateo County	This program supports Hepatitis B awareness, prevention, and treatment for at-risk populations in San Mateo County. · 270 hepatitis screenings conducted · 2100 people directly educated on risk factors, diagnosis, and treatment for Hepatitis B Investment: $15,000 Persons served: 2100

E. Obesity & Diabetes

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

Partner	Program	Program Details and FY18 Impact
Ravenswood Family Health Center (RFHC)	Diabetes Education and Management	This program helps diabetic and pre-diabetic patients successfully manage their conditions, adopt healthy lifestyles, and achieve improved health outcomes. · 243 unduplicated patients completed the program · 72% of patients decreased their A1c level by 2% OR met their personal A1c goal · Blood pressure clinic established, operating two days per week bimonthly Investment: $75,000 Persons served: 243
Samaritan House Free Clinic, Redwood City	Diabetes Care Days 2.0 (DCD 2.0)	This program offers monthly multi-station group visits for comprehensive diabetes care. · 281 patients participated in the DCD+ program · 99% of participants increased knowledge of diabetes after completing the program · 650 patients met with a nurse practitioner for diabetes-related care · 9.5% improvement in HbA1c levels among participants after three months · 0.5% mean weight loss among obese participants · 2.4% mean weight loss among overweight partipants · 18 participants attended a healthy lifestyle health education course · 82% of participants were screened for depression · 20 new referrals to behavioral health serves were made Investment: $125,000 Persons served: 281

VI. HOSPITAL-BASED PROGRAMS SUPPORTING COMMUNITY HEALTH IMPROVEMENT

Program	Program Details and FY18 Impact
Emergency Department Registration Unit	In partnership with Santa Clara and San Mateo counties, this program links uninsured pediatric patients treated in SHC's emergency department with health insurance including Medi-Cal, Healthy Kids, Healthy Families, etc. Investment: $688,460 Persons served: 120
MedData (Patient financial advocacy services)	This program assists low income, uninsured, underinsured and homeless patients in researching their healthcare options. Services, provided at no cost to the client, included helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers as needed. Investment: $2,605,673 Persons served: 2484
Post-Hospital Support	For patients that have limited or no ability to pay for necessary medical and non-medical services, the Social Work and Case Management department provides funding and resources. Services include medical equipment, transportation, temporary housing, medications and meal assistance. Investment: $120,463
Stanford Medical Youth Science Program (SMYSP)	SMYSP is an annual five-week science and medicine-based enrichment program for low-income and ethnically diverse high school sophomores and juniors. Students are linked with an SHC staff mentor and participate in real-life health professions education. The program goal is to promote representation of ethnic minority and low-income groups across all health professions, including orthopedics, pharmacy, Life Flight, physical therapy, and emergency. Investment: $250,239 Persons served: 24 students
Stanford Health Library (SHL)	SHL provides scientifically based health information to assist in making informed decisions about health and health care. Staffed with health librarians at all five branches, including at the Ravenswood Family Health Center in East Palo Alto, culturally-competent services, resources, and health education are provided to the community free of charge. Investment: $2,520,519 Persons served: 28,192

Stanford Supportive Care Programs for Cancer and Neuroscience (SSCP)	SSCP provides free, non-medical support services to cancer and neuroscience patients, family members, and caregivers regardless of where patients receive treatment. ·60+ services are provided, including support groups, health education classes, clinical trials, caregiver workshops, exercise and yoga classes, and art therapy classes Investment: $1,074,063 Persons served: 13,000
Cancer Clinical Trials Information and Referral Website and Phone Line	This program increases awareness of and links cancer patients with appropriate clinical trials. Given challenges with diversity among clinical trial participants, information is provided in English, Spanish, Chinese, and Russian. · Webpage views: 38,157 · Mobile search app users: 174 · Email alert subscriptions service subscribers: 693 · Information service line inquiries: 961 in English, 27 in Spanish · 1826 people reached with community education Investment: $1,300,000 Persons served: 41,838
Stanford Life Flight	Helicopter transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient's ability to pay. ·73% of flight volume transports critically ill patients from partner hospitals to major medical centers, including Stanford Health Care ·27% of flight volume is transported from accident sites or medical emergencies to Trauma Centers or specialty medical centers, such as stroke or burn centers Investment: $3,530,258 Persons served: 394

Community Emergency Response	As the only Level 1 Trauma Center between San Francisco and San Jose, SHC plays a key role in disaster planning for the community. Through the Office of Emergency Management, SHC collaborates with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community. The goal of these activities is to minimize the impact on life, property, and the environment from catastrophic events such as pandemic flu, earthquakes, and other disasters. · Coordination with emergency management services (EMS) in joint disaster exercises, disaster planning and mitigation, and best practices · Maintains caches of emergency medical equipment and supplies for ready access and deployment in the case of a disaster or emergency · Provides regular inventory review and 24/7 security to ensure that these EMS supplies are service-ready at all times Investment: $36,526
Chronic Disease Self-Management Program (CDSM)	Through a six-week behavior modification workshop, this program teaches older adults how to manage their chronic conditions. Participants learn to do appropriate exercises, eat better, manage stress and pain, manage their medications, and better communicate with their families and health care providers. · Two six-week programs were offered in FY18 Investment: $11,521 Persons served: 30
Aging Adult Community Health Education Programs	A variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have the resources, tools, and support needed to manage their health and live an enriched life. Investment: $35,138

VII. COMMUNITY-BASED PROGRAMS SUPPORTING COMMUNITY HEALTH IMPROVEMENT

Program	Program Details and FY18 Impact
Support Groups	The Social Work and Case Management Department facilitates support groups for patients, families and community members. Support groups include transplant groups for patients and caregivers; cancer-related groups, and a pulmonary hypertension group. Investment: $59,600 Persons served: 132
Traffic and Bicycle Safety	SHC provides several traffic and driving safety educational programs to reduce traffic-related injuries and deaths. Programs include: · Bike rodeo and helmet fitting program: provides and fits bicycle helmets and offers bike safety instruction to elementary school students · Distracted Driving program: educates high school students on the consequences of distracted driving and offers tools to avoid distracted driving · Every 15 Minutes program: car crash simulation for high school students Investment: $947 Persons served: 629
Stanford Home Technology Lifeline	This program offers in-home medical alert services for older adults. Through the service, older adults are supported to remain independent by providing an easy way to summon help in an emergency and community-based resources for clients at-risk for falls or other emergencies. Need-based subsidies are provided. Investment: $9,415 Persons served: 350 free or reduced cost subsidies provided
Strong for Life	This program is a group exercise program that helps older adults increase strength, balance and mobility, and reduce isolation. This program is provided free of charge. Investment: $81,971 Persons served: 8268
Farewell to Falls	This best-practice fall prevention program offers occupational therapist home visits to assess fall risk-factors, makes recommendations for risk-factor mitigation, including exercise and home safety improvements, and provides ongoing follow-up for one year. This program is provided free of charge. Investment: $177,516 Persons served: 256

Stepping On	This program empowers older adults to make behavior change to reduce their risk of falling. Resources include strength and balance exercises and risk-factor education, such as home safety, footwear, medications, and vision issues. Program facilitators include physical and occupational therapists, pharmacists, and vision specialists. This program is provided free of charge. · Four eight-class sessions were conducted in FY18 Investment: $10,967 Persons served: 37
Matter of Balance	This evidence based program works with older adults to reduce the fear of falling. Through occupational therapists and volunteer lay leaders, participants learn to view falls as controllable, set goals for increasing activity, learn appropriate home modifications to reduce the risk of falling, and practice exercises to increase strength and balance. ·23 two-hours sessions were conducted in FY18 Investment: $30,558 Persons served: 295
Rebuilding Together	SHC provides funding and volunteer support for housing and infrastructure improvements for low-income community members and not-for-profit organizations. Investment: $3,590
Aging Adult Community Health Education Programs	A variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have the resources, tools, and support needed to manage their health and live an enriched life. Investment: $35,138
Hepatitis B Screenings	To support Hep B Free – Bay Area's community-based Hepatitis B screenings in San Mateo County, SHC provides no-cost blood draw supplies and coordinates volunteer nurse event staffing. Investment: $21,266 Persons served: 324
Rehabilitation Community Health Education Programs	The Rehabilitation Department provides a variety of community health education programs, including a Speech Communication group therapy program that supports those recovering from a stroke with opportunities to improve their speech, language, and cognitive skills. Investment: $5,939 Persons served: 614

VIII. HEALTH EDUCATION, RESEARCH, AND TRAINING

Program	Program Details and FY18 Impact
Medical Student, Resident, and Fellow training	Student training programs included all primary and specialty care programs. Investment: $101,850,189
Allied Health Professions Education	Student training programs, included Clinical Laboratory Clinical Nutrition Nuclear Medicine Nursing Paramedic Pharmacy Psychology Radiology Rehabilitation Services Respiratory Care Services Investment: $8,177,460
Clinical Pastoral Education	Students, from a range religious traditions, enroll in this program to prepare for a career in chaplaincy or receive continuing education in pastoral/spiritual care. Upon completion of this year-long program, students use their training as clergy to provide effective spiritual care to individuals and families facing health challenges, including death, dying, and bereavement. Investment: $465,477
Office of Research	This program, staffed by research scientists and coordinators, conducts research students and clinical trials to improve care delivery and health outcomes across the health care field. FY17 research initiatives included: · Refining stroke diagnosis and treatment protocols for emergency management personnel and streamlining stroke treatment referrals · Healthcare Con: an interdisciplinary conference developed to disseminate the latest in research, innovation, quality and evidence-based healthcare improvement projects Investment: $1,693,965
Health Professions Continuing Education	As experts in their field, SHC staff host continuing education courses for the community, these include continuing education for people working with the aging adult and social work fields. Investment: $626,316

IX. 2019 Community Benefit Plan

This plan represents the final 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.

Strategy Research

SHC developed strategies to address the health needs by reviewing literature on evidence-based and promising practices.

References to these sources are provided in numbered endnotes found at the end of this report.

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).[x] Supported 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.[xi]
  - 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.[xii]
  - Staff-assisted depression care supports to ensure increased screening, accurate diagnosis, effective treatment, and follow-up.[xiii]
- Supporting local programs that provide appropriate medical care and supportive, social services for homeless individuals transitioning out of acute care hospitals,[xiv] such as funding the Medical Respite Program (MRP).[xv]

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.[xvi]

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.[xvii]
- 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.[xviii]

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.[xix]

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.[xx]

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.[xxi]

- 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.[xxii]
- 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.[xxiii]
- 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).[xxiv]
- 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.[xxv]
- 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.[xxvi]

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.[xxvii]
- 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.[xxviii]

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.[xxix]
- 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.[xxx]
- 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).[xxxi]

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.[xxxii]

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.

Intermediate Goal E.4: Increase rates of detection and successful treatment of latent TB infection (LTBI) in San Mateo and Santa Clara Counties.

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: [25]
  - Appropriate, "targeted public education for foreign-born populations at high risk to explain that TB is a treatable, curable disease."
  - "[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:[25]
  - Adequate access to "reliable and competent medical translation."
  - 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.[xxxiii]
- 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.[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.[xxxiv]

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.[xxxv]

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."[xxxvi]

Intermediate Goal F.1: "Strengthen and sustain health and emergency response systems" in San Mateo and Santa Clara Counties.[10]

Goal F.1 Strategies:

[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.

Participate in collaboration and partnerships to address community emergency response such as:[xxxvii]

- 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 Health[2]

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:

- 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.[xxxviii]
- 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.

[2] 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.

- 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.[xxxix]
- Reduced-rate or subsidized in-home medical alert service, Stanford Lifeline, for low-income older adults.[xl]

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.

Endnotes

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

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

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

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

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

[vi] 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.

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

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

[ix] 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

[x] 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*. Retrieved from https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf.

[xi] Community Preventive Services Task Force. (2012). *Recommendation from the Community Preventive Services Task Force for Use of Collaborative Care for the Management of Depressive Disorders*. Retrieved from http://www.thecommunityguide.org/mentalhealth/CollabCare_Recommendation.pdf.

[xii] Guide to Community Preventive Services (2008). *Interventions to reduce depression among older adults: clinic-based depression care management*. Retrieved from http://www.thecommunityguide.org/mentalhealth/depression-clinic.html.

[xiii] U.S. Preventive Services Task Force (2014). *Final Recommendation Statement: Depression in Adults: Screening*. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening.

[xiv] O'Connell, J. J., Oppenheimer, S. C., Judge, C. M., Taube, R. L., Blanchfield, B. B., Swain, S. E., & Koh, H. K. (2010). The Boston Health Care for the Homeless Program: A Public Health Framework. *American Journal of Public Health*, *100*(8): 1400–1408. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2901289/.

[xv] 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.

[xvi] 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/2013/04/SAMHSA-GAINS.pdf. For more information on Integrated Mental Health and Substance Abuse Services, visit http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367 and http://gainscenter.samhsa.gov/pdfs/ebp/IntegratingMentalHealth.pdf.

[xvii] Guide to Community Preventive Services. (2009). Increasing cancer screening: group education for clients. Retrieved from http://www.thecommunityguide.org/cancer/screening/client-oriented/GroupEducation.html; Underwood, J.M., Lakhani, N., Finifrock, D., Pinkerton, B., Johnson, K., Mallory, S.H., Santiago, P.M., & Stewart, S.L. (2015). *Evidence-Based Cancer Survivorship Activities for Comprehensive Cancer Control.* Retrieved from http://www.ajpmonline.org/article/S0749-3797%2815%2900485-7/pdf; see also http://www.cancersupportcommunity.org/publications-presentations; and http://www.cscpasadena.org/about-us/our-history/evidence-based-research.

[xviii] Baquet, C. R., Henderson, K., Commiskey, P., & Morrow, J. N. (2008). Clinical Trials – The Art of Enrollment. *Seminars in Oncology Nursing*, 24(4): 262–269.. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3262589/.

[xix] U.S. Preventive Services Task Force. (2015). *Final Update Summary: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling.* Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd.

[xx] Vachon, G. C., Ezike, N., Brown-Walker, M., Chhay, V., Pikelny, I., & Pendergraft, T. B. (2007). Improving access to diabetes care in an inner-city, community-based outpatient health center with a monthly open-access, multistation group visit program. *Journal of the National Medical Association*, 99(12): 1327.

[xxi] Acosta, C., Dibble, C., Giammona, M., & Wang, N.E. (2009). A model for improving uninsured children's access to health insurance via the emergency department. *Journal of Health Care Management,* March/April; 54(2):105-116.

[xxii] 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

[xxiii] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Retrieved from http://health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf (strategies include health library collections).

[xxiv] 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 http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/rationalefordiversity.pdf; 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 http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/pipelinediversityprograms.pdf; also 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.

[xxv] 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.

[xxvi] **Used as primary transport:**

Baxt, W.G. & Moody, P. (1983). The impact of a rotorcraft aeromedical emergency care service on trauma mortality. *Journal of the American Medical Association* 249:3047-3051.

Baxt, W.G., Moody, P., Cleveland, H.C., et al. (1985). Hospital-based rotorcraft aeromedical emergency care services and trauma mortality: A multicenter study. *Annals of Emergency Medicine*, 14:859-864.

Cunningham, P., Rutledge, R., Baker, C.C., et al. (1997) A comparison of the association of helicopter and ground ambulance transport with the outcome of injury in trauma patients transported from the scene. *Journal of Trauma*, 43:940-946.

Used as secondary transport:

Boyd, C.R., Corse, K.M., Campbell, R.C. (1989). Emergency interhospital transport of the major trauma patient: Air versus ground. *Journal of Trauma*, 29:789-794.

Moylan, J.A., Fitzpatrick, K.T., Beyer, J.A. III, et al. (1988) Factors improving survival in multisystem trauma patients. *Annals of Surgery*, 207:679-685.

[xxvii] Addresses Healthy People 2020 goal to "Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life," https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[xxviii] New England Healthcare Institute. (2010). *A Matter of Urgency: Reducing Emergency Department Overuse*. Retrieved from http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf; U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services. (2014). *CMCS Informational Bulletin: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings.* Retrieved from https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf; and Enard, K. R., & Ganelin, D. M. (2013). Reducing Preventable Emergency Department Utilization and Costs by Using Community Health Workers as Patient Navigators. *Journal of Healthcare Management / American College of Healthcare Executives*, 58(6): 412–428. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142498/.

[xxix] Addresses Healthy People 2020 goal to "Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life," https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[xxx] Centers for Disease Control and Prevention. (2006). *A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (AICP) Part II: Immunization of Adults.* MMWR 2006; 55 (No. RR-16):1-33. Retrieved from http://www.cdc.gov/mmwr/pdf/rr/rr5516.pdf; includes the following activities:

— 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.

[xxxi] 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.

[xxxii] Centers for Disease Control and Prevention. (2005). *Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America.* MMWR 2005; 54 (No. RR-12):1-81. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm, including all quoted below:

"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."

[xxxiii] Centers for Disease Control and Prevention. (2105). *Epidemiology and Prevention of Vaccine-Preventable Diseases.* See Chapter 3: Immunization Strategies for Healthcare Practices and Providers. Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/strat.html; and Centers for Disease Control and Prevention. (1997). *Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP).* MMWR 1997; 46 (No. RR-08):1-24. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm.

[xxxiv] Casey, M.M., Klingner, J., Prasad, S., Gregg, W., & Moscovice, I. (2011). *Evidence-Based Pneumonia Quality Improvement Programs and Strategies for Critical Access Hospitals.* Retrieved from http://www.flexmonitoring.org/wp-content/uploads/2013/07/PolicyBrief22_QI-Pneumonia.pdf.

[xxxv] 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.

[xxxvi] Office of Disease Prevention and Health Promotion, HealthyPeople.gov. (Undated). *Preparedness*. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/preparedness.

[xxxvii] Auf der Heide, E., & Scanlon, J. (2007). The role of the health sector in planning and response. In: Waugh, W.L., & Tierney, K. (2007): *Emergency Management Principles and Practice for Local Government*, 2nd ed., ICMA Press, Washington, DC. Retrieved from http://www.atsdr.cdc.gov/Auf_der_Heide_2007_Role_of_the_Health_Sector_in_Planning_&_Response.pdf.

[xxxviii] Area Agency on Aging 1B. (2013). *Evidence-Based Disease Prevention Programs*. Retrieved from http://www.aaa1b.org/wp-content/uploads/2012/05/List-of-Evidence-Based-Programs.pdf.

[xxxix] Chang, J.T., Morton, S.C., Rubenstein, L.Z., Mojica, W.A., Maglione, M., Suttorp, M.J., Roth, E.A., & Shekelle, P.G. (2004). *Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomised clinical trials.* Retrieved from https://ubmm.med.buffalo.edu/uploads/DH22/Fall%20Prevention_Meta%20Analysis.pdf.

[xl] Mann, W. C., Ottenbacher, K. J., Fraas, L., Tomita, M., & Granger, C. V. (1999). Effectiveness of assistive technology and environmental interventions in maintaining independence and reducing home care costs for the frail elderly: A randomized controlled trial. *Archives of Family Medicine*, 8(3): 210.