

STANFORD HEALTH CARE
COMMUNITY HEALTH AND PARTNERSHIPS PROGRAM

2025 Community Benefit Report
2026 Community Benefit Plan



Improving health.
Advancing equity.



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

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Stanford, CA 94305

www.stanfordhealthcare.org/community

EIN 94-6174066

Report and plan prepared by:



Helping organizations discover and act on data-driven insights.

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Letter from the President & CEO

At Stanford Health Care, our mission to improve health for everyone extends far beyond the walls of our hospitals and clinics. Through our Community Health & Partnerships Program, we work hand in hand with local organizations to address critical needs, expand access to essential resources, and support the health and wellbeing of our most vulnerable neighbors. Together, we are committed to making a lasting impact and helping all individuals and families thrive.

In FY25, Stanford Health Care's community benefit totaled over \$841 million in services and activities to support our neighbors through charity care, health improvement programs, and training of clinicians in community-focused care. We strengthened longstanding collaborations with safety net providers, increasing access to our expertise through both in-person care and digital health tools. In addition, our grant support to Federally Qualified Health Centers and community clinics helped fund vital services, such as dental care, behavioral health care, and social work case management.

Recognizing the importance of addressing root drivers of poor health, we also partnered with trusted organizations to reduce economic and food insecurity and help prevent homelessness. Notably, we supported Destination Home's Silicon Valley Guaranteed Income Project, a pilot program designed to help participants achieve housing stability and greater independence over their lives, finances, and future. We also expanded our support for mobile hygiene services providing showers, laundry facilities, and other basic necessities for high-needs populations.

Beyond this ongoing work, Stanford Health Care also responded to urgent community crises in FY25. During a critical supply shortage, we provided IV fluid solutions to help safety net health systems continue caring for patients. Following devastating wildfires in Southern California, we provided funding to support housing and shelter for displaced community members. And when cuts to the Supplemental Nutrition Assistance Program (SNAP) threatened food access during the federal government shutdown, we deployed emergency funding to organizations serving older adults, homebound residents, and other vulnerable neighbors.

We are proud to work alongside such extraordinary partners in making these programs possible, directly strengthening the health of our surroundings communities and all those we serve. As community needs continue to evolve, we remain committed to listening, learning, and investing where it matters most. I invite you to explore this report and see how, together, we are shaping a healthier future.

Sincerely,



David Entwistle
President and CEO, Stanford Health Care

Stanford Health Care

2024–2025



Health Care

Stanford Health Care, along with Stanford Health Care Tri-Valley and Stanford Medicine Partners, is part of the adult health care delivery system of Stanford Medicine. Combining clinical care, research, and education to advance the understanding and practice of medicine, Stanford Health Care provides compassionate, coordinated care personalized for the unique needs of every patient.

Stanford Hospital at 500 Pasteur Drive opened for patient care in 2019 with 824,000 sq. ft. of space.



The only Level I Trauma Center between San Francisco & San Jose

By the Numbers

Services

 426 Life Flight Transports
 643 Licensed Beds
 119 Licensed ICU Beds

Patient Visits

 1,424,913 Outpatient
82,971 Adult Emergency Room
29,830 Pediatric Emergency Room
501,961 Video Visits

Community Support

 \$841M Community Benefit Investment
 \$1.3B Financial Assistance for Medicare Patients

Our People



18,400 Employees
2,755 Physicians on Active Medical Staff
4,712 Nurses
1,504 Residents & Fellows

98.4% ★★★★★
Stanford Health Care Physicians
With a Star Rating of 4.5 or Higher

 8 Stanford Medicine Nobel Prize Laureates

Patient Experience

Interpreters & Translators

Staff interpreters are available on demand in person, by phone, and by video in the most commonly requested languages, including Spanish, Mandarin, Cantonese, Vietnamese, Russian, American Sign Language (ASL), Farsi/Dari, and Korean. Translators work on vital documents, such as consents, medical records, and patient education. Interpreters proficient in 200+ other languages are available upon request.



Health Education, Engagement, and Promotion



3,000 Patient Education Classes and Lectures
19,400 Participants
51 Non-English Classes and Lectures

Stanford Medicine is an integrated academic health system comprising the Stanford School of Medicine and pediatric and adult health care delivery systems. Together, we harness the full potential of biomedicine through collaborative research, education, and clinical care.

Data is based on 2024–2025 health system statistics for Stanford Health Care only. It does not include Stanford Health Care Tri-Valley and Stanford Medicine Partners.

Awards & Recognition



U.S. News & World Report Best Hospital
Stanford Hospital is on the Best Hospitals Honor Roll and is nationally recognized in 11 specialties.



The Joint Commission's Sustainable Healthcare Certification
Stanford Health Care is among the first hospitals in the nation to receive the certification, which celebrates our progress toward reducing emissions that contribute to climate change.



NCI-Designated Comprehensive Cancer Center
The **Stanford Cancer Center** is part of the Stanford Cancer Institute, the only NCI-Designated Comprehensive Cancer Center between San Francisco and Los Angeles.



Comprehensive Stroke Center
The **Stanford Stroke Center** is designated by The Joint Commission as a Comprehensive Stroke Center, providing the most advanced and rapid stroke care for patients.



Magnet Hospital
Stanford Health Care was first designated as a Magnet hospital in 2007. Magnet Recognition is a prestigious award developed by the American Nurses Credentialing Center to recognize health care organizations that provide nursing excellence. Only 9% of U.S. health care organizations achieve this honor.



Healthcare Equality Index (HEI)
Stanford Health Care earned a top score on the HEI from the Human Rights Campaign Foundation, a leading LGBTQ+ rights organization. The HEI is the national LGBTQ+ benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of their LGBTQ+ patients, visitors, and employees.

2025 Community Benefit Report



Stanford
MEDICINE

Health Care

Mission

To care, to educate,
to discover.

Vision

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

INTRODUCTION

Stanford Health Care (SHC) is a leading academic health system and is part of Stanford Medicine. 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, including efforts to improve health equity, and dedicates considerable resources to support its community benefit program.

Stanford Medicine: Working Across the Health System

Stanford Medicine is an integrated academic health system comprising the Stanford School of Medicine and pediatric and adult health care delivery systems, including Lucile Packard Children's Hospital Stanford, Stanford Health Care, and Stanford Health Care Tri-Valley.

Together, we harness the full potential of biomedicine through collaborative research, education, and clinical care.



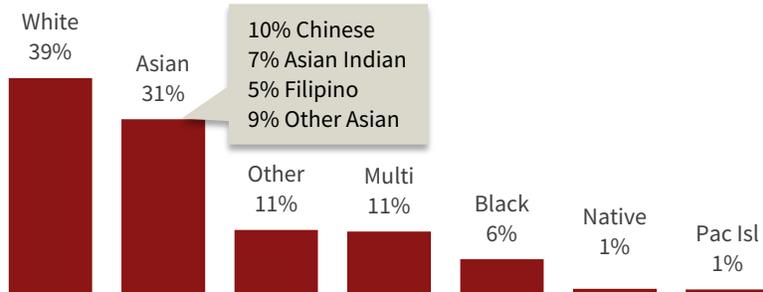
COMMUNITY SERVED

As an academic health system and leading teaching and research facility, Stanford Medicine provides primary care and highly specialized health care for adult and pediatric patients from throughout California, across the country, and around the globe. Stanford Medicine integrates a premier medical school, three world-class hospitals (Stanford Health Care, Stanford Health Care Tri-Valley, and Lucile Packard Children's Hospital), a network of

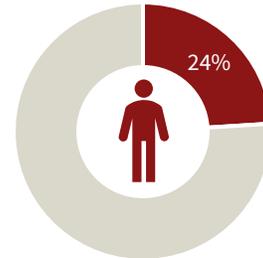
FOUR-COUNTY AREA

Alameda, Contra Costa, San Mateo, and Santa Clara counties

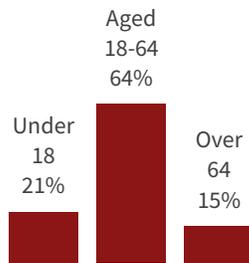
A majority of residents are non-White.



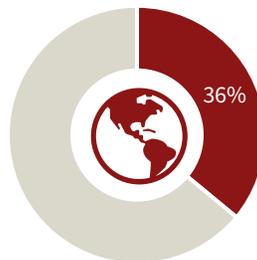
About one-quarter are Hispanic/Latino.



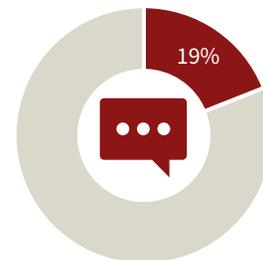
More than one in five residents are children.



Over one-third of residents are foreign-born.



About one in five over age 5 speak limited English.



\$125,241

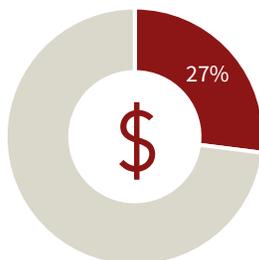
household Real Cost Measure (RCM), 4-county average*



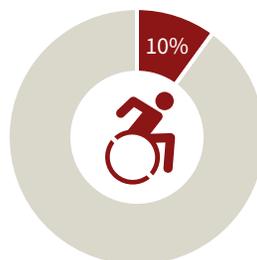
\$1.2M

median home sale price, 4-county average

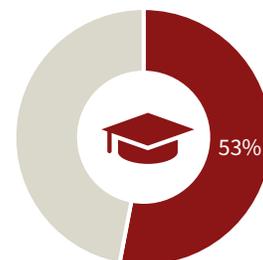
On average, more than one in four households live below the Real Cost Measure.



One in ten residents lives with a disability.



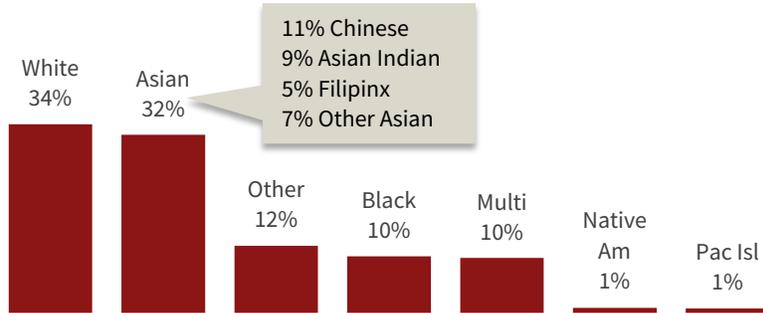
More than half of residents aged 25+ have earned at least a Bachelor's degree.



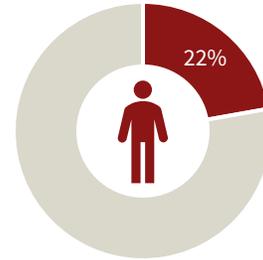
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

ALAMEDA COUNTY

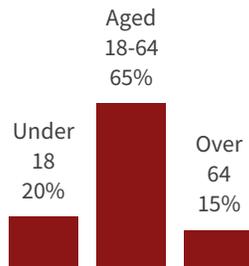
A majority of residents are non-White.



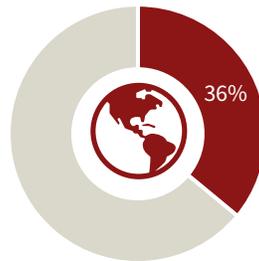
Over one in five are Hispanic/Latino.



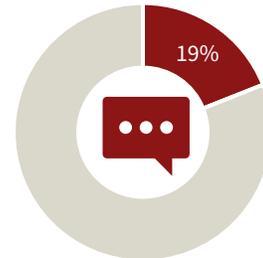
One in five residents are children.



Over one-third of residents are foreign-born.



About one in five over age 5 speak limited English.



\$121,703

4-person household
Real Cost Measure (RCM)*



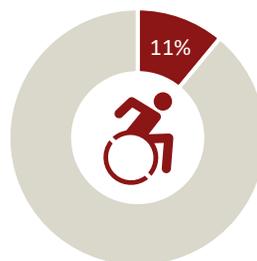
\$1.0M

median home sale price

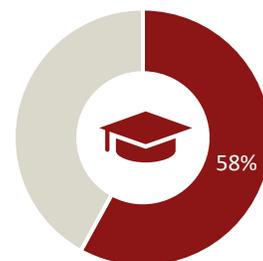
On average, close to one in three households lives below the Real Cost Measure.



Over one in ten residents lives with a disability.



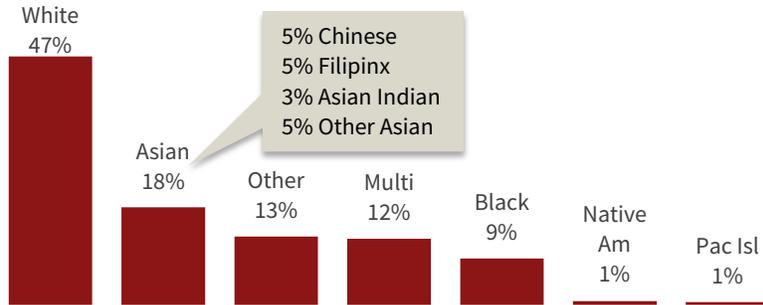
Nearly three in five residents aged 25+ have earned at least a Bachelor's degree.



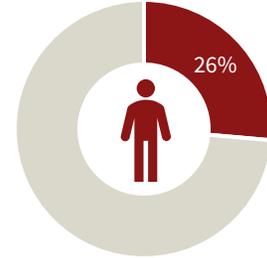
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

CONTRA COSTA COUNTY

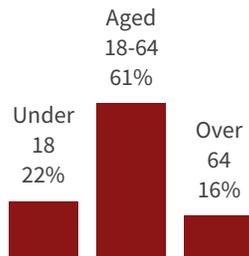
A majority of residents are non-White.



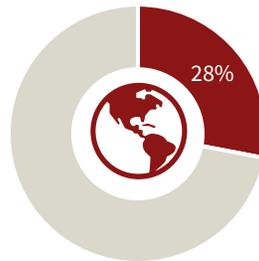
About one-quarter are Hispanic/Latino.



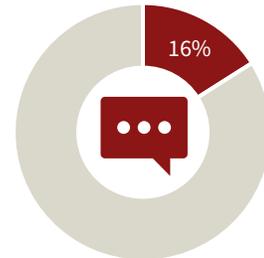
Over one in five residents are children.



More than one in four residents are foreign-born.



About one in six over age 5 speak limited English.



\$109,770

4-person household
Real Cost Measure (RCM)*



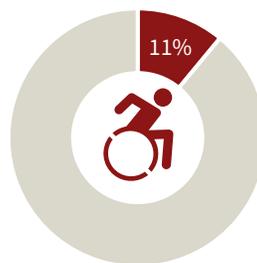
\$795K

median home sale price

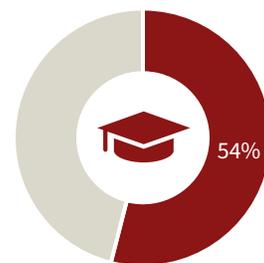
On average, more than one in four households lives below the Real Cost Measure.



More than one in ten residents lives with a disability.



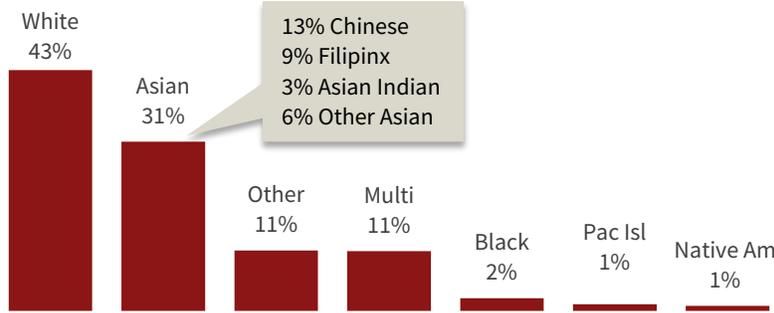
Just over half of residents aged 25+ have earned at least a Bachelor's degree.



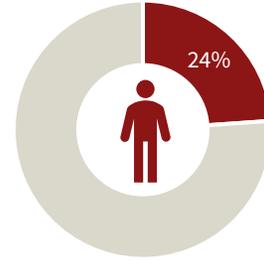
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

SAN MATEO COUNTY

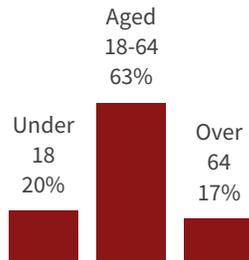
A majority of residents are non-White.



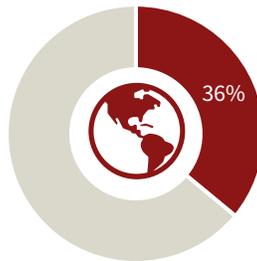
About one-quarter are Hispanic/Latino.



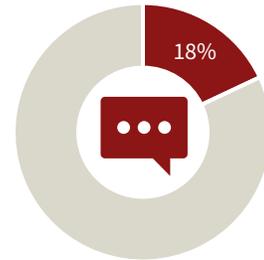
One in six residents are older adults.



More than one in three residents are foreign-born.



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



\$141,316

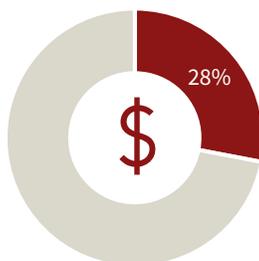
4-person household
Real Cost Measure (RCM)*



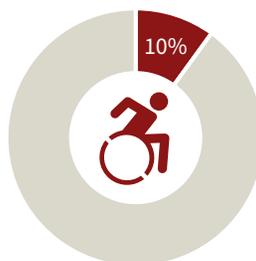
\$1.5M

median home sale price

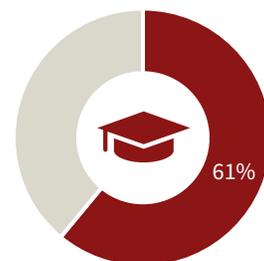
On average, more than one in four households lives below the Real Cost Measure.



One in ten residents lives with a disability.



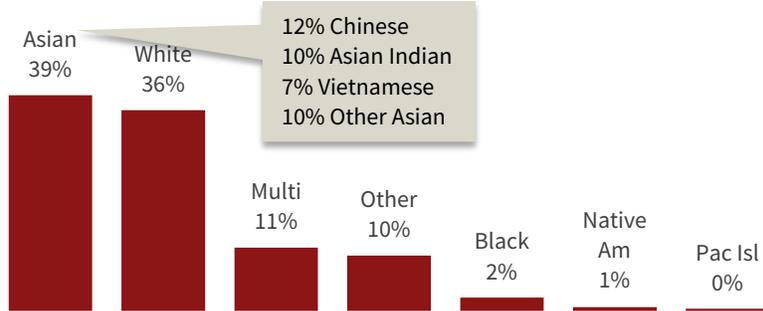
About three in five residents aged 25+ have earned at least a Bachelor's degree.



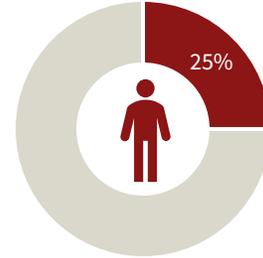
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

SANTA CLARA COUNTY

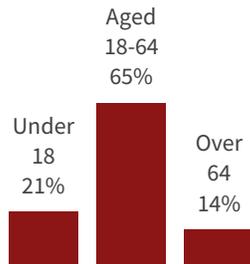
A majority of residents are non-White.



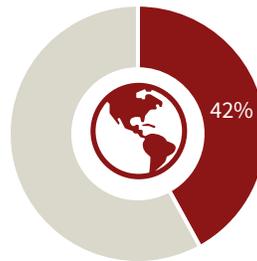
One-quarter are Hispanic/Latino.



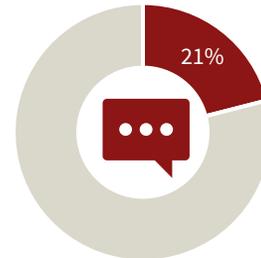
About one in five residents are children.



Over two in five residents are foreign-born.



About one in five over age 5 speak limited English.



\$128,176

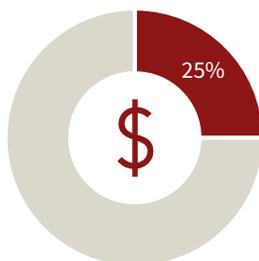
4-person household
Real Cost Measure (RCM)*



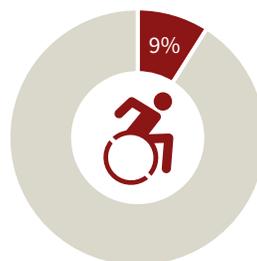
\$1.7M

median home sale price

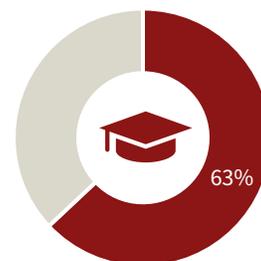
On average, one in four households lives below the Real Cost Measure.



Almost one in ten residents lives with a disability.



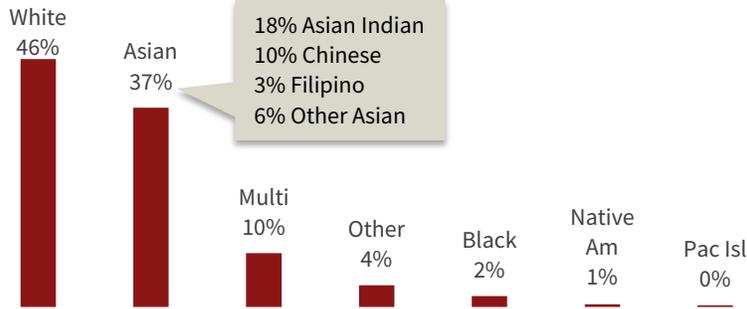
Over three in five residents aged 25+ have earned at least a Bachelor's degree.



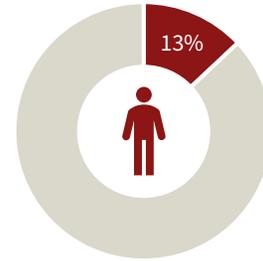
*Note: RCM factors in the costs of housing, food, health care, child care and other basic needs. Sources: United Way: RCM, 2021. Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2018-2022, other demographics, 2023.

TRI-VALLEY AREA

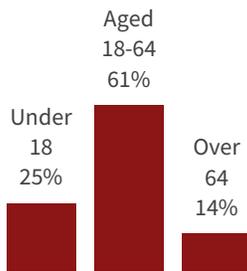
A majority of residents are non-White.



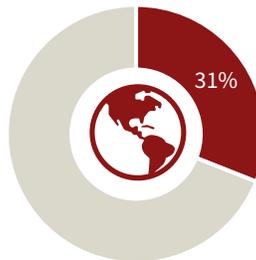
More than one in ten residents are Hispanic/Latino.



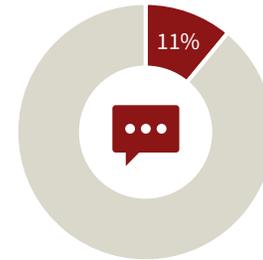
One in four residents are children.



Close to one-third of residents are foreign-born.



About one in ten people over age 5 speak limited English.



\$121,703

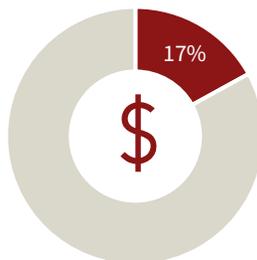
household Real Cost Measure (RCM), Alameda County*



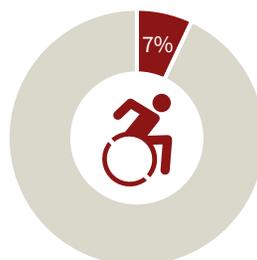
\$1.5M

median home sale price across Tri-Valley cities

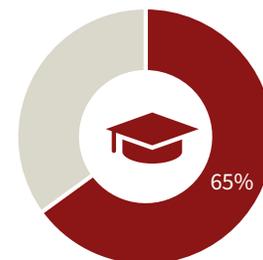
One in six Dublin, Livermore, and Pleasanton households live below the county's RCM.



Fewer than one in ten Tri-Valley residents lives with a disability.



About two-thirds of residents aged 25+ have earned at least a Bachelor's degree.



*Dollar amount not provided for sub-county area. Sources: United Way: Real Cost Measure, 2021. Five cities' data: Redfin.com: Median home sale price, 2024. U.S. Census Bureau: race and age, 2019-2023, other demographics, 2023.

ABOUT COMMUNITY BENEFIT

From the beginning, Stanford Health Care has been dedicated to improving the health of the communities it serves. Over the past three decades, the hospital has listened closely—through community forums, focus groups, and surveys—to identify health and wellness needs, and to address the needs by shaping its work around what it has learned.

SHC’s Community Health & Partnerships Program was created to provide essential health care services to members of the community, with a focus on the most vulnerable. At the core of this work is a commitment to addressing the social determinants of health and breaking down barriers that affect well-being and opportunity, including housing, economic security, and social support.

To address these needs, SHC partners with local community-based organizations and government agencies to support programs that improve the health of the community, working together to address the various needs of community members. This annual Community Benefit Report describes the impact of these partnerships over the past fiscal year and the [2026–2028 Community Benefit Plan](#) outlines the strategies SHC will pursue to further improve community health in the year ahead.

SHC is committed to delivering exceptional Community Benefit across all the communities throughout its service area. Every three years, SHC selects several priority health areas and, with its partners, carries out related initiatives and programs that improve community health and well-being.

SHC’s community engagement efforts also include community building, workforce development, advocacy, and health education and prevention. By supporting and advancing positive change, we work to promote health equity now and for future generations.

In the Community: Beyond Hospital Walls



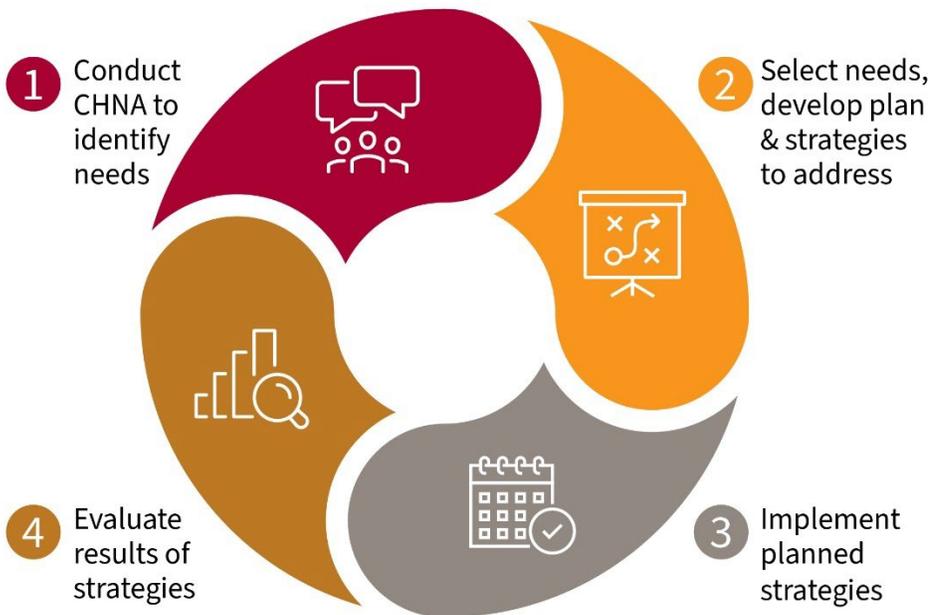
The Community Benefit Cycle

Stanford Health Care's Community Benefit work starts with a comprehensive Community Health Needs Assessment (CHNA) every three years to determine the greatest health needs of the community. This work is in collaboration with public health departments, hospital partners, community-based organizations, and community leaders—listening closely to people from the communities these partners serve. Based on the CHNA, SHC engages in its Community Benefit planning process to develop the initiatives and strategies that it will deploy, in concert with its partners, to address selected community health needs for the coming three years.

SHC partners with community-based organizations already working on each health need, participates in local collaboratives, and provides community health improvement grants. By building on the strong foundation already in place, SHC advances priority health initiatives and supports community members in reducing barriers to care and achieving improved health and wellness.

The hospital reports annually on the status of its Community Benefit plan to the California Department of Health Care Access and Information.

The Community Benefit Process



2022 CHNA PROCESS, PRIORITIZATION, AND 2023-2025 SELECTED HEALTH NEEDS

As required by California Senate Bill 697, SHC produced a CHNA in 2022. It actively collaborated with other nonprofit hospitals in this work. The goal was to collectively gather community feedback, understand existing data about health status, and prioritize local health needs in each hospital area.¹

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 leaders with knowledge and expertise in local community health needs and trends after reviewing the Community Health Needs Assessment findings and supporting data for each need.

The Community Health and Partnerships steering committee, comprised of experts and stakeholders from across Stanford Medicine (Stanford hospitals and School of Medicine) and the local community, completed a comprehensive strategic planning process to select the health needs and strategies. The committee paid special attention to the needs and desires of the community that were identified during the Community Health Needs Assessment. Committee members reviewed the data, prioritization process, and current SHC community health initiatives. Members participated in several prioritizing and ranking exercises to determine which needs SHC would address and what strategies SHC would pursue to address them. Four significant health needs were selected:



Behavioral Health: Access to mental health care and substance use treatment is limited for all, worse for members of vulnerable populations. COVID-related stress has led to depression, anxiety, trauma, grief, and economic factors. Isolation is an issue for older adults and youth. Suicide is higher than the California average for all age groups. Drug overdose deaths are rising among community members.

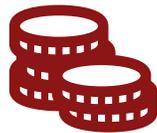
¹ Find California SB 657 at <https://hcai.ca.gov/wp-content/uploads/2020/10/SB697-Report-to-the-Legislature-Community-Benefit.pdf>. For information about Stanford Health Care's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit <https://stanfordhealthcare.org/community>.



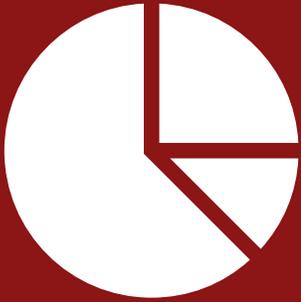
Housing: Housing affordability is worse than the California average for households spending more than one third of income on housing, and worse for vulnerable populations. Fewer housing units are available than demand. There is lower homeownership for all groups, especially vulnerable populations. These issues result in: Housing unit overcrowding as a result of unaffordability; poor housing quality, substandard conditions, and landlord-deferred maintenance/neglect; and outmigration, which is higher among vulnerable populations (impacting employment and the economic stability of the region).



Health Care Access and Delivery: There are fewer primary and specialty care providers than California average. Health insurance affordability is an issue for middle- and low-income community members, health insurance enrollment for low-income community members is low. Telehealth, digital health care access and use challenges exist for low-income older adults. There is a lack of culturally competent/trauma-informed care, especially for LGBTQ individuals, speakers of languages other than English, individuals with mental health co-morbidities, and individuals with limited technology or health literacy.



Economic Security: Wages for frontline and essential workers rarely meet the California Self-Sufficiency Standard. Despite low unemployment locally, annual wage increases are not meeting inflation. Local minimum wages in each county are less than half of the California Self-Sufficiency Standard minimum wage requirements. Community members face trade-offs between paying for housing, food, transportation, child care, medical care, etc.), and have limited access to healthy foods.



STANFORD HEALTH CARE'S FY25 TOTAL QUANTIFIABLE COMMUNITY BENEFIT

This report covers fiscal year (FY) 2025 beginning September 1, 2024, and ending August 31, 2025. During this time, Stanford Health Care community benefit totaled over \$841 million in services and activities to improve the health of the communities it serves. In addition to providing FY25 community benefit details, this report describes the community benefit planning process and the [Community Benefit Plan for FY26](#).



GIVING BACK THROUGH COMMUNITY BENEFIT

Stanford Health Care's annual community benefit services and activities focus on improving the health of our community's most vulnerable populations, supporting the health of the broader community, and providing opportunities for health education, research, and training. To accomplish these goals, all community benefit addresses the four prioritized community health needs: behavioral health; housing; health care access and delivery; and economic stability.



Total net value of quantifiable benefits provided to the community:

\$841,533,282
in fiscal year 2025

**plus \$1,375,113,324 in uncompensated Medicare*

A Note from Community Health & Partnerships Staff

Community Health & Partnerships is committed to supporting the health and well-being of our community. We focus on helping individuals and families stay healthy, prevent illness and access the care, education and resources they need to thrive. Our work is rooted in a belief that healthier communities are built through trust, connection and shared responsibility.

Our work is guided by identified health needs and shaped by the voices of the communities we serve. We use local health data and assessments to better understand trends, gaps, and emerging needs, while actively listening to residents, families and community leaders. This combination allows us to respond thoughtfully and ensure our work reflects real experiences, local priorities and co-create community-centered solutions.

We believe meaningful and lasting change happens through collaboration and proven approaches. Community Health & Partnerships works hand-in-hand with community partners to apply evidence-based strategies that improve health outcomes. Together, we strengthen community resources, address root causes of health challenges and create measurable, positive impact.

Above all, Community Health & Partnerships is dedicated to protecting and supporting our most vulnerable neighbors by reducing barriers and strengthening supports. Through compassion, informed decision-making and strong partnerships, we remain committed to advancing community health today while building a healthier future for generations to come.

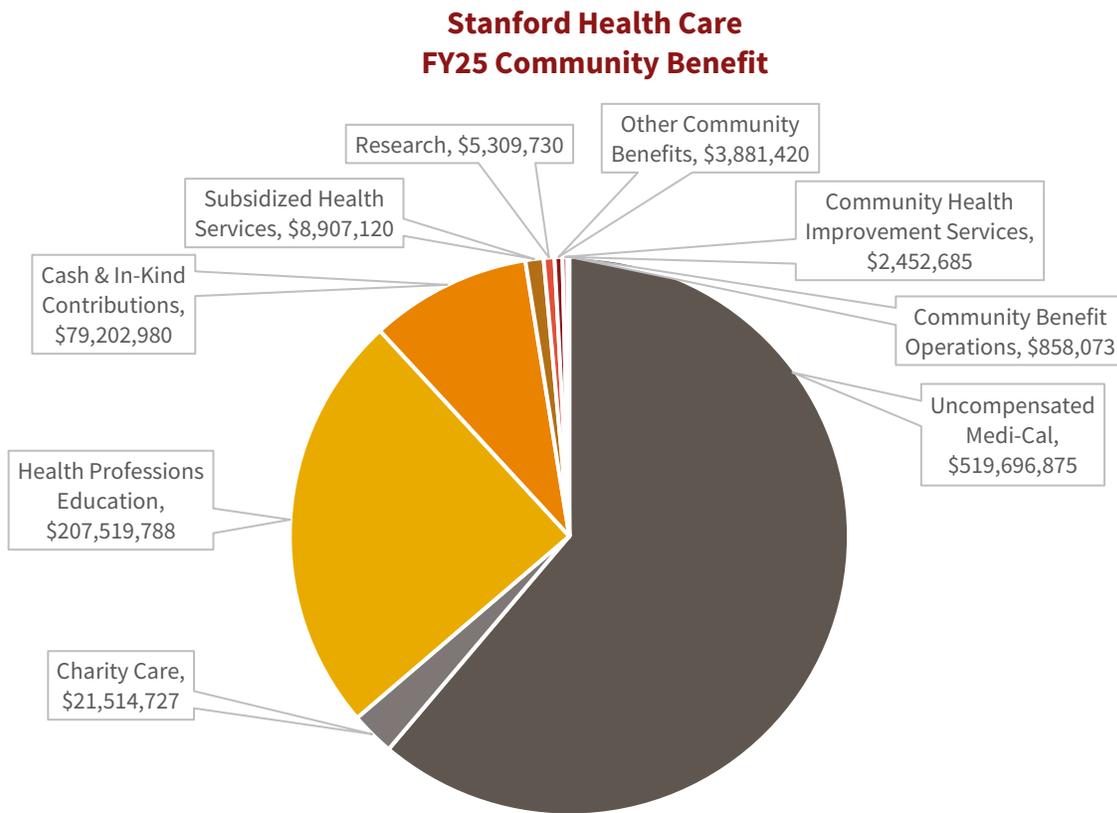
Jessica Arline
Senior Director
Community Health & Partnerships

Sharan Johal
Senior Program Manager
Community Health & Partnerships

Learn more about Community Health & Partnerships by visiting us at <https://stanfordhealthcare.org/community>.

Stanford Health Care's FY25 Overall Community Benefit

Stanford Health Care provides programmatic and philanthropic support to expand access to care and address the social drivers of health for our most vulnerable and underserved patients and communities each year. This report covers fiscal year (FY) 2025 beginning September 1, 2024 and ending August 31, 2025. During this time, Stanford Health Care's community benefit totaled over \$841 million in services and activities to improve the health of the communities it serves, including vulnerable populations.



Financial Assistance

SHC is proud to be part of the safety net supporting the community's most vulnerable groups. Although this is one of the nation's most affluent areas, many people still struggle and often go without essential health care and community resources. Along with its community benefit services and activities, SHC provides financial assistance to people who qualify² and includes those efforts in its community benefit valuation as undercompensated costs of medical care and charity care costs.

² To learn more about our financial assistance programs, please visit <https://stanfordhealthcare.org/for-patients-visitors/financial-assistance.html>.



FY25 Financial Assistance, \$533,401,486*

Charity Care, \$21,514,727

Uncompensated care provided to patients who cannot afford to pay

Medi-Cal, \$519,696,875

Costs associated with serving Medi-Cal beneficiaries

** In FY25, Stanford Health Care also received refunds totaling \$7,810,116 related to serving out-of-state Medicaid enrollees and participants in other government means tested programs. These refunds are accounted for in the Financial Assistance total above. SHC also experienced a Medicare shortfall of over \$1.375 billion in uncompensated funds, which is not included above.*

The remaining categories of SHC’s FY25 community benefit are shown below.



Health Professions Education, \$207,519,788

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



Cash and In-Kind Contributions, \$79,099,505

- Community clinic capacity building and support
- Community health improvement grants
- Fundraising support for nonprofits
- Donating essential equipment, supplies and food to nonprofit organizations
- Stanford University health professions education, community health improvement and access to care, and research



Community Health Improvement Services, \$2,452,685

- Community health education programs
- Patient financial advocacy
- Healthy lifestyles programs for older adults
- Sexual Assault Response Team
- Stanford Health Library
- Wellness and supportive care programs (e.g., for cancer)



Other Community Benefits, \$3,881,420

- Workforce development opportunities
- Physical improvements and housing support
- Support for community emergency preparedness



Subsidized Health Services, \$8,907,120

- Stanford Life Flight
- Community-based second opinion services



Community Benefit Operations, \$858,073

- Day-to-day operations related to community benefits



Research, \$5,309,730

- Research into improved care delivery and better health outcomes



STANFORD HEALTH CARE'S FY25 COMMUNITY BENEFIT FOR VULNERABLE POPULATIONS

Vulnerable populations are defined as groups of people at higher risk for poor health outcomes due to factors including significant barriers to care and economic disparities. Vulnerability is influenced by a combination of social, economic, cultural, and environmental factors, as well as individual circumstances such as disability or health status.

Community Benefit for Vulnerable Populations

According to the California Department of Health Care Access and Information, vulnerable populations include:³

- Populations exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, state Children's Services Program, or county indigent programs
- Racial and ethnic groups experiencing disparate health outcomes
- Socially disadvantaged groups, including the following:
 - Unhoused populations
 - Communities with inadequate access to clean air and safe drinking water, as defined by an environmental Healthy Places Index score of 50% or lower
 - People with disabilities
 - People identifying as LGBTQ+
 - Individuals with limited English proficiency

These groups are a focus of community benefit efforts because they are at greater risk for health disparities, including significant gaps in the quality of care they receive compared to others. A failure to address their needs can lead to significant negative health outcomes and an increased burden on the healthcare system. Community benefit plans aim to improve access to care, reduce health disparities, and ensure that all individuals can receive the health services they need.



Total net value of quantifiable
benefits provided to vulnerable
populations:

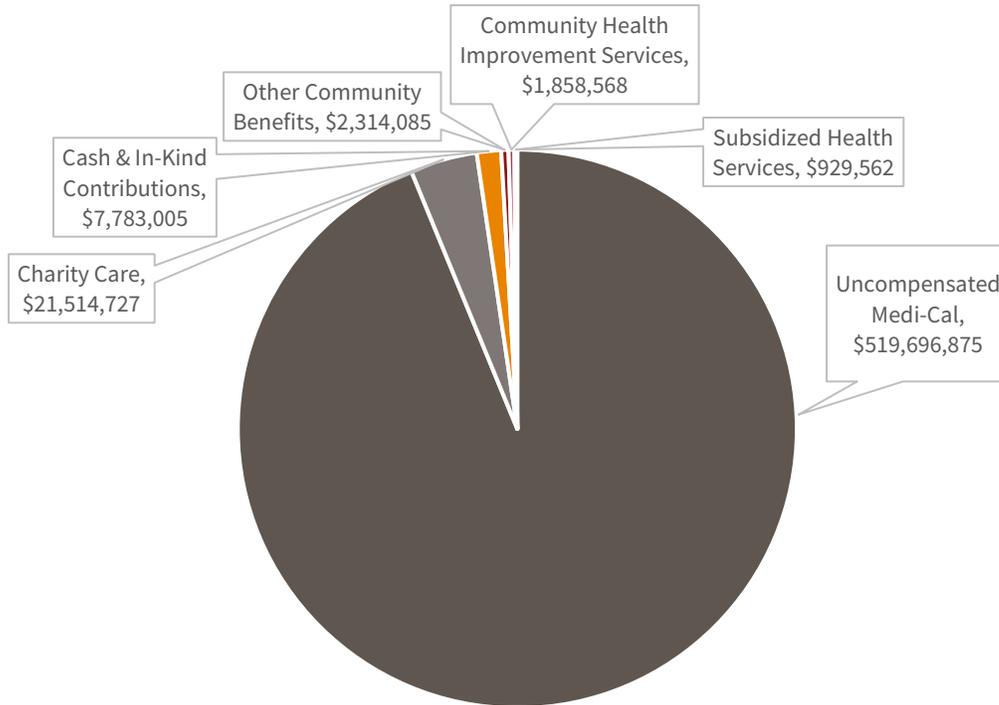
\$546,286,706*

in fiscal year 2025

**plus \$1,375,113,324 in uncompensated Medicare*

³ California Department of Health Care Access and Information (2022). *HCAI factsheet, hospital community benefits plans: vulnerable populations*. Retrieved from <https://hcai.ca.gov/wp-content/uploads/2022/01/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-March-2022-Final.pdf>.

**Stanford Health Care
FY25 Vulnerable Populations Community Benefit⁴**



As mentioned previously, Stanford Health Care provides financial assistance to people who qualify⁵ (i.e., are economically vulnerable), and the hospital includes these efforts in its community benefit valuation as uncompensated costs of medical care and charity care costs. See the [Financial Assistance](#) call-out box in the Overall Community section above for details.

The remaining categories of SHC’s FY25 community benefit for **vulnerable populations** are shown on the next page.

⁴ In FY25, Stanford Health Care also received refunds totaling \$7,810,116 related to serving out-of-state Medicaid enrollees and participants in other government means tested programs. These refunds are accounted for in the total on the previous page.

⁵ To learn more about our financial assistance programs, please visit <https://stanfordhealthcare.org/for-patients-visitors/financial-assistance.html>.



Community Health Improvement Services, \$1,858,568

- Community health education programs
- Patient financial advocacy
- Healthy lifestyles programs for older adults
- Stanford Health Library
- Supportive care programs (e.g., for cancer)



Subsidized Health Services, \$929,562

- SWCM Post Hospital Care Funding



Cash and In-Kind Contributions, \$7,791,730

- Community clinic capacity building/support
- Community health improvement grants
- Fundraising support for nonprofits
- Donating essential equipment, supplies and food to nonprofit organizations



Other Community Benefits, \$2,314,085

- Workforce development opportunities
- Emergency preparedness
- Community service initiatives for staff
- Employee Resource Groups' community service activities
- Monitor and advocate for public health
- Mobilize expertise of the Stanford community in support of regional, state and national initiatives



Stanford Health Care’s Community Benefit for Vulnerable Populations, by Health Need

Stanford Health Care (SHC) understands that good health is achieved through access to high-quality care as well as social and physical environments that promote good health. As such, all community benefit activities aim to improve access to and delivery of care and/or the social drivers of health for our most vulnerable community members, including the medically underserved, low-income, and populations affected by health disparities.

Note: An asterisk () indicates investments that are hospital-based rather than community-based.*

BEHAVIORAL HEALTH

Based on the 2022 Community Health Needs Assessment findings, our interventions to improve behavioral health outcomes in our community are focused on screening and referral for mental and behavioral health services and substance use services/treatment for co-occurring mental illness and addiction, as well as supporting initiatives aimed at increasing the supply of diverse mental/behavioral health providers in community/safety net clinics. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit: <https://stanfordhealthcare.org/community>.

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
<p>LifeMoves</p>	<p>Behavioral Moves</p>	<p>This program improves access to high-quality behavioral healthcare for adolescents, adults, parents and children who are experiencing homelessness, many of whom have struggled with additional trauma, including poverty, serious mental illness, substance use disorders, and interpersonal violence.</p> <ul style="list-style-type: none"> • 100% of adults and children over age five received a comprehensive screening to ensure early identification of behavioral health concerns as part of program intake and regular wellness check-ins. • The permanent housing exit rate for clients engaging in Behavioral Health services exceeded that of non-engaged clients by 10%, underscoring the importance of integrating behavioral health support with housing programs. • 95% of clients reported improved personal well-being and increased trust in their behavioral health providers after attending at least three therapy sessions. <p>Investment: \$400,000 Persons served: 5,061</p>

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
Momentum for Health	La Selva Community Clinic	<p>La Selva Community Clinic provides behavioral health services for clients who do not have access to treatment because they cannot afford to pay for services.</p> <ul style="list-style-type: none"> • 78% of patients reported a reduction of 2 or more points in the PHQ-9 measure of depression severity from pre- to post-test • 67% of patients reported a reduction of 2 or more points in the GAD-7 measure of anxiety severity from pre- to post-test • 100% of patients avoided psychiatric hospitalization for 12 months after beginning services <p>Investment: \$150,000 Persons served: 37</p>
New Directions	Community-based Case Management Program	<p>This program provides case management to reduce access barriers to healthcare and housing for unhoused community members in need of psychosocial services.</p> <ul style="list-style-type: none"> • 96% of case managed clients received a full housing needs assessment and were connected to resources • 92% of clients were connected to at least one basic need service that addressed food insecurity, healthcare, and income aid • 81% of clients established care with a primary care provider <p>Investment: \$350,000 Persons served: 51</p>
Roots Community Health Center	Behavioral Health Connections	<p>Behavioral health, which encompasses mental health, substance use, domestic violence, and trauma, has emerged as a critical community health concern in Santa Clara County. Behavioral Health Connections is a strategic initiative by Roots, tailored to address these complex behavioral health disparities and service gaps in this region.</p> <ul style="list-style-type: none"> • 201 underrepresented minority individuals received increased awareness of available culturally competent services through outreach events, partnerships with community organizations, and awareness campaigns • 134 clients experiencing moderate to severe mental health challenges received culturally competent, evidence-based mental health interventions including individual counseling, group therapy, and psychiatric evaluations <p>Investment: \$120,000 Persons served: 334</p>

HOUSING

Based on the 2022 Community Health Needs Assessment findings, our interventions to housing outcomes in our community include homelessness prevention, expanded supportive care and social services for self-sufficiency, and access to care for those experiencing and/or at-risk for homelessness.. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit: <https://stanfordhealthcare.org/community>.

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
Destination: Home	Silicon Valley Guaranteed Income Project	<p>This is a pilot program designed to help participants achieve housing stability as well as greater independence over their lives, finances, and future, while addressing systemic racial and economic inequities, all of which are critical to living a healthy life. UCSF Benioff Homelessness and Housing Initiative has partnered to conduct a research and evaluation component to assess the effectiveness of guaranteed income on participants’ housing and economic stability, health, and overall well-being.</p> <ul style="list-style-type: none"> • Initial progress reports have found that the project has achieved a 90% follow-up survey rate, • 12 months into the program, families receiving guaranteed income payments have saved modestly more money than the usual care group, • Guaranteed income payments are allowing families to pay for activities that alleviate stress and mental health symptoms for themselves and their children, and in addition to material benefits of the guaranteed income payments, participants feel restored dignity and hope. <p>Investment: \$500,000 Persons served: 551</p>
Housing Support*	N/A	<p>To better support patients during treatment and post-discharge, the Social Work and Case Management department provides free and reduced cost housing support.</p> <p>Investment: \$1,649,210</p>
Rebuilding Together Peninsula	N/A	<p>Stanford Health Care provides funding and volunteer support for housing and infrastructure improvements for low-income community members and not-for-profit organizations.</p> <p>Investment: \$10,000</p>

HEALTH CARE ACCESS & DELIVERY

Based on the Community Health Needs Assessment findings, our interventions to address access and delivery to care include improving access to health care, specialty care, medical social work and case management for vulnerable community members, including older adults and under- and uninsured populations. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit: <https://stanfordhealthcare.org/community>.

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
AC Care Alliance	Advanced Illness Care Program and Enhanced Care Management (ECM) Preparation	<p>AC Care Alliance builds relationships in the faith, health, and community settings to establish referral pathways for caregivers and individuals with advanced illness and build a base for future Enhanced Care Management (ECM) referral opportunities.</p> <ul style="list-style-type: none"> • Advanced Illness Care Program services provided 72 persons needing care and caregivers, tailoring a personalized program for each participant across 4-12 visits • Over 335 individuals in the community provided with information on AC Care Alliance Advance Illness Care Program including advance care planning, communication with providers, caregiving support, and palliative care through community events and meetings. • Developed, implemented and refined a two-week training program for ACCA ECM work for the current team and new hires. Training materials were developed and refined based on care team feedback and ever changing payer requirements. <p>Investment: \$260,000 Persons served: 407</p>
Aging Adult Community Health Education Programs*	N/A	<p>Offering a variety of community-based health education courses, such as caregiver support groups, exercise classes, and home safety, seniors and their caregivers have access to resources, tools, and the support needed to manage their health and live an enriched life.</p> <p>Investment: \$73,163</p>
Avenidas – Rose Kleiner Center	Community-Based Home Health Program	<p>This program provides intensive care coordination for low-income older adults with highly complex medical, cognitive, and behavioral health conditions.</p> <ul style="list-style-type: none"> • 90% of participants had no emergency room visits • 90% of participants avoided hospital admissions • 93% of participants of participants achieved stabilized health

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
		<p>conditions, leading to enhanced caregiver involvement, increased support systems, and improved medication management.</p> <p>Investment: \$195,000</p> <p>Persons served: 124</p>
Cardinal Free Clinics *	N/A	<p>Support for Cardinal Free Clinics, which provides free basic services to adult patients who do not have insurance. Provided free tests that included chemistry, hematology, special chemistry and urinalysis.</p> <p>Investment: \$81,311</p>
Financial Donations	N/A	<p>Restricted financial contributions to organizations helps support program and service delivery to address emerging health needs of the most vulnerable members of the community.</p> <p>Investment: \$1,256,947</p>
Operation Access	Access to Surgical Services and Specialty Care	<p>The 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.</p> <ul style="list-style-type: none"> • 100% of patient survey respondents reported improved health or quality of life post-procedure, avoided return emergency department visits, and reduction in pain • Built capacity and promoted efficiency with 98% of medical volunteers indicating they are “very satisfied” or “satisfied” with their overall experience • Achieved high quality care coordination and prompt service as measured by median wait time to appointment with a specialist of 76 days and median wait time to procedure of 87 days <p>Investment: \$132,300</p> <p>Persons served: 165</p>
Patient Financial Advocacy Services (MedData)*	N/A	<p>This program assists low income, uninsured, underinsured, and homeless patients in researching their healthcare options. Services are provided at no cost to the client, and include helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow-up with county case managers as needed.</p> <p>Investment: \$1,846,896</p>

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
Peninsula Healthcare Connection	Improved Clinic Efficiency and Capacity	<p>Through improved clinic efficiency and capacity achieved by a full-time clinic administrator, the program provides health care services to unhoused individuals and individuals at-risk for homelessness</p> <ul style="list-style-type: none"> • 100 diagnostic tests, including Hepatitis A, Hepatitis B, and PPD screenings for tuberculosis, were administered to homeless and high risk for homeless individuals • 24 Backpack Medicine visits conducted throughout the community • 21.7% increase in distinct patients served over previous year <p>Investment: \$200,644 Persons served: 504</p>
Post-Hospital Support*	N/A	<p>The Social Work and Case Management department provides funding and resources for patients with limited or no ability to pay for necessary medical and non-medical services. Services include skilled nursing facility and/or home health care costs, medical equipment, transportation, temporary housing, medications, and meal assistance.</p> <p>Investment: \$1,220,035</p>
Ravenswood Family Health Center	Social Work/Case Management Department	<p>The program supports a social services manager and clinical nurse manager in Medication Assisted Treatment/Enhanced Care Management, and a social service patient navigator to address the social drivers of health needs of high-risk and vulnerable patients</p> <ul style="list-style-type: none"> • 96% of medically high-risk, complex patients who needed a home visit received one within 30 days of referral • 96% of Emergency Department discharges sent by Stanford Health Care received a follow-up <p>Investment: \$250,000 Persons served: 968</p>
Samaritan House	Free Clinic Care Coordination and Care Delivery Redesign	<p>Adopting the Rush University Total Health Collaborative model, the program improves health outcomes through reduced inequities caused by social, economic, and structural determinants of health</p> <ul style="list-style-type: none"> • 4,440 medical, dental, and mental health patient visits provided for uninsured, low-income residents of San Mateo County • 412 people served through the Food Pharmacy Program with 6,638 bags of food distributed

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
		<ul style="list-style-type: none"> • 696 vaccines administered (including COVID-19, shingles, influenza, tetanus/pertussis, Hepatitis B, and/or pneumococcal infections.) Investment: \$300,000 Persons served: 1,171
Sonrisas Dental Health, Inc.	Oral Health Access to Care Program Expansion	The program increases critical access to high-quality dental and oral health care for low-income adults in San Mateo County. The Access to Care Program provides a range of high-quality dental services, including diagnostic, preventative, and restorative procedures, for patients facing financial barriers. <ul style="list-style-type: none"> • 146 low-income adult patients established or maintained a dental home • 82% of adult low-income active patients covered by Health Plan of San Mateo received 2 visits this year • 100% of patients received individualized oral health education and oral hygiene supply kits. • 94% of Sonrisas patients are highly likely to recommend Sonrisas Dental Health Inc. Investment: \$82,280 Persons served: 3,601
Subsidized Health Services	N/A	To expand access to health care for vulnerable residents, Stanford Health Care providers offer services at federally qualified health centers, county health systems, and government first responders. Investment: \$1,323,599

ECONOMIC SECURITY

Based on the 2022 Community Health Needs Assessment findings, our interventions to improve economic stability in our community are focused on food and income security. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit:

<https://stanfordhealthcare.org/community>.

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
<p>Downtown Streets Team</p>	<p>Income Security: Work Exchange Program for Chronically Homeless Individuals and Streets Team Enterprises</p>	<p>Unhoused team members volunteer in work experience teams, beautifying their community in exchange for basic needs stipends, case management, and employment services.</p> <p>Streets Team Enterprises is the next step for unhoused participants, providing termed employment with case management as clients (now employees) continue on their self-sufficiency journey.</p> <ul style="list-style-type: none"> • 476 additional individuals served in the Streets Team Volunteer Program • Removed 2,080 barriers to self-sufficiency for Team Members (Examples: enrolled in government programs, received personal identification and employment application) • 59 individuals hired as Streets Team Enterprises employees and provided with case management <p>Investment: \$214,000 Persons served: 476</p>
<p>Loaves & Fishes Family Kitchen</p>	<p>Food Security: Meals on Wheels for Low Income Homebound Older Adults in Santa Clara County</p>	<p>The program increases food security and support for seniors and older adults who cannot leave their homes to shop or eat, cannot prepare meals for themselves at home, and are without a social support network.</p> <ul style="list-style-type: none"> • Provided 126,464 home-delivered meals to 474 unduplicated clients who are nutritionally insecure and ineligible for other meal delivery programs • 90% of Client Satisfaction Survey respondents reported that they agree or strongly agree that the program helps them remain independent in their home • 85% of clients agreed or strongly agreed that the program is important to their wellbeing <p>Investment: \$350,000 Persons served: 474</p>

Partner or Topic	Program, if Applicable	Program Details and FY25 Impact
<p>Second Harvest Food Bank of Silicon Valley</p>	<p>Food Security: Lean Proteins for Local Food Distribution Centers</p>	<p>The program provides lean proteins (dairy, eggs, poultry, fish, peanut butter, and almonds) for local food bank sites.</p> <ul style="list-style-type: none"> • 2.6 months or 77 days’ worth of healthy proteins distributed • Served an average 22,517 low-income clients/month through 39 partner sites collaborating with 26 partner agencies • Working with 14 medical partners in San Mateo County, screened 349 medical clients for food insecurity and referred them for food assistance. • Prescreened 1,964 clients for CalFresh eligibility and submitted 433 CalFresh applications for eligible clients; 294 or 68% CalFresh applications were approved to receive monthly CalFresh benefits. <p>Investment: \$423,000 Persons served: 22,517</p>
<p>Senior Coastsiders</p>	<p>Food Security: Safety Net Services</p>	<p>This program provides safety net services for older adults who survive on low fixed incomes and, importantly, an increasing segment of middle-income seniors who earn too much to qualify for public benefits assistance but can’t keep pace with the rapidly increasing cost of living in Northern California.</p> <ul style="list-style-type: none"> • Provided over 1,500 classes and activities for over 2,000 unduplicated participants • Provided over 2,200 rides for an average of 205 older adults per month • Provided over 67,000 meals to over 440 unduplicated participants per month • Provided Case Management for over 125 older Coastside adults; intensive case management provided for 21 participants • Provided minor home repairs for 47 low-income older Coastside adults to reduce housing instability, support independent aging in place, and improve health outcomes <p>Investment: \$42,000 Persons served: 2,600</p>
<p>Workforce Development</p>	<p>N/A</p>	<p>Stanford Health Care is committed to partnering with community organizations on workforce development opportunities in community-based settings and at Stanford Health Care. Opportunities may include internships, hiring pipelines, mentorship, recruitment practice and support and initiatives that aim to support vulnerable communities.</p> <p>Investment: \$1,554,892</p>



STANFORD HEALTH CARE'S FY25 COMMUNITY BENEFIT FOR THE BROADER COMMUNITY

A nonprofit hospital must provide a benefit to the community as a whole, not limited to a narrow group, and it must be for a public purpose, not for private benefit. While helping vulnerable populations is a key component, it must be part of a broader community benefit strategy, such as maintaining an emergency room that is open to all, or providing health professions education to train new medical professionals..

Community Benefit Investment in the Broader Community

According to the Internal Revenue Service, to qualify for exemption under section 501(c)(3), a hospital must:⁶

- Demonstrate that it provides benefits to a class of persons that is broad enough to benefit the community, and
- Operate to serve a public rather than a private interest

Nonprofit hospitals provide community benefits to the broader community not only because their tax-exempt status creates an obligation to serve the public good, but because it is part of their broad mission. Hospitals like Stanford Health Care are focused on improving community-level social determinants of health like housing and food security, which ultimately benefits everyone by creating a healthier population and reducing health disparities. As major employers and institutions, hospitals play a role in community well-being beyond their walls, investing in local infrastructure and economic development to ensure long-term community stability and prosperity.

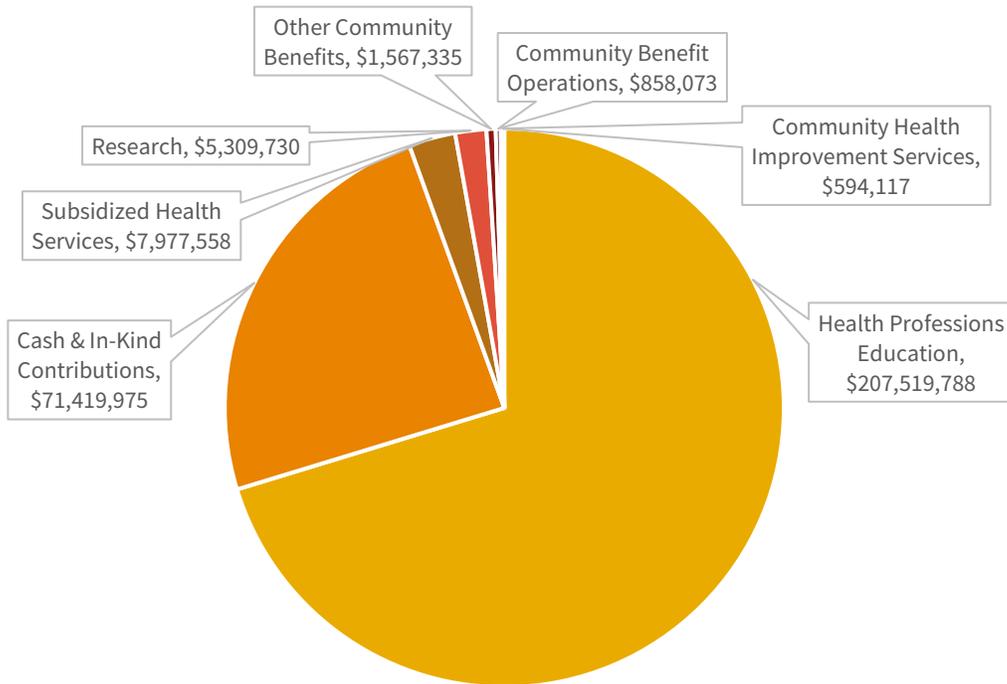


Total net value of quantifiable
benefits for the broader community:

\$295,246,576
in fiscal year 2025

⁶ Internal Revenue Service. (2025). *Charitable hospitals - general requirements for tax-exemption under Section 501(c)(3)*. Retrieved from <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>.

Stanford Health Care FY25 Broader Community Benefit



The categories of SHC’s FY25 community benefit for the **broader community** are shown below.



Health Professions Education, \$207,519,788

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



Subsidized Health Services, \$7,977,558

- Stanford Life Flight
- Community-based second opinion services



Community Health Improvement Services, \$594,117

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



Other Community Benefits, \$1,567,335

- Workforce development opportunities
- Emergency preparedness
- Community service initiatives for staff
- Employee Resource Groups’ community service activities
- Monitor and advocate for public health
- Mobilize expertise of the Stanford community in support of regional, state and national initiatives



Research, \$5,309,730

- Research into improved care delivery and better health outcomes



Community Benefit Operations, \$858,073

- Day-to-day operations related to community benefits



Cash and In-Kind Contributions, \$71,419,975

- Community health improvement grants
- Fundraising support for nonprofits
- Donating essential equipment, supplies and food to nonprofit organizations

Stanford Health Care’s Community Benefit for the Broader Community, by Health Need

Stanford Health Care (SHC) understands that good health is achieved through access to high-quality care as well as social and physical environments that promote good health. As such, all community benefit efforts aim to improve access to and delivery of care for the broader local community. Community benefit activities addressing behavioral health and health care access and delivery may be found below. Community benefit activities addressing housing and economic security are focused on [vulnerable populations](#) and may be found in that section.

Note: An asterisk () indicates investments that are hospital-based rather than community-based.*

BEHAVIORAL HEALTH

Based on the 2022 Community Health Needs Assessment findings, our interventions to improve behavioral health outcomes in our community are focused on screening and referral for mental and behavioral health services and substance use services/treatment for co-occurring mental illness and addiction, as well as supporting initiatives aimed at increasing the supply of diverse mental/behavioral health providers in community/safety net clinics. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit: <https://stanfordhealthcare.org/community>.

Partner, Program, or Topic	Program Details and FY25 Impact
Arts in Wellness	Program offers art and music activities to promote healing, social connection and well-being while strengthening environment and fostering positive engagement. Investment: \$390,393
Clinical Pastoral Education*	Students from a range of religious traditions enroll in this program to prepare for a career in chaplaincy or to 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: (\$59,416)
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: \$80,297

HEALTH CARE ACCESS & DELIVERY

Based on the Community Health Needs Assessment findings, our interventions to address access and delivery to care include improving access to health care, specialty care, medical social work and case management for vulnerable community members, including older adults and under- and uninsured populations. For more information about Stanford Health Care’s Community Health Needs Assessment, please visit: <https://stanfordhealthcare.org/community>.

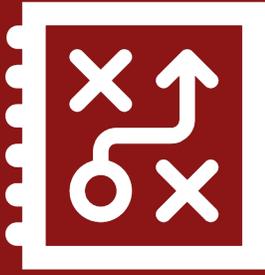
Partner, Program, or Topic	Program Details and FY25 Impact
<p>Allied Health Professions Education*</p>	<p>Student training programs in the field of:</p> <ul style="list-style-type: none"> • Clinical Laboratory • Clinical Nutrition • Dosimetry • Nuclear Medicine • Nursing • Pharmacy • Physician Assistant • Psychology • Radiology • Rehabilitation Services • Respiratory Care Services • Social Work • Ultrasound • Vascular • Wound Care <p>Investment: \$16,645,499</p>
<p>Board Service</p>	<p>To support improved community health and access to care for vulnerable populations, Stanford Health Care leaders and staff offer expertise, advocacy, and resources to local and national professional organizations, nonprofit community service organizations, and advocacy groups.</p> <p>Investment: \$5,854</p>
<p>Community Emergency Response*</p>	<p>As the only Level 1 Trauma Center between San Francisco and San Jose, Stanford Health Care (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.</p> <ul style="list-style-type: none"> • 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 • Leader among COVID-19 emergency management and response. <p>Investment: \$12,443</p>

Partner, Program, or Topic	Program Details and FY25 Impact
<p>Community Health Education Programs</p>	<p>Health education has an important role in preventing disease and injury, improving health, and enhancing quality of life. As such, Stanford Health Care offers numerous community health education programs at a reduced or no cost to patients and the broad community. The following are among SHC’s community health education offerings:</p> <ul style="list-style-type: none"> • COVID-19 prevention and treatment • Falls and other injury prevention • Life-saving techniques • Palliative Care • Spiritual Care • Arts and Wellness • Annual community health event, Health Matters • International Medicine Services: health conference and physician observership program <p>Investment: \$1,664,092</p>
<p>Medical Student, Resident, and Fellow Training*</p>	<p>Student training programs included all primary and specialty care programs.</p> <p>Investment: \$190,933,705</p>
<p>Online Second Opinion</p>	<p>Seeking to improve high quality care and access to specialty services, the Stanford Medicine Online Second Opinion program offers review of clinical diagnosis, treatment options, and care plans for community members.</p> <p>Investment: \$1,308,702</p>
<p>Sexual Assault Response Team (SART)*</p>	<p>Stanford Hospital became the second medical center in Santa Clara County to offer a dedicated, private and confidential space co-located in the Emergency Department for survivors of sexual assault to receive care and undergo evidence collection. The county’s SART team administers the Sexual Assault Forensic Exam (SAFE), working closely with hospital Emergency Department staff. Survivors receive trauma-informed care, including seamless access to medical forensic care, critical laboratory work, emergency contraception, and medications for sexually transmitted infections (STIs), all provided free of charge.</p> <p>Investment: \$40,258</p>
<p>Stanford Health Library*</p>	<p>The Health Library provides scientifically-based health information to assist in making informed decisions about health and health care. Staffed with health librarians at all four branches, culturally-competent services, resources, and health education is provided to the community free of charge.</p> <p>Investment: \$2,936,049</p>

Partner, Program, or Topic	Program Details and FY25 Impact
<p>Stanford Life Flight*</p>	<p>Helicopter transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient’s ability to pay.</p> <ul style="list-style-type: none"> • 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 <p>Investment: \$6,668,856</p>
<p>Stanford Wellness Programs*</p>	<p>The Supportive Care Program provides free, non-medical support services to patients, family members, and caregivers regardless of where patients receive treatment.</p> <ul style="list-style-type: none"> • 60+ services are provided, including support groups, health education classes, caregiver workshops, exercise and yoga classes, and art therapy classes <p>Investment: \$954,841</p>
<p>Support for Stanford University Health Professions Education and Training</p>	<p>Grant support provided to Stanford University School of Medicine for health professions education, community health improvement and community benefit activities.</p> <p>Investment: \$69,849,974</p>
<p>Support for Stanford University: Research</p>	<p>Funds support research aimed at advancing knowledge and evidence that benefits communities and populations. Supported work includes studies with vulnerable populations, cancer research, early drug development, and may span a broad range of focus areas, with an emphasis on improving outcomes, addressing unmet needs, and contributing to meaningful societal impact.</p> <p>Investment: \$5,309,730</p>
<p>Sustainability Program Office*</p>	<p>This program coordinates donations of medical supplies, food, furniture and equipment to local, national, and international charitable organizations.</p> <p>Investment: \$2,648,871</p>

2026–2028 Community Benefit Plan





STANFORD HEALTH CARE'S FISCAL YEAR 2026 COMMUNITY BENEFIT PLAN

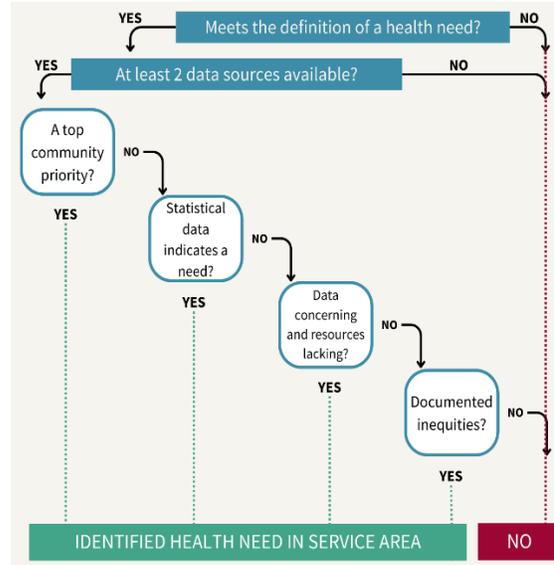
This plan represents the first year of a three-year strategic investment in community health. Stanford Health Care believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan is based on documented community health needs disclosed in the 2025 Community Health Needs Assessment.

2025 CHNA: IDENTIFICATION AND COMMUNITY PRIORITIZATION OF NEEDS

The 2025 Community Health Needs Assessment (CHNA)⁷ assessed community health needs by gathering input from persons representing the broad interests of the community. Through qualitative research software tools, transcripts were analyzed to identify common themes relevant to community priorities. To further assess community priorities, the number of times health needs had been prioritized by each of the focus groups and key informant interviews was tabulated. Statistical data were reviewed for their magnitude and severity in relation to established benchmarks (California state rates and averages) and/or based on advice from public health departments.

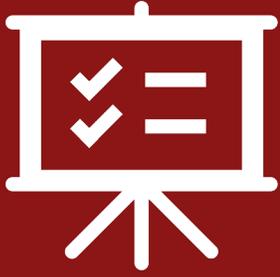
To be identified as one of the community's prioritized health needs for the purposes of the 2025 CHNA, the issue had to fit the definition of a health need,⁸ be present in at least two data sources, and either be prioritized by at least half of key informants and/or focus groups or rise to the list based on statistical data, with at least two direct indicators exhibiting documented differences between groups, failing the state average by five percent or more, or showing worsening trends and few supporting resources. The 2025 CHNA identified a total of 14 health needs.

Health needs were identified using a set of collaboratively agreed-upon criteria.



⁷ For information about Stanford Health Care's 2025 CHNA process and for a copy of the 2025 CHNA report, please visit <https://stanfordhealthcare.org/community>.

⁸ A health need was defined in the CHNA report as a poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome. For further information, see Section 5 of the 2025 CHNA report at <https://stanfordhealthcare.org/community>.



HEALTH NEEDS PRIORITIZATION AND SELECTION

Stanford Health Care’s Community Health & Partnerships (CH&P) staff met with the Community Engagement & Partnerships committee, which completed a comprehensive strategic planning process to select the health needs and strategies. The group included experts and stakeholders from across Stanford Medicine (Stanford hospitals and School of Medicine).

2026–2028 PLAN: HOSPITAL PRIORITIZATION AND SELECTION OF NEEDS

In the first half of 2025, members of the Community Engagement & Partnerships (CE&P) committee (together, the “team”) met to review the information collected for the 2025 CHNA and Community Benefit planning process, paying special attention to the needs and priorities of the community that were identified during the CHNA. The team was presented with the results of the 2025 CHNA, as well as criteria to prioritize (rank) and select the needs that the community had identified. Team members participated in structured exercises across several months to evaluate the identified health needs, rank them, and select the three health needs SHC would address.

Ranking criteria involved in needs selection were:

1. **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. Scored 3 if prioritized as one of the top five needs by at least one-half (50%) of all focus groups and key informants combined, scored 1 if prioritized as one of the top five needs by 15% or fewer, and scored 2 otherwise.
2. **Potential impact on need.** SHC can make a meaningful contribution to addressing the need because of its relevant competencies, and/or unique expertise as a health system, and because of an organizational mission/commitment to addressing the need. Scored 3 (substantial differences/strong concern), 2 (moderate differences/some concern), or 1 (minor differences/less concern) by leaders based on expertise and knowledge.

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



Access to Care



Mental and Behavioral Health



Economic Stability

STANFORD HEALTH CARE'S FY26 COMMUNITY BENEFIT PLAN

This Community Benefit Plan is a companion to the 2025 CHNA and the 2026–2028

Implementation Strategy report, in that it describes how hospitals will use community benefit and other resources to address priority health needs in their service areas..

STANFORD HEALTH CARE'S COMMUNITY BENEFIT PLAN

Our Strategic Approach

Stanford Health Care's annual community benefits focus on improving the health of the community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. In response to the 2025 Community Health Needs Assessment, we developed this Community Benefit Plan to guide our investments, institutional practices, and community engagement over the next three years (FY26–FY28).

What Is an Anchor-Inspired Approach?

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

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

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

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

This approach blends direct service, internal system improvements rooted in anchor principles, and community partnerships. Through these strategies, SHC aims to strengthen positive outcomes across its service area and support a healthier future for the communities it serves.

Access to Care

Why This Matters

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

Key Data Highlights

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

Community Voice

Community members and stakeholders shared:

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

At a Glance: Barriers to Care



Long wait times



Language & literacy challenges



High cost even with insurance



Transportation gaps

LONG-TERM GOAL

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

Our Approach

A. Investments & Grants

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

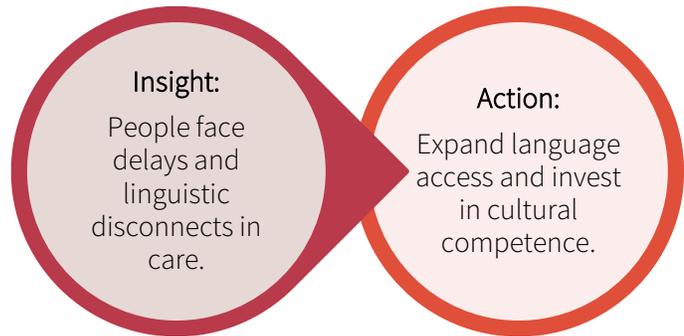
B. Institutional Systems & Practices

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

C. Advocacy & Community Engagement

- Advocate for access-focused policies at all government levels

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

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

What We Aim to Achieve

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

Mental and Behavioral Health

Why This Matters

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

Key Data Highlights

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

At a Glance: What Else We Heard



Long wait times



Language barriers



Culture/service match lacking



Earlier prevention efforts needed

Community Voice

CHNA participants highlighted the following:

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

LONG-TERM GOAL

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

Our Approach

A. Investments & Grants

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

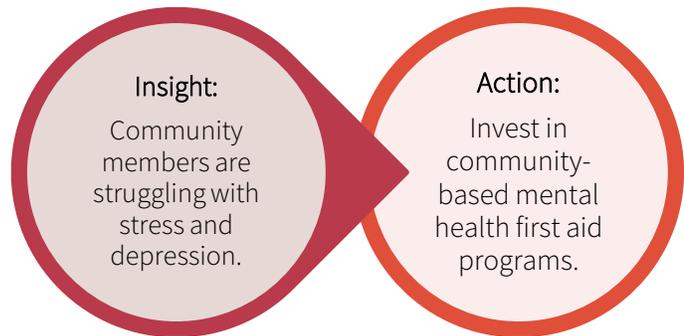
B. Institutional Systems & Practices

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

C. Advocacy & Community Engagement

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

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

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

What We Aim to Achieve

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

Economic Stability

Why This Matters

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

Key Data Highlights

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

Community Voice

CHNA participants highlighted the following:

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

At a Glance: Barriers to Economic Stability



High housing costs



Limited access to financial aid, job training



Many needing food support



Overcrowded living conditions

LONG-TERM GOAL

Reduce economic instability among community members to support improved health.

Our Approach

A. Investments & Grants

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

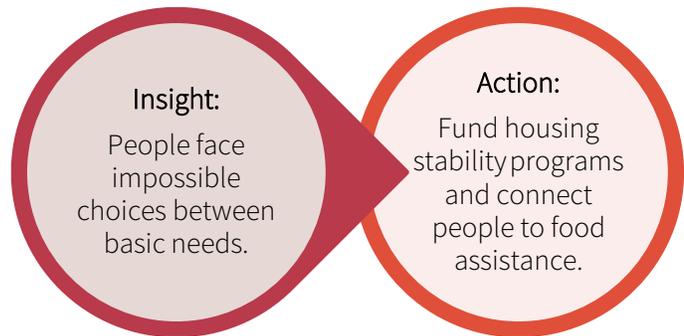
B. Institutional Systems & Practices

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

C. Advocacy & Community Engagement

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

From Insight to Action



How Our Strategies Reflect an Anchor-Inspired Approach

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

What We Aim to Achieve

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

APPENDIX A: SUPPORTING RESEARCH ON STRATEGIES

Access to Care

Financial assistance:

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

Health insurance coverage:

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

Care coordination interventions:

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4. Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 2013(347):f4913.
5. Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care*, 15(6). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/>
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8. Singer, C., & Porta, C. (2022). Improving patient well-being in the United States through care coordination interventions informed by social determinants of health. *Health & social care in the community*, 30(6), 2270-2281. Retrieved from <https://www.connectionriversidehealthcare.com/wp-content/uploads/SDOH-Care-Coordination.pdf>

Capacity building:

9. Increasing community health center capacity works best when paired with efforts to increase health insurance coverage. See Hadley, J., & Cunningham, P. (2004). Availability of safety net providers and access to care of uninsured persons. *Health services research*, 39(5), 1527-1546. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC1361082/pdf/hesr_00302.pdf See also Cunningham, P., &

Hadley, J. (2004). Expanding care versus expanding coverage: how to improve access to care. *Health Affairs*, 23(4), 234-244. Retrieved from https://d1wqtxts1xzle7.cloudfront.net/54271737/234-libre.pdf?1503958817=&response-content-disposition=inline%3B+filename%3DExpanding_Care_Versus_Expanding_Coverage.pdf&Expires=1746570621&Signature=fszrCtONwztllkOVPKQBE74XxKjHIL78cU0Aj0~Egw2Gm6qodnmRAva296rMM-JFGSygkreli3YyFOkXisFsITyMAhRbS8uoFbCtu5DGKnSDSrAgQA9qNMuWiNmVhaVMmO7An-9kRojHwqvclsPUgydoeQqx84kl-JyFh8EwVkr1cT6Aayj4rahl2FnnAiKLGTomrXnOgF9ZT-nc4uFlUKRxAAR5ahxkuZ4wptkYY5ql~NSqbjzSilhE~2SRhTDYO5F54WHvND5AOzzql-4S8ZkTj6~x-vAja1Fw40iLzgxOGTz-fCIts1KMC59Ns~s5-0kHoJCEqvs~y55Pb927yA &Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

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11. Bhatt, J, Bathija, P. *Ensuring Access to Quality Health Care in Vulnerable Communities* (2018). *Academic Medicine* (93) 1271-1275.

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