2023

Implementation Strategy Report

for Lucile Packard
Children's Hospital Stanford

Fiscal Years 2023–2025

Stanford MEDICINE

Children's Health

General Information

Contact Person
Joseph Vaughan

Years the Plan Refers to
Fiscal Years 2023–2025

Date Written Plan Was Adopted by Authorized Governing Body
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Authorized Governing Body that Adopted the Written Plan
Lucile Packard Children's Hospital Stanford Board of Directors

Name and EIN of Hospital Organization Operating Hospital Facility
Lucile Salter Packard Children's Hospital at Stanford
EIN 77-0003859

Address of Hospital Organization
725 Welch Rd.
Palo Alto, CA 94304

actionable insights

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I. About Lucile Packard Children's Hospital Stanford

Lucile Packard Children's Hospital Stanford is a 397-bed pediatric and obstetric facility located on the Stanford University campus in Palo Alto, California. Packard Children's also operates 30 pediatric acute care licensed beds at El Camino Health: 15 for the Comprehensive Care Program (within the eating disorders clinic) and 15 for standard pediatric acute care. Also, Packard Children's operates six intensive-care nursery licensed beds at Sequoia Hospital.

Community Health Initiatives

For more than 30 years, Packard Children's Hospital has been committed to improving the health of its community. Providing exceptional services, programs, and funding far beyond its hospital walls has been part of the vision and mission of Packard Children's since day one. As part of that original commitment, Packard Children's provides direct health care services to some of its community's most vulnerable members, and it partners with government and local community-based organizations to fund programs that improve the health of its community. In addition to addressing the health disparities that exist in maternal health outcomes, Packard Children's Hospital adopted four Community Health Initiatives for 2020–2022:

- Improving access to health care services for children, teens, and expectant mothers
- Preventing and treating pediatric diabetes and obesity
- Improving the social, emotional, and mental health of children and youth
- Improving maternal and infant health disparities

In addition to providing financial and other support for these initiatives, Packard Children's invests in many other hospital- and community-based programs that promote the health of children, teens, and expectant mothers.

II. Lucile Packard Children's Hospital Stanford's Service Area

Because of its international reputation for providing outstanding care to babies, children, adolescents, and expectant mothers, Packard Children's serves patients and their families around the entire San Francisco Bay Area. In the 13-county Northern California region, Packard Children's ranks first for pediatrics, with 10.1 percent market share, and third for obstetrics, with 4.4 percent market share.[1]

However, Packard Children's 2021 discharge data show that slightly less than half (46.7 percent) of its inpatient pediatric cases (excluding normal newborns) and 81.1 percent of obstetrics cases come from San Mateo and Santa Clara counties. So, for purposes of its community benefit initiatives, Packard Children's has identified these two counties as its target community. This hospital ranks first in market share (19.9 percent) for pediatrics and second for obstetrics (9.3 percent) in its primary service area.

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

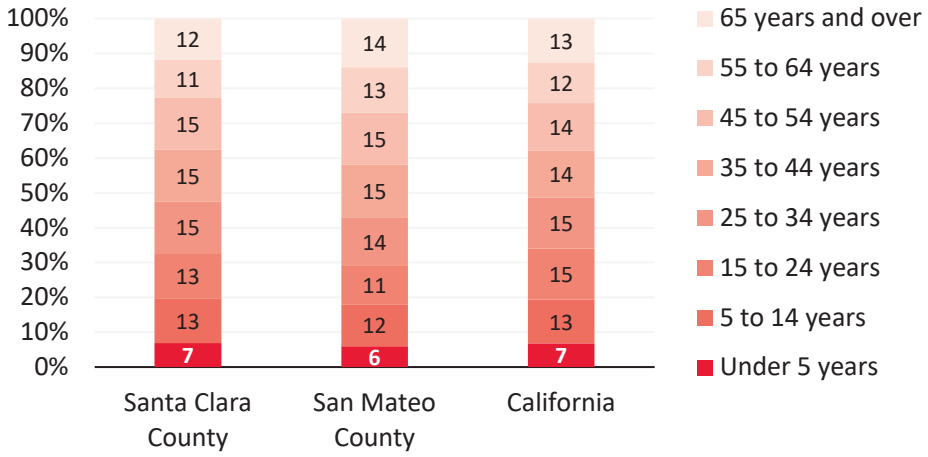
Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2019, approximately 1.92 million people lived there, making it the sixth largest county in California by population. San José is its largest city, with over 1.02 million people (53% of the total). The population of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

1 California Office of Statewide Health Planning and Development, 2020.

with 9,115 people per square mile compared to 8,486 per square mile in California. The median age in Santa Clara County is 38.1 years old. More than 22% of the county's residents are under the age of 18, and over 13% are 65 years or older.[2]

In both counties, residents aged 0–14 make up about one fifth of the population, which is similar to the state, as shown in the chart below. The percentage of women aged 15–50 who have given birth is 5 percent in both counties and in California.[3]

AREA POPULATION BY AGE RANGE



Source: *San Mateo County and California data from San Mateo County All Better Together*, http://www.smcalltogetherbetter.org/demographicdata?id=278&sectionId=942; *Santa Clara County data from World Population Review*, https://worldpopulationreview.com/us-counties/ca/santa-clara-county-population.

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

More than 34% of residents in San Mateo County and more than 39% of residents in Santa Clara County are foreign-born. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[5]

Our communities earn some of the highest annual median incomes in the U.S., but they also bear some of the highest costs of living. Median household incomes are $130,820 in San Mateo County and $129,210 in Santa Clara County, both far higher than California's median of $82,053.[6]

Yet the California Self-Sufficiency Standard,[7] set by the Insight Center for Community Economic Development, suggests that many households in San Mateo and Santa Clara counties are unable to meet their basic needs.[8] (The Standard in 2021 for a family with two children, the 2021 standard was $166,257 in San Mateo County and $144,135 in Santa Clara County.) Housing costs are high: In 2021, the median home price was $1.6 million[9] and the median rent was $2,451 in San Mateo County; this compares to $1.4 million[10] and $2,374 in Santa Clara County. In both counties, 26% of children are eligible for free or reduced-price lunch and close to one quarter of children live in single-parent households (22% of children in San Mateo County and 23% of children in Santa Clara County). About 4% of people in our communities are uninsured.

2 Census data in prior paragraphs from https://www.census.gov/quickfacts.
3 Births data from https://www.towncharts.com/California/Demographics/Santa-Clara-County-CA-Demographics-data.html.
4 U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
5 Data from https://www.census.gov/quickfacts.
6 U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019.
7 The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.
8 Center for Women's Welfare, University of Washington. (2021). Self-Sufficiency Standard Tool. "Family" is considered as two adults, one infant and one school-age child. See http://www.selfsufficiencystandard.org/node/44.
9 Redfin. (2021). San Mateo County Housing Market. Retrieved from https://www.redfin.com/county/343/CA/San-Mateo-County/housing-market
10 Redfin. (2021). Santa Clara County Housing Market. Retrieved from https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market

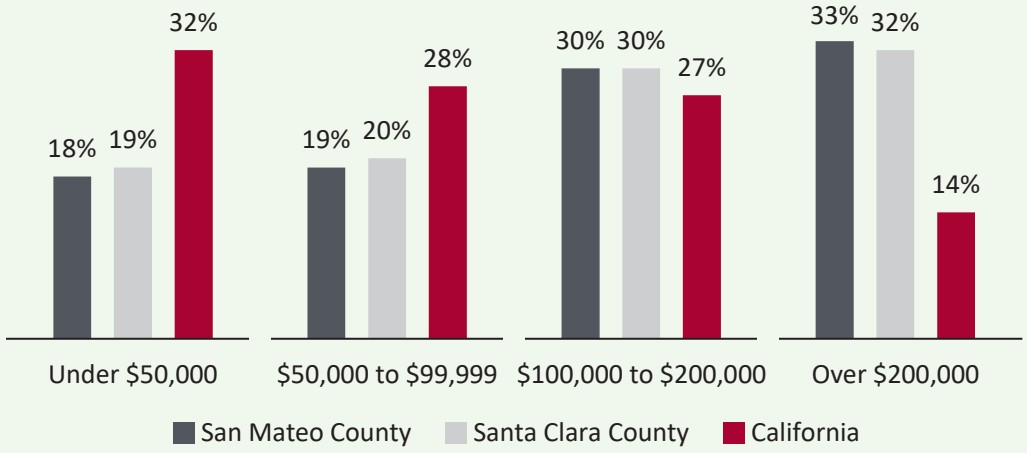
RACE/ETHNICITY IN HOSPITAL SERVICE AREA

Race/Ethnicity	San Mateo County Total Percent of County (Alone or in Combination with Other Races)*	Santa Clara County Total Percent of County (Alone or in Combination with Other Races)*
American Indian/Alaskan Native	0.1%	0.2%
Asian	30.1%	38.5%
Black	2.2%	2.3%
Hispanic/Latinx	24.2%	25.1%
Pacific Islander/Native Hawaiian	1.3%	0.3%
White	37.8%	29.9%
Multiracial	4.0%	3.4%
Some Other Race	0.4%	0.2%

Source: U.S. Census Bureau, *American Community Survey, 5-Year Estimates, 2015–2019.*

*Percentages do not add to 100% because they overlap.

AREA HOUSEHOLD INCOME RANGES



Source: *Census Reporter*, https://censusreporter.org/profiles (American Community Survey, 2015–2019).

The minimum wage in San Mateo County[11] was $14–$15.90 per hour in 2021 and in Santa Clara County[12] was $14–$16.30 per hour, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 26% increase in the cost of living in San Mateo County and a 27% increase in Santa Clara County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 5.4% per year average increase in wages in the San José-Sunnyvale-Santa Clara metropolitan area between 2018 and 2020.

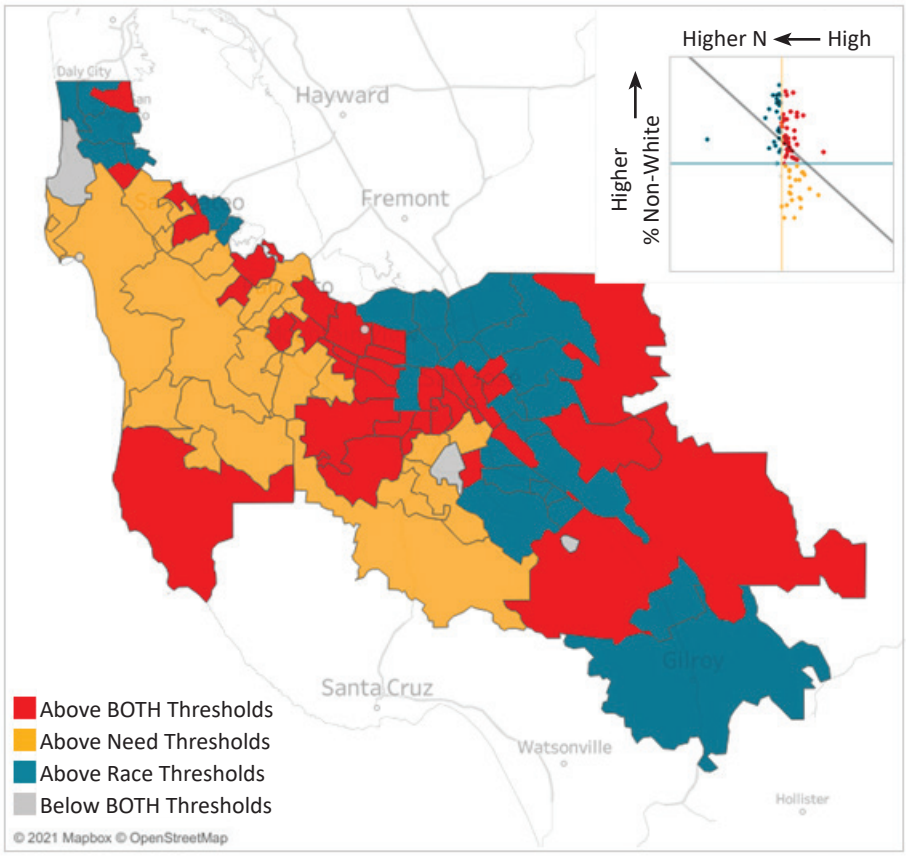
11 Bay City News Foundation. (2021). Several San Mateo County cities hike minimum wage for 2021. The Daily Journal. Retrieved from https://www.smdailyjournal.com/news/local/several-san-mateo-county-cities-hike-minimum-wage-for-2021/article_47e4717a-4f0b-11eb-ac74-6fa7c18ed062.html

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

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, both counties' populations overall are healthier than the national average.[13] Although San Mateo and Santa Clara counties are quite diverse and have substantial resources, there is significant inequality in their populations' social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality,[14] is higher in certain ZIP Codes compared to others.

Certain areas also have poorer access to high-speed internet (e.g., ZIP Codes 95013, 94074), walkable neighborhoods (e.g., ZIP Codes 95002, 94060), or jobs (e.g., ZIP Codes 95020, 94044). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

CORRELATION BETWEEN INCOME INEQUALITY & NON-WHITE POPULATION, BY ZIP CODE



Note: Parts of both counties exhibit income inequality (red and yellow areas). In many places where income inequality is high, non-white community members are also in the majority (red areas). "Need Threshold" is the U.S. Gini Index, 0.4. "Race Threshold" is 50% non-white. Source: *Community Health Data Platform, 2021.*

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

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

III. Purpose of Implementation Strategy

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

For information about Lucile Packard Children's Hospital Stanford's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit communitybenefits.stanfordchildrens.org.

IV. List of Community Health Needs Identified in the 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. The CHNA study team[15] used this primary qualitative input to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. The study team compiled statistical data and provided comparisons against statewide averages and rates.

To be considered a health need for the purposes of the 2022 CHNA, the need had to fit the definition of a health need,[16] affect children and/or youth, and either be prioritized by multiple focus groups or key informants or rise to the list based on statistical data, with at least two direct indicators exhibiting documented inequities by race, showing worsening trends, or failing the benchmark by five percent or more. The 2022 CHNA identified a total of 12 health needs. The health need prioritization and selection process is described in Section VI of this report.

2022 Community Health Needs List

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

15 The study team was composed of Lucile Packard Children's Hospital Stanford, El Camino Health, Stanford Health Care, Sutter Health (including Mills-Peninsula Medical Center, Menlo Park Surgical Hospital, and Palo Alto Medical Foundation), and Actionable Insights, LLC. For more details, see Packard Children's 2022 CHNA report.

16 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 CHNA report.

V. Those Involved in the Implementation Strategy (IS) Development

Packard Children's selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. Health Needs that Lucile Packard Children's Hospital Stanford Plans to Address

A. Process And Criteria Used To Select Health Needs

Lucile Packard Children's Hospital Stanford met with Actionable Insights on February 17, 2022, to discuss the health needs identified through the community assessment and to prioritize the list. After prioritizing the 12 health needs documented in the 2022 CHNA, Packard Children's, by consensus, selected four of the health needs that had been identified. The selected needs are listed below in alphabetical order.

- **Behavioral Health**
- **Economic Stability**
- **Health Care Access and Delivery**
- **Maternal and Infant Health**

For the purposes of this IS, the Packard Children's community benefit team renamed the first need **"Social/Emotional Health,"** and the third need **"Access to Care"** in order to better express the topics on which it will focus in addressing the needs.

B. Description Of Health Needs That Lucile Packard Children's Hospital Stanford Plans To Address

See Appendix B for health needs profiles, which summarize key statistical and qualitative data for each health need described below.

Social/Emotional Health

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

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

SELF-HARM INJURY HOSPITALIZATIONS PER 100,000 CHILDREN AGES 0–17

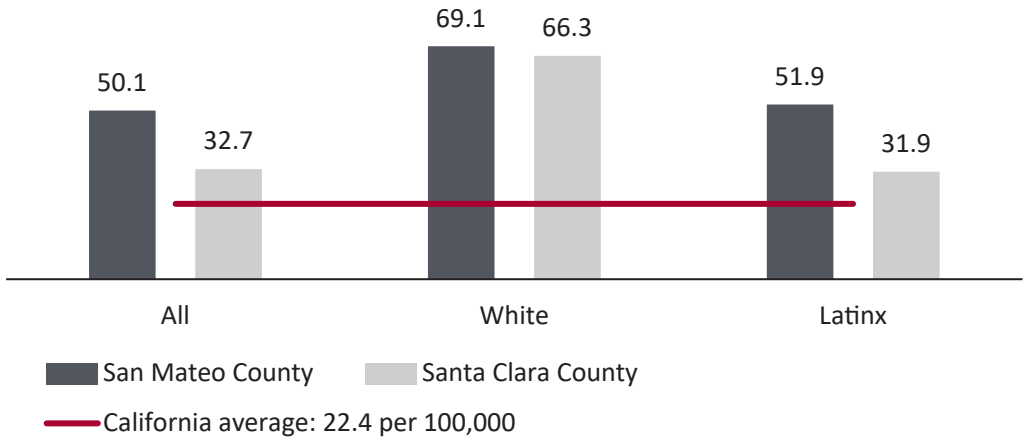


Chart data source: California Department of Health, EpiCenter (2019).

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

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among San Mateo and Santa Clara counties' Black populations occur at nearly twice the rate as all Californians. Self-harm injury hospitalizations are much higher for both counties' white and Latinx youth than for all California youth. Both counties' white suicide rate for all ages remains persistently higher than the state rate. Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[17] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[18] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10–17) are substantially higher for Black and Latinx youth in both counties than for California youth overall.

"I think one of the questions is how do we, as hospital systems, commit to parity, to equity in terms of access to mental health support, knowing it really is the primary health need of our families right now across the country and within San Mateo and Santa Clara counties."

— Health Equity Focus Group Participant

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

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

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

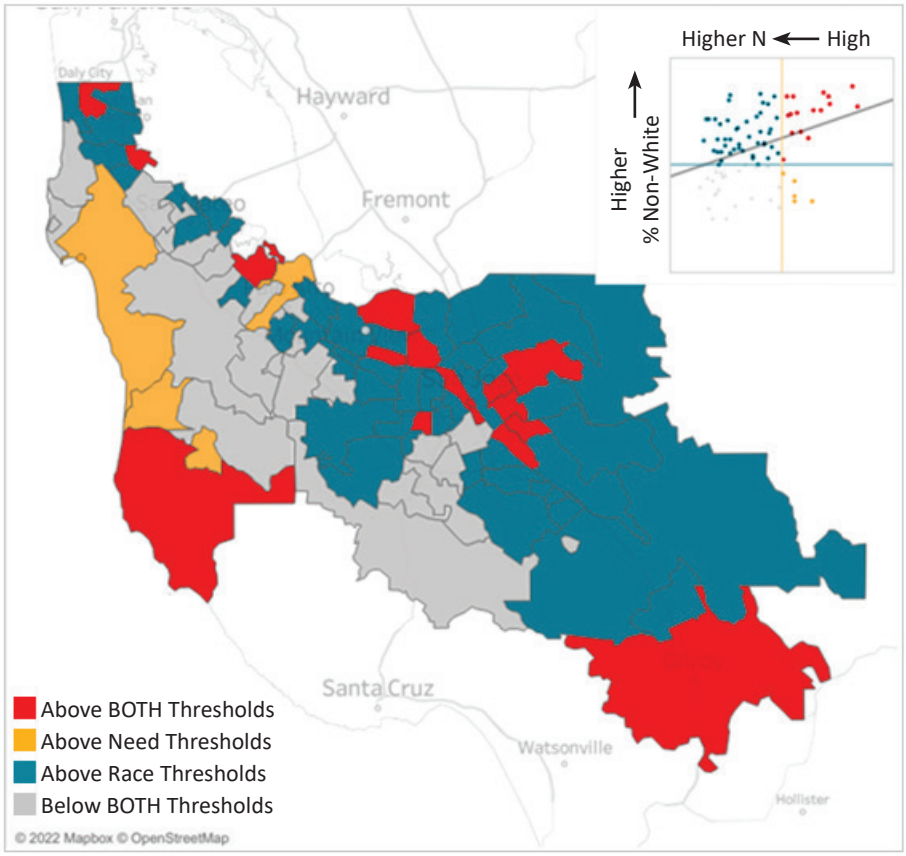
Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services, and there are very few inpatient psychiatric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

Economic Stability

Nearly all focus groups and over three quarters of all key informants identified economic stability as a top community priority, while more than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo and Santa Clara counties are extremely high; both counties' median home rental costs are more than 40% higher than the median state home rental cost, and the home ownership affordability indices[19] for both counties are substantially worse than for the state overall. Moreover, while homeowners statewide are spending approximately just under one-third of their income on their mortgages, homeowners in San Mateo and Santa Clara counties are spending more than one-third of their income on their mortgages.

Data available on economically precarious households shows that while half of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion is higher among households in both San Mateo and Santa Clara counties. Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty). In our 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic precariousness can force people to choose between paying rent and accessing health care; it can also lead to homelessness and the many barriers to health that unhoused individuals face. In both counties, homelessness rose in 2019 (the most recent homeless count).

CORRELATION BETWEEN FREE- AND REDUCED-PRICE LUNCH ENROLLMENT AND NON-WHITE POPULATION, BY ZIP CODE



Notes: Parts of both counties exhibit income inequality (red and yellow areas). In many places where free- and reduced-price lunch enrollment is high, non-white community members are also in the majority (red areas). "Need Threshold" is the U.S. average of free- and reduced-price lunch enrollment, 39.5%. "Race Threshold" is 50% non-white. Source: Community Health Data Platform, 2021.

19 The housing affordability index has a base of 100; figures above 100 indicate better affordability and those below 100 indicate less-affordable areas, where "median income is not high enough to purchase a median valued home." See Krivacsy, K. (2018). The Delicate Balance between Housing Affordability, Growth, and Income. ESRI ArcGIS Blog, December 14, 2018. Retrieved from https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income

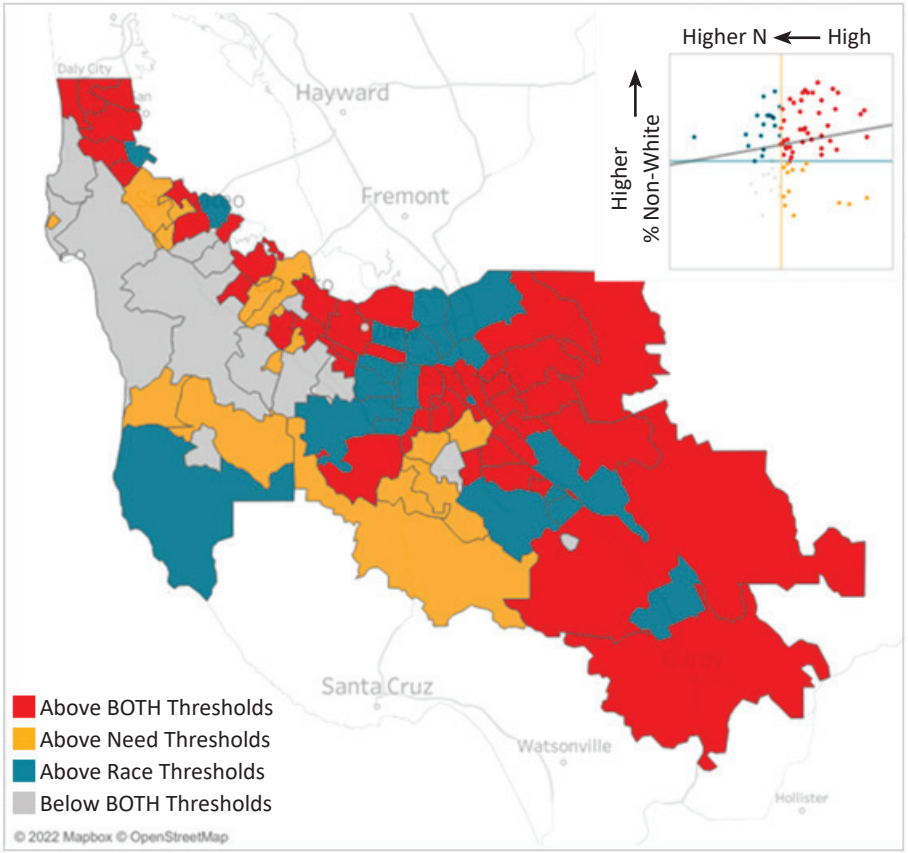
Income inequality in Silicon Valley is 1.5 times higher than the state level. Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander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

Most feedback about housing from key informants and focus group participants concerned housing affordability. CHNA participants reported the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. Experts noted that during COVID, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

Other CHNA participants said high housing costs are driving overcrowding, which they noted can contribute to the spread of infectious

> "It's even gotten harder for my staff to find housing in the Bay Area...One of the major issues we're facing is actually being able to attract talent for the salaries that we're able to pay. And it's a reflection not just of low salaries, but at the cost of housing in the Bay Area...
>
> We're increasingly going to have our workers work outside the Bay Area because it's more affordable to live."
>
> *— Behavioral Health Focus Group Participant*

CORRELATION BETWEEN SEVERE HOUSING COST BURDEN AND NON-WHITE POPULATION, BY ZIP CODE



Note: Severe housing cost burden (more than 50% of household income) is a significant problem in many parts of both counties (red and yellow areas), ranging from 14.0% in Zip Code 95136 up to 40.5% in Zip Code 94074. In many places where the severe housing cost burden is high, non-white community members are also in the majority (red areas). "Need Threshold" is the average proportion of households experiencing severe housing cost burden in the U.S., 14%. "Race Threshold" is 50% non-white.

diseases, including COVID. However, housing quality is also a concern; for example, children and young adults ages 6–20 in Santa Clara County have worse blood lead levels than California children overall.

Qualitative data also showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also "overrepresented in both frontline and hardest-hit sectors" of the economy.[20] Before the pandemic, the cost of childcare may also have been a limiting factor; the annual costs of infant child care (ages 0–2) and pre-K child care (ages 3–5) were substantially higher in both counties than the state average.

"Extremely low-income households, primarily from communities of color, were hit the hardest [by COVID-19]. The groups that we served saw their incomes drop by two-thirds from the start of the pandemic until now [one year later]... outside of just paying the rent, health care, food, and transportation were all the top things that they needed money for, to help with. And before this pandemic started, all these extremely low-income households were most likely severely rent-burdened, paying more than 50 percent of their income towards rent, but they were one crisis away, and now we've got a thousand crises."

— Social Services Agency Focus Group Participant

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

Access To Care

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

Many key informants and focus group participants connected health care access with economic instability. For example, some mentioned that low-income residents might be required to prioritize rent and food over health care. Some reported that low-income and undocumented community members especially have difficulty accessing insurance. Affordability, both of insurance premiums and of health care itself, especially preventive care, was a particular concern; in our 2019 CHNA report, community members of Latinx and "Other" ancestries[21] in both counties were significantly less likely to have health insurance than others. In 2021, CHNA participants identified the lack of information about health care costs for patients as another barrier to accessing care.

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. They also

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

expressed concern about the lower reimbursement rate for telephone appointments (i.e., without video). Once in-person appointments were more common again, transportation returned as a barrier to care for those living on the Coastside.

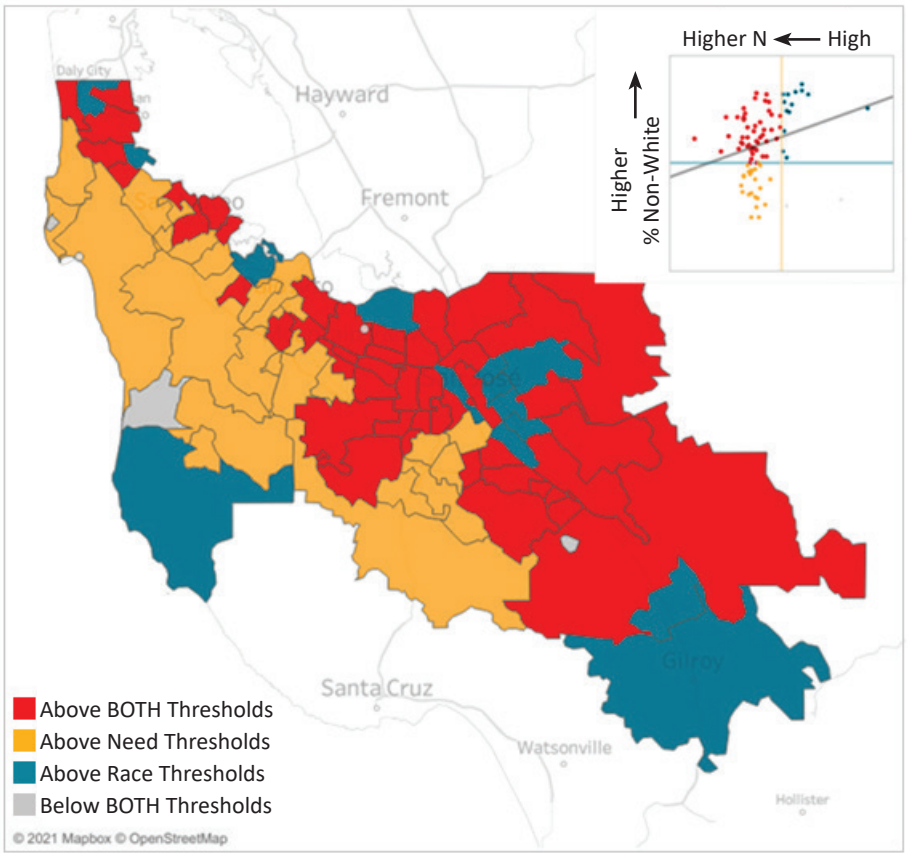
> ""I think one of the questions is how do we, as hospital systems, commit to parity, to equity in terms of access to mental health support, knowing it really is the primary health need of our families right now across the country and within San Mateo and Santa Clara counties?"
>
> *— Expert, Focus Group Participant*

The need for health care workforce training to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas identified included: LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients with mental health issues, who are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included the education of health care workers around public charge issues and the need for greater language capacity. More than one in ten Santa Clara County residents speak limited English, compared to fewer than one in ten in San Mateo County and in California overall. Limited English proficiency can restrict health care access.

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

Access issues related to oral health arose as well. An oral health expert described the lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral health care into whole-person care. Most specifically, the oral health expert called out the fact that of the few pediatric dentists in Santa Clara County, still fewer take Denti-Cal due to the low reimbursement rates, leading to a gap in services. For example, a substantially smaller proportion of Santa Clara County Asian/Pacific Islander children and youth involved in the child welfare system received a dental

CORRELATION BETWEEN MEDICAID/PUBLIC INSURANCE ENROLLMENT AND NON-WHITE POPULATION, BY ZIP CODE



Notes: Enrollment in Medicaid or another public insurance plan is higher than the U.S. average in many parts of both counties (red and yellow areas). In much of San José and parts of the Peninsula, non-white community members are in the majority (red and blue areas). "Need Threshold" is the Medicaid/public insurance enrollment proportion of 35% (U.S. average). "Race Threshold" is 50% non-white. Source: Community Health Data Platform, 2021.

check-up than child welfare-involved children and youth statewide. In our 2019 CHNA report, a smaller proportion of children countywide had a recent dental exam compared to children across the state. Other data from our 2019 CHNA suggest that Santa Clara County's adults were more likely to experience dental decay than Californians overall and had a higher rate of emergency department visits for non-traumatic dental conditions than the state rate. Finally, the oral health expert noted that low-income pregnant women often do not know they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

Maternal And Infant Health

Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinas in both counties and young Black women in San Mateo County than all females ages 15–19 statewide. A maternal and child health expert suggested that cultural norms and access issues may play into these differences.

As another example, low infant birth weight is a more frequent issue among Asian and Black babies born in both counties than all babies statewide, and the overall trend is worsening in Santa Clara County. Low birth weight is also more of an issue for San Mateo County Native American babies. Additionally, a smaller proportion of Black and Latina mothers in Santa Clara County receive early prenatal care than all California mothers. CHNA participants felt that BIPOC people who are pregnant or have recently given birth need improved access to care. A maternal and child health expert indicated that these inequities may also be traced back not only to health care access and delivery barriers but also to social determinants of health such as racism.

"The Black and Pacific Islander populations have continued to shoulder a lot of layers of disparity and inequity,... which we already saw in our maternal, child, and adolescent health indicators, whether it was low birth weight or exclusive breastfeeding."

— Public Health Expert

LOW BIRTH WEIGHT BY RACE/ETHNICITY

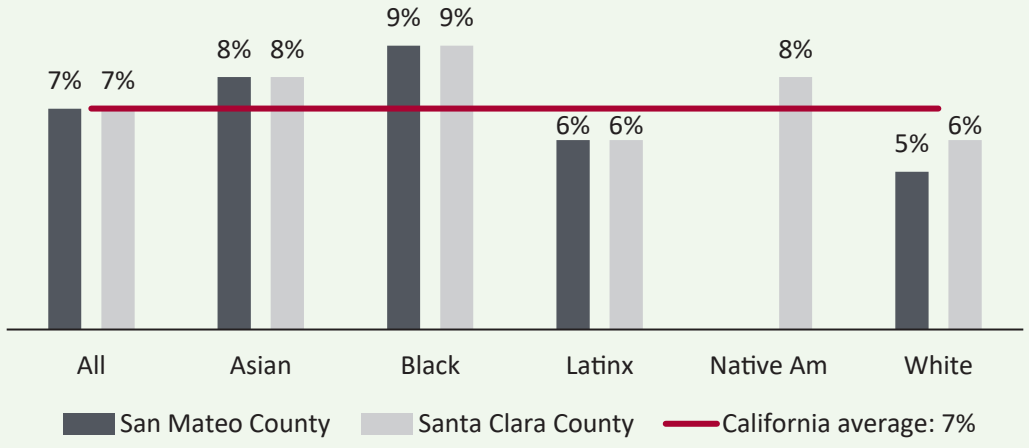


Chart data source: National Center for Health Statistics - Natality files (2013-19).

VII. Packard Children's Implementation Strategy

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

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

The goals and strategies proposed to address the chosen needs are described in the section below. Packard Children's will implement these strategies through a combination of grants, sponsorships, and in-kind support to community-based organizations, community health centers, clinics, or FQHCs. Associated indicators of anticipated impact are listed for each goal.

As described in its CHNA, Packard Children's Hospital's definition of "community health" includes not only the physical health of both counties' residents, but also broader social and environmental determinants of health (such as access to health care, affordable housing, child care, education, and employment). This more inclusive definition reflects the understanding that myriad factors impact community health. Packard Children's is committed to supporting community health improvement through strategies that address both upstream (social determinants of health) and downstream (health condition) interventions.

Health Need 1: Social/Emotional Health

Long-Term Goal: Children, adolescents, and young adults experience good social and emotional health (mental health) and are able to cope with life's stressors.

Various social conditions can impact youth mental health, including household income, family dynamics, the availability of social support, and school climate. In Santa Clara County, the ratio of students to school-based psychologists is much worse than the state overall. The number of mental health providers per capita in Santa Clara County is also smaller than the state. In San Mateo County, high-school students are somewhat more likely to think about suicide than their peers statewide. By ethnicity, San Mateo County's Pacific Islander high schoolers as well as Santa Clara County's Asian high schoolers are more likely than their peers countywide to seriously consider suicide. In both counties, Pacific Islander youth are more likely than their peers of other ethnicities to experience depressive symptoms, as are Black youth in Santa Clara County. The proportions of children and youth who are hospitalized for mental health issues in San Mateo County are significantly higher than state averages. Children also are much more likely to be hospitalized for self-harm injury in both counties compared to children statewide. Drug overdose death rates were highest among Black youth in both counties, but also higher than the state rate for white youth in both counties.

CHNA participants in San Mateo and Santa Clara counties ranked behavioral health as a high priority. The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data; children and adolescents were of particular concern. Experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families. Finally, experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment.

Goal	Social/Emotional Health Strategies	Anticipated Impact
1.A Provide high-quality mental health services to youth	i. Expand access to programs and services that prevent poor mental health (e.g., mindfulness-based stress reduction)[1,2,3] ii. Expand access to programs and services (including screening and counseling/therapy) that address stress, depression, and suicidal ideation, including increasing mental/behavioral health workforce[4,5,6,7,8,9,10] iii. Support school-based interventions, policies, programs, and approaches to improve school climate and prevent or reduce bullying[11,12,13,14,15,16,17,18,19,20,21,22,23] iv. Support programs and policies that prevent or reduce domestic violence and increase healthy relationships, both between adults and children and between peers[24,25,26] v. Participate in collaboratives and partnerships to address mental health in the community[27, 28, 29, 30, 31]	a. Reduced bullying b. Improved access to social/ emotional health programs and services c. Increased knowledge among youth about methods of coping with stress and depression d. Increased proportion of youth served with effective social/ emotional health services e. Improved social/emotional health among those served f. Improved coping skills among those served g. Healthier relationships for those served h. Reduced disciplinary actions (suspensions, expulsions) in schools served i. Improved school climate in schools served
1.B Address the systemic/ institutional barriers to mental health	i. Support collaboration and referrals between primary care providers, educational professionals, social workers, and others, and mental health specialists (aka youth mental health continuum of care)[32,33] ii. Support coordination of behavioral health care and physical health care, such as co-location of services, and mental/behavioral health providers to support co-located services[34,35] iii. Advocacy for mental health parity and similar legislation[36]	a. Among providers/professionals, increased knowledge of local resources available for treatment of depression and related disorders b. Greater collaboration and coordination in providing mental health services to youth c. Improved access to coordinated social/emotional health services
1.C Improve media literacy among youth and parents in light of mental health	i. Support initiatives, programs, and services for youth and their parents targeting media literacy, critical thinking, and the role of peers[37,38,39]	a. Greater media literacy among those served b. Increased critical thinking abilities among those served c. Healthier use of social media by those served d. Reduced impact of cyberbullying among those served

Health Need 2: Economic Stability

Long-Term Goal: Increase the number of infants, children, adolescents, and young adults who experience economic stability and related improved health outcomes.

Economic stability is one of the most widely recognized social determinants of health. Nearly one third of Silicon Valley households are not meeting economic self-sufficiency standards. Housing costs and other costs of living in San Mateo and Santa Clara counties are extremely high. Disparities in median household income amounts suggest that BIPOC community members in both counties are at a significant economic disadvantage compared to their white and Asian peers in everything from the cost of housing to the cost of childcare (which is already substantially higher in both counties compared to the average cost statewide).

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. For example, average third-grade math scores are substantially higher among white and Asian children than among Latinx and Black children in San Mateo County. Similarly, much smaller proportions of BIPOC high school graduates completed college prep courses in both counties than did their white and Asian counterparts. Food insecurity, which can increase the likelihood of obesity, is also an issue in our community. One sign of food insecurity is the proportion of children eligible for free or reduced-price lunch. In a number of school districts in Silicon Valley, more than half of the students are eligible for free- or reduced-price meals (a proxy for poverty). In many places where free- and reduced-price lunch enrollment is high, non-white community members are also in the majority.

CHNA participants indicated that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work, and that this tended to affect women more than men. Participants also reported the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Some mentioned out-migration from the area due to the high cost of housing, and others described the difficulty of recruiting employees for the same reason. Still others said high housing costs were driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID.

Goal	Economic Stability Strategies	Anticipated Impact
2.A Reduce housing instability among vulnerable community members to support better health outcomes	i. Support efforts to improve equitable access to social services that address housing insecurity and financial instability[40] ii. Support local homelessness prevention organizations and collaboratives that provide temporary financial assistance, legal support, case management and/or other needed services to low-income individuals and families at risk of losing their housing[41,42,43,44] iii. Support integrated case management programs that link vulnerable individuals with housing[45, 46]	a. Increased equitable access to social services to prevent homelessness b. Increased utilization of social services c. Reduced proportion of individuals who are housing insecure d. Reduced racial/ethnic disparities in housing instability e. Increased housing stability among those served f. Increased financial stability among those served g. Improved health outcomes among those served
2.B Reduce food insecurity among vulnerable community members to support better health outcomes	i. Support efforts to improve equitable access to social services that address food insecurity[47] ii. Support efforts to increase enrollment in CalFresh/SNAP & WIC iii. Support efforts to increase equitable utilization of existing food banks and other food distribution sites[48,49] iv. Support improvements in social determinants of health screening and referral systems in hospitals and community clinics[50,51,52] v. Support healthy food access interventions in communities (e.g., community gardens, farmers markets)[53, 54, 55, 56] vi. Support opportunities for community health education about nutrition/healthy eating[57,58,59]	a. Increased equitable access to social services to reduce food insecurity b. Increased utilization of social services c. Reduced racial/ethnic disparities in food insecurity d. Increased food security among those served e. Improved health outcomes among those served
2.C Reduce economic instability among vulnerable community members to support better health outcomes	i. Support distribution of "essential resources" to vulnerable community members[60,61] ii. Support efforts to increase workforce-related educational attainment and/or job training[62,63] iii. Advocacy for Universal Basic Income pilots[64]	a. More families can meet their basic needs b. Reduced unemployment rates c. Reduced pay disparities d. Reduced inequities in educational attainment e. Reduced poverty rates

Health Need 3: Access To Care

Long-Term Goal: Increase the number of infants, children, adolescents, and young adults who have access to needed health care services.

One of the social determinants of health is access to health care. Primary care physicians often rely on other personnel to add capacity to their practices, but the high cost of living in the Bay Area can affect their ability to recruit and retain staff. In San Mateo County (SMC), for example, the ratio of primary care providers who aren't doctors, including registered nurses and physician assistants, is much worse than the state. The impact on families may include longer appointment wait times and fewer practices accepting new patients. In San Mateo and Santa Clara counties, the ratios of school nurses to students are also much worse than state benchmarks. School nurses provide needed screenings and preventative care. Meanwhile, parents who don't speak English fluently may face language barriers during doctor visits. The percentage of children in Santa Clara County who live in households where limited English is spoken exceeds the state average. Poor health care access and delivery can affect medical outcomes for many conditions that could otherwise be controlled through preventive care and proper management.

CHNA participants ranked access to care, particularly its availability and affordability, as a high priority. For example, some mentioned that low-income families might be required to prioritize rent and food over health care. Experts and county residents reported a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Experts also said they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts expressed worries about the digital divide and patients' lack of privacy. Finally, the need for health care workforce training to deliver care in a sensitive manner, including to LGBTQ+ youth and young adults, as well as patients who are low-income, lack digital and/or English literacy, or who have mental health issues, was a common theme among key informants and focus group participants.

Goal	Access to Care Strategies	Anticipated Impact
3.A Increase availability of health care services for vulnerable children, youth, and young adults (ages 0–24)	i. Support health care clinics in close geographic proximity to vulnerable populations (e.g., low socioeconomic status neighborhoods and other neighborhoods where health care disparities exist) [65] ii. Support systems approaches to increased equitable access to care, including telemedicine, after-hours availability, etc.[66,67,68,69,70,71,72,73,74,75,76]	a. Increased number of children and expectant mothers served b. Increased access to preventative medicine c. Increased equitable access to health care services d. Improved patient relationships with primary care physicians e. Reduced unnecessary ED visits/hospitalizations f. Increased vaccination rates g. Decreased outbreaks of vaccine-preventable diseases h. Reduced health inequities
3.B Direct provision of care to vulnerable patients	i. Continue to provide uncompensated Medi-Cal care to Medi-Cal patients ii. Continue to provide charity care to low-income patients	a. Increased number of children and expectant mothers served b. Increased equitable access to health care services c. Reduced health inequities
3.C Ensure future supply of diverse health care providers	i. Provide training to diverse health care professionals[77] ii. Support efforts to increase diversity of health care workforce[53,54,78,79,80,81]	a. Increased number of qualified, diverse providers in the community focused on community-based practices b. Standard of care raised c. Increased equitable access to health care services
3.D Address systemic/ institutional barriers to access	i. Advocate for health care policy change at the local, state, and federal levels that improves health care access for vulnerable children and families	a. System-wide health care improvements for children and families b. Increased equitable access to health care services c. Reduced health inequities

Health Need 4: Maternal and Infant Health

Long-Term Goal: Improve the health of infants and new mothers.

Statistics show that health disparities exist among mothers and infants. While greater proportions of women receive first-trimester prenatal care in both counties than their counterparts statewide, inequities are apparent: In Santa Clara County, lower percentages of Latinx, Black, and Native American women receive first-trimester prenatal care than their peers. Inadequate or late prenatal care increases certain risks to mother and child, including low birth weight, maternal smoking, and lack of breastfeeding. Teen births in both counties have been decreasing in recent years. However, Latinx teens in both counties are still more likely than their peers to become mothers. The impact of teen pregnancy is felt at both the individual and societal levels. Women who become teenaged mothers tend to have lower educational attainment and income than their peers, and their children are at higher risk for a variety of problems. Additionally, pregnant mothers who are low-income, and children in low-income families, are more likely to experience poor health outcomes than mothers and children in higher-income families. Low birth weight births, an indicator of concern, are rising in Santa Clara County. Greater proportions of Native American babies in Santa Clara County, as well as Black and Asian babies in both counties, are born at low birth weight compared to all babies statewide.

Health experts expressed concern about various issues and vulnerable groups in our community, including access to care for low-income pregnant women and new mothers. A maternal and child health expert indicated that these inequities in care may also be traced back not only to health care access and delivery barriers but also to social determinants of health such as racism.

Goal	Strategies	Anticipated Impact
4.A Reduce the rates of teen births and disparities in teen birth rates, and improve the lives of teen mothers and their children	i. Expand access to teen pregnancy prevention programs among populations with historically high rates of teen pregnancy[82, 83, 84] ii. Expand access to depression screening programs for pregnant and new teen mothers, individual- or group-based parenting programs, home visits, and nurse/family partnerships[85,86,87,88,89]	a. Lower rate of teen births b. Reduce disparities in teen birth rates c. Improved mental health of pregnant teens and teen parents
4.B Increase levels of adequate prenatal care	i. Expand access to enhanced prenatal care programs among Black women and other populations with historical disparities in birth outcomes[90] ii. Expand access to group prenatal care among Black women and other populations with historical disparities in birth outcomes[91,92,93] iii. Expand community access to prenatal health education[94]	Among Black women and women from other populations with historical disparities in birth outcomes: a. Increased number of pregnant women who benefit from home visits b. Improved access to prenatal health education c. Higher enrollment in group prenatal care programs d. Improved access to prenatal care e. More favorable birth outcomes (fewer incidences of low or very low birthweight, preterm or very preterm birth, and infant mortality)
4.C Reduce disparities in birth outcomes	i. Expand access to enhanced prenatal care programs among Black women and other populations with historical disparities in birth outcomes[90] ii. Expand access to group prenatal care among Black women and other populations with historical disparities in birth outcomes[91,92,93] iii. Expand community access to prenatal health education[94]	a. Greater equity in birth outcomes
4.D Reduce risks of injury to infants	i. Support public campaigns, advocacy, education, and/or programs aimed at reducing unintentional injuries (e.g., SIDS, vehicular accidents, falls), including infant CPR[82,83,84,95,96,97,98,99] ii. Support public campaigns, advocacy, education, and/or programs aimed at reducing child abuse and neglect, including home visits[100,101]	a. Increased awareness of infant safety b. Reduced number of infant injuries c. Reduced number of infant deaths due to unintentional injuries, abuse, or neglect

VIII. Evaluation Plans

Packard Children's will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, Packard Children's will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

IX. Health Needs that Lucile Packard Children's Hospital Stanford Does Not Plan to Address

As described in Section VI(A) of this report, Packard Children's will address the four health needs that met all of the prioritization/selection criteria. Packard Children's will not address the following identified health needs:

Not chosen because the need was not strongly prioritized by the community:

- Asthma
- Climate/Natural Environment
- Cancer
- Community Safety
- Diabetes and Obesity
- Unintended Injuries
- Sexually Transmitted Infections

Despite the fact that Packard Children's will not address these needs through its IS efforts, the hospital does address some (e.g., unintended injuries, sexually transmitted infections) through its standard work and dedicated programs/services.

Appendix A: Implementation Strategy Report IRS Checklist

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

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

Appendix B: Health Needs Profiles

Health needs profiles summarize key statistical and qualitative data related to each need. The following pages contain profiles for the health needs that Packard Children's plans to address:

1. **Social/Emotional Health**
2. **Economic Stability**
3. **Access to Care**
4. **Maternal and Infant Health**

Appendix C: Endnotes

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Lucile Packard
Children's Hospital
Stanford