



2022

Community Health Needs Assessment



Acknowledgments

The 2022 Community Health Needs Assessment report was prepared by the research firm Actionable Insights, LLC.

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Table of Contents

ACKNOWLEDGMENTS	2
1. EXECUTIVE SUMMARY	6
Community Health Needs Assessment Background	6
Process and Methods	6
Prioritized 2022 Community Health Needs	7
Next Steps	7
2. INTRODUCTION AND BACKGROUND	8
Purpose of the Community Health Needs Assessment	8
ACA Requirements	8
SB 697 and California’s History of Assessments	9
Brief Summary of the Prior CHNA Conducted	9
Written Public Comments to the 2019 CHNA	9
3. ABOUT LUCILE PACKARD CHILDREN’S HOSPITAL STANFORD	10
Community Health Initiatives	10
Community Served	10
Correlation Between Income Inequality and Nonwhite Population, by ZIP Code	13
4. ASSESSMENT TEAM	14
Hospitals and Other Partner Organizations	14
Identity and Qualifications of Consultants	14
5. PROCESS AND METHODS	16
Secondary Data Collection	16
Primary Data Collection (Community Input)	16
Key Informant Interviews	17
Focus Groups	18
CHNA Participant Demographics	19
Information Gaps and Limitations	20
Data Synthesis: Identification of Community Health Needs	21
Prioritization of Health Needs	23
COVID-19	23
Health Disparities and Inequities	25

6. PRIORITIZED 2022 COMMUNITY HEALTH NEEDS	26
Economic Stability	26
Correlation Between Free- and Reduced-Price Lunch Enrollment and Nonwhite Population, by Zip Code	27
Housing and Homelessness	28
Correlation Between Severe Housing Cost Burden and Nonwhite Population, by ZIP Code	29
Health Care Access and Delivery	29
Correlation Between Medicaid/Public Insurance Enrollment and Nonwhite Population, by ZIP Code	31
Behavioral Health	31
Self-Harm Injury Hospitalizations per 100,000 Children Ages 0–17	32
Diabetes and Obesity	33
Fifth-, Seventh-, and Ninth-Grade Students Meeting All Fitness Standards	33
Asthma	34
Asthma ED Visits per 10,000 Children Ages 0–17, by Race/Ethnicity	34
Maternal and Infant Health	35
Low Birth Weight by Race/Ethnicity	35
Climate/Natural Environment	36
Correlation Between Air Pollution and Nonwhite Population, by Zip Code	36
Cancer	37
Selected Cancer Incidence Rates per 100,000 People	37
Community Safety	38
Selected Seventh- and Ninth-Grade Student Safety Statistics	38
Unintended Injuries/Accidents	40
Selected Emergency Department Visit Rates for Accidents Among Children Ages 0–12, by Race/Ethnicity	40
Sexually Transmitted Infections	41
Trends of New Chlamydia Cases per 100,000 Youth Ages 10–19	41
7. EVALUATION FINDINGS FROM 2020–2022 IMPLEMENTED STRATEGIES	42
2019 Prioritized Health Needs	42
Implementation Strategies for Fiscal Years 2020 and 2021	42
Community Benefit Investments in Fiscal Years 2020 and 2021	42
8. CONCLUSION	52
9. LIST OF ATTACHMENTS	52



1. Executive Summary

Community Health Needs Assessment Background

The Community Health Needs Assessment (CHNA) is designed as a tool for guiding policy, advocacy, and program-planning efforts. For hospitals, it also supports the development of community benefit plans mandated by California State Senate Bill 697, and it meets the IRS requirements for Community Health Needs Assessment and Implementation Strategies mandated by the 2010 Affordable Care Act. The CHNA report is available to the public for review and comment.

To identify and address the critical health needs of the community, coalitions formed in San Mateo and Santa Clara counties in 1995. The Healthy Community Collaborative of San Mateo County (HCC) and the Santa Clara County Community Benefit Hospital Coalition (CBHC) brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, Lucile Packard Children’s Hospital Stanford collaborated with these two groups to conduct an extensive CHNA.

In 2019, two nonprofit hospital members of the CBHC were sold to Santa Clara County,¹ and in 2020, a nonprofit health care system member of the HCC was acquired by a for-profit company.² Therefore, beginning in 2021, four of the remaining nonprofit hospitals/health care systems across San Mateo and Santa Clara counties,³ with additional support from the Palo Alto Medical Foundation (a nonprofit multispecialty group), formed an informal collaborative to conduct a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA builds upon the

earlier assessments conducted by these entities, distills new qualitative and quantitative research, prioritizes local health needs, and identifies areas for improvement. Using this information, the members of this informal collaborative will develop strategies to address critical health needs and to improve the health and well-being of community members. As with prior CHNAs, this assessment also lists San Mateo and Santa Clara counties’ assets and resources related to identified health needs.

Process and Methods

The members of the informal CHNA collaborative started planning the 2022 Community Health Needs Assessment in January 2021 and began collecting data in spring 2021. In both counties, the research firm Actionable Insights (AI) obtained community input through interviews with local experts and focus groups with community residents and people who serve residents. AI culled secondary data from various sources, including the public Community Health Data Platform sponsored by Kaiser Permanente and the two county public health departments. (*See Attachment 1: Secondary Data Indicators for a complete list.*)

For the purposes of this assessment, the definition of “community health” goes beyond traditional measures to include indicators about not only the physical health of the county’s 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 Packard Children’s Hospital’s understanding that myriad factors impact community health. Our hospital is committed to supporting community health improvement through upstream (social determinants of health) and downstream (health condition) interventions.

AI identified health needs by (1) synthesizing primary qualitative research and secondary data and (2) filtering those needs against a set of criteria. Packard Children’s convened its Community Benefit Advisory Council (CBAC) on February 16, 2022. AI described the CHNA process and findings, and the CBAC rated the needs via an online survey.

1 County of Santa Clara, Office of Communications and Public Affairs. (2019). Acquisition Information. Retrieved from <https://news.sccgov.org/office-public-affairs/hospital-acquisition-update/acquisition-information>.

2 Woo, E. (2020). “AHMC Healthcare finalizes purchase of Seton Medical Center.” San Jose Mercury News. Retrieved from <https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/>.

3 The four entities are El Camino Hospital, Lucile Packard Children’s Hospital Stanford, Stanford Health Care, and Sutter Health.

The Packard Children’s CBAC used these criteria to determine the priority order:

- **Community priority.** We used the data from the qualitative research to ascertain the top priorities of the community, such as the high frequency with which the community prioritized the issue over others it expressed concern about during the CHNA primary data collection process.
- **Disparities/inequities exist.** We used quantitative data to identify differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Lacking sufficient community assets and/or resources.** Packard Children’s seeks to impact the well-being of the community at large beyond the traditional health services provided by our hospital. Additionally, the IRS requires that hospitals take into consideration whether existing assets/resources are available to address the issue. So, we used the list of assets and resources to consider to what extent community supports were lacking in health and wellness services or programs.
- **Broad perspective.** The Packard Children’s Community Partnerships department convened its Community Benefit Advisory Committee to present the preliminary CHNA findings and solicit feedback, which was factored into the prioritization of the health needs list. We also used the knowledge gained from our participation on various boards of directors and health-focused coalitions, which include stakeholders from diverse sectors.

Prioritized 2022 Community Health Needs

Based on the criteria described above, Packard Children’s prioritized 12 health needs, listed below in priority order. *(For summarized descriptions of each one, see Section 6: Prioritized 2022 Community Health Needs.)*

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/Accidents**
12. **Sexually Transmitted Infections**

Next Steps

After making the 2022 CHNA report publicly available on our website by Aug. 31, 2022, Packard Children’s will solicit feedback and comments about the report until two subsequent CHNA reports have been published. We will also develop an implementation plan based on the CHNA results, which will be filed with the IRS by Jan. 15, 2023. Each year, Packard Children’s describes the strategies we are implementing in our annual Community Benefits Report, which is also published online.

2. Introduction and Background

Purpose of the Community Health Needs Assessment

Lucile Packard Children’s Hospital Stanford is pleased to have conducted the 2022 Community Health Needs Assessment (CHNA).

To identify and address the critical health needs of the community, coalitions formed in San Mateo and Santa Clara counties in 1995. The Healthy Community Collaborative of San Mateo County (HCC) and the Santa Clara County Community Benefit Hospital Coalition (CBHC) brought together representatives of nonprofit hospitals, public health departments, and other local organizations. Every three years between 1995 and 2019, Lucile Packard Children’s Hospital Stanford collaborated with these two groups to conduct an extensive community health needs assessment.

In 2019, two nonprofit hospital members of the CBHC were sold to Santa Clara County,⁴ and in 2020, a nonprofit health care system member of the HCC was acquired by a for-profit company.⁵ Therefore, beginning in 2021, four nonprofit hospitals/health care systems across San Mateo and Santa Clara counties,⁶ with additional support from the Palo Alto Medical Foundation (a nonprofit multispecialty group), formed an informal collaborative to conduct an extensive, dual-county, triennial Community Health Needs Assessment (CHNA) in compliance with current state and federal requirements (see details below). Although not required, the benefits of collaborating on the CHNA

are multifold, including the leveraging of various sets of knowledge, shared understanding of health needs in our service area, and reduced burden on the community for participation in the assessment.

The 2022 CHNA builds upon earlier assessments, distills new qualitative and quantitative research, prioritizes current local health needs, and identifies areas for improvement. With these data, the informal collaborative members will develop strategies to tackle critical health needs as well as improve the health and well-being of community members. The assessment findings may also be used as a guideline for policy and advocacy efforts. As with prior CHNAs, the 2022 assessment also lists assets and resources available to address the identified health needs in San Mateo and Santa Clara counties.

The 2022 CHNA will serve as the basis for implementation strategies that are required to be filed with the IRS as part of Packard Children’s Hospital’s 2022 Form 990, Schedule H, four and a half months into the next taxable year.

ACA Requirements

Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a community health needs assessment every three years. The CHNA report must document how the assessment was done, a description of the community served, who was involved in the assessment, the process and methods used to conduct the assessment, and the community’s health needs that were identified and prioritized as a result of the assessment. Final requirements were published in December 2014.

The definition of a community health need includes the social determinants of health in addition to morbidity and mortality. For the purposes of this assessment, the informal collaborative members went beyond traditional measures to define

4 County of Santa Clara, Office of Communications and Public Affairs. (2019). Acquisition Information. Retrieved from <https://news.sccgov.org/office-public-affairs/hospital-acquisition-update/acquisition-information>.

5 Woo, E. (2020). “AHMC Healthcare finalizes purchase of Seton Medical Center.” San Jose Mercury News. Retrieved from <https://www.mercurynews.com/2020/08/14/ahmc-healthcare-finalizes-purchase-of-seton-medical-center/>.

6 The four entities are El Camino Hospital, Lucile Packard Children’s Hospital Stanford, Stanford Health Care, and Sutter Health.

“community health” by including indicators about the physical health of the county’s residents, as well as 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 Packard Children’s Hospital’s understanding that myriad factors impact community health. We are committed to supporting community health improvement through upstream (social determinants of health) and downstream (health condition) intervention.

In addition to providing a national set of standards and definitions related to community health needs, the ACA has had an impact on upstream factors. For example, the ACA created more incentives for health care providers to focus on prevention of disease by including lower or no copayments for preventive screenings. The ACA also established new funding to support community-based primary and secondary prevention efforts. At Packard Children’s, we believe these improvements to the health care system are vital and necessary to continue improving the way hospitals deliver health care.

SB 697 and California’s History of Assessments

California Legislative Senate Bill 697, enacted in 1994, stipulates that private nonprofit hospitals submit an annual report to the Office of Statewide Health Planning and Development (OSHPD) that includes, but is not limited to, a description of the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Additionally, hospitals must describe the process by which they involved community groups and local government officials in helping identify and prioritize community needs to be addressed. This community needs assessment must be updated at least once every three years. The community benefit report required for OSHPD also describes the strategies that are implemented to address health needs identified in the CHNA and the Implementation Strategy Report.

The 2022 CHNA meets both State of California (SB 697) and federal (IRS) requirements mandated by the ACA.

Brief Summary of the Prior CHNA Conducted

In 2019 (the third cycle of ACA-required CHNA assessments), Packard Children’s participated in a collaborative process to identify significant community health needs and to meet the IRS and SB 697 requirements. The resulting 2019 CHNA report is posted on the Packard Children’s website.⁷

The 12 health needs that were identified and prioritized through the 2019 CHNA process were (in prioritized order, highest to lowest): Health Care Access and Delivery, Behavioral Health, Diabetes and Obesity, Unintentional Injuries, Economic Stability, Housing and Homelessness, Transportation, Oral/Dental Health, Cancer, Communicable Diseases, Asthma, and Natural Environment.

Written Public Comments to the 2019 CHNA

To offer the public a means to provide written input on the CHNA reports, Packard Children’s maintains a Contact Us form on our website.⁸

At the time the 2022 CHNA report was completed, Packard Children’s had not received written comments about the 2019 CHNA report.⁹ We will continue to accept submissions and make sure that all relevant feedback is reviewed and addressed by appropriate hospital staff.

⁷ <https://forms.stanfordchildrens.org/contact-us/contactus.jsp>

⁸ <https://www.stanfordchildrens.org/en/about/community-benefits>

⁹ <https://www.stanfordchildrens.org/en/about/government-community/benefits-reports>

3. 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 eight 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 our community. Providing exceptional services, programs, and funding far beyond our hospital walls has been part of the vision and mission of Packard Children's since day one. As part of that original commitment, we provide direct health care services to some of our community's most vulnerable members, and we partner with government and local community-based organizations to fund programs that improve the health of our community.

Packard Children's Hospital adopted four Community Health Initiatives for 2020–2022:

1. Supporting children, adolescents, and young adults in experiencing good social and emotional health (mental health) and being able to cope with life's stressors.
2. Reducing obesity and overweight among children and adolescents.
3. Increasing the number of infants, children, adolescents, and young adults who have access to needed health care services.
4. Improving the health of infants and new mothers, with a particular focus on reducing 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.

Community Served

Because of our 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. Within our primary service area, which encompasses the 13-county Northern California region, Packard Children's ranks first for pediatrics, with 10.1% market share, and third for obstetrics, with 4.4 percent market share (2020 OSHPD).

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

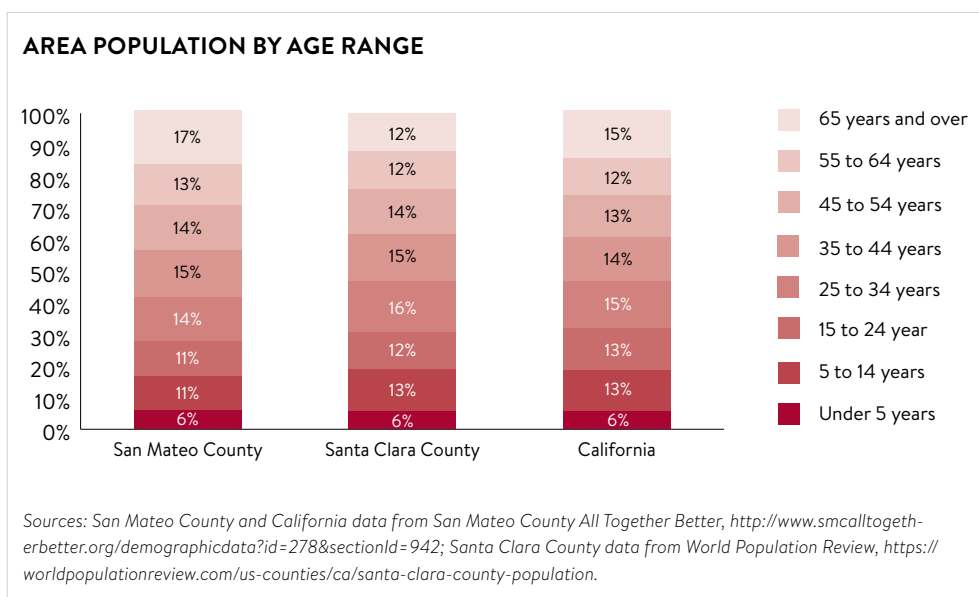
Hospital Primary Service Area



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 denser than the state, with 9,206 people per square mile compared with 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 denser than the state, with 9,115 people per square mile compared with 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.¹⁰

In both counties, residents ages 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



Race/Ethnicity in Hospital Service Area

RACE/ETHNICITY	SAN MATEO COUNTY Total Percentage of County (Alone or in Combination With Other Races)*	SANTA CLARA COUNTY Total Percentage of County (Alone or in Combination With Other Races)*
White	37.8	29.9
Asian	30.1	38.5
Hispanic/Latinx	24.2	25.1
Black	2.2	2.3
Native Hawaiian/ Pacific Islander	1.3	0.3
American Indian/ Alaskan Native	0.1	0.2
Multiracial	4.0	3.4
Some Other Race	0.4	0.2

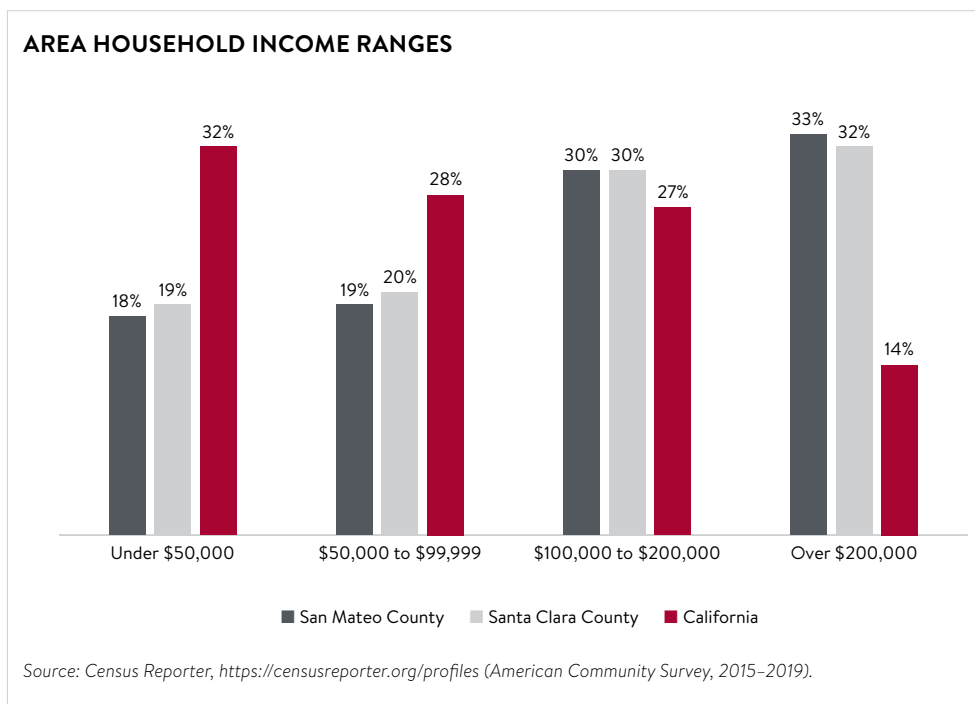
*Percentages do not add up to 100% because they overlap.
Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2015–2019

women ages 15–50 who have given birth in the last 12 months is 5% in both counties and in California.¹¹

The ethnic makeup of both counties is extremely diverse. In total, the nonwhite population of San Mateo County represents about 62% of its total population, while 70% of Santa Clara County’s total population is nonwhite.

10 Census data in prior paragraphs from <https://www.census.gov/quickfacts>.

11 Births data from <https://www.towncharts.com/California/Demographics/Santa-Clara-County-CA-Demographics-data.html>



with two children 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 million¹⁶ and the median rent was \$2,451 in San Mateo County; this compares to \$1.4 million¹⁷ and \$2,374 in Santa Clara County. In both counties, 26% of the 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.

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%).¹²

Our communities earn some of the highest annual median incomes in the United States, 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 \$82,053.¹³

Yet the California Self-Sufficiency Standard,¹⁴ 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.¹⁵ (The Standard in 2021 for a family

The minimum wage in San Mateo County¹⁸ was \$14–\$15.90 per hour in 2021, and in Santa Clara County¹⁹ it 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 Jose–Sunnyvale–Santa Clara metropolitan area between 2018 and 2020.

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education,

12 Data from <https://www.census.gov/quickfacts>

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

14 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.

15 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. <https://selfsufficiencystandard.org/calculator/>

16 Redfin. (2021). *San Mateo County Housing Market*. Retrieved from <https://www.redfin.com/county/343/CA/San-Mateo-County/housing-market>

17 Redfin. (2021). *Santa Clara County Housing Market*. Retrieved from <https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market>

18 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.

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

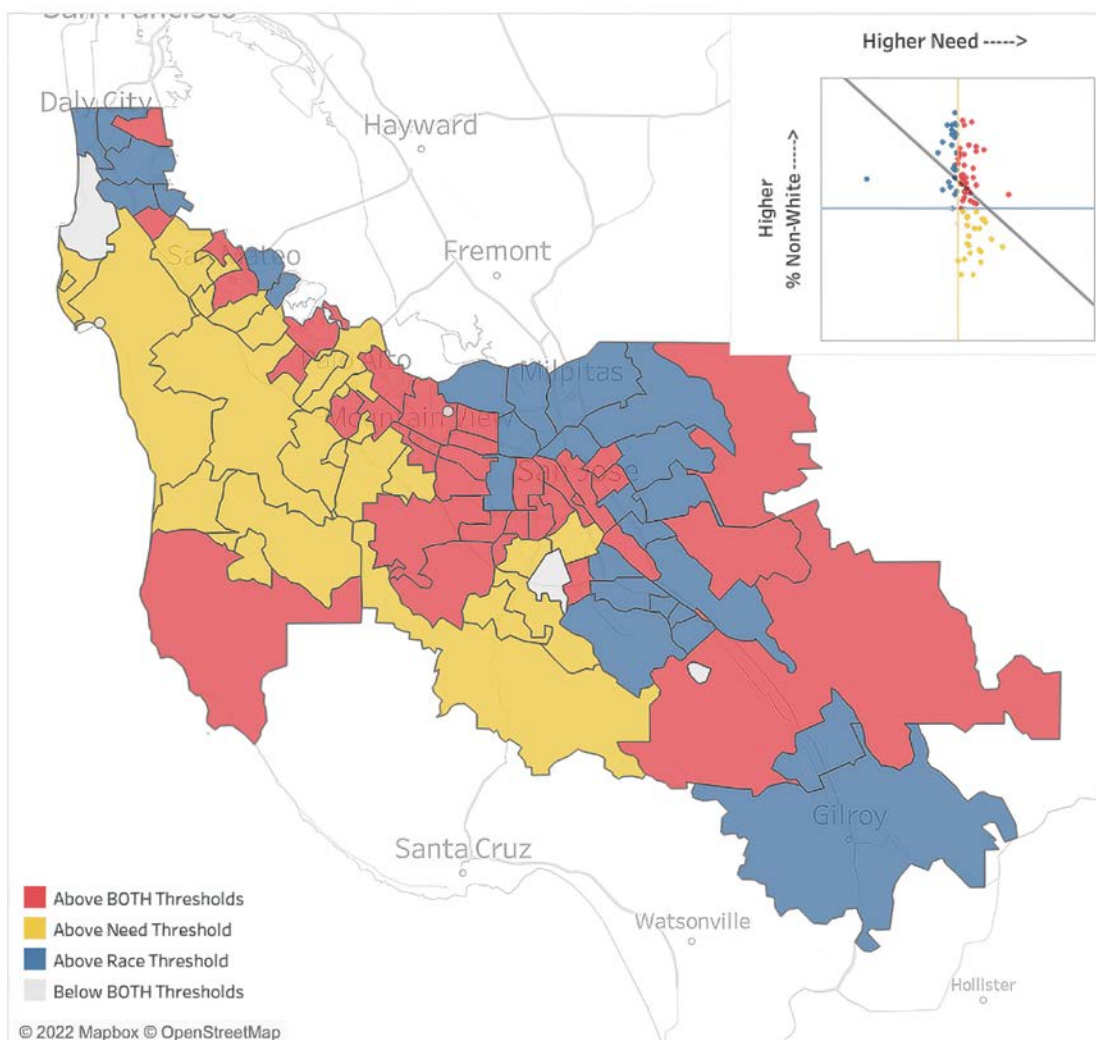
employment, and housing conditions, both counties’ populations overall are healthier than the national average.²⁰ Although San Mateo and Santa Clara counties are quite diverse and have substantial resources (see Attachments 5 and 6: *Community Assets and Resources*), there is significant inequality in their populations’ social determinants of health and health outcomes. For example, the Gini index, a

measure of income inequality,²¹ is higher in certain zip codes compared with others (see map below).

Certain areas also have poorer access to high-speed internet (e.g., zip codes 95013, 94074) or to walkable neighborhoods (e.g., zip codes 95002, 94060) or to 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 with California or the nation as a whole.

20 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. and O’Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041–62. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/>.

21 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. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from <https://stats.oecd.org/glossary/detail.asp?ID=4842>.



Correlation Between Income Inequality and Nonwhite Population, by ZIP Code

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

4. Assessment Team

Hospitals and Other Partner Organizations

Lucile Packard Children's Hospital Stanford collaborated with the following health systems and organizations to prepare the 2022 CHNA:

- El Camino Health
- Stanford Health Care
- Sutter Health (including Mills-Peninsula Medical Center, Menlo Park Surgical Hospital, and Palo Alto Medical Foundation)

Identity and Qualifications of Consultants

Actionable Insights, LLC, an independent local research firm, completed the CHNA. For this assessment, AI assisted with CHNA planning, conducted primary research, collected secondary data, synthesized primary and secondary data, facilitated the processes of identifying community health needs and assets, assisted with determining the prioritization of community health needs, and documented the processes and findings into a report.

The project managers for this assessment were Melanie Espino and Jennifer van Stelle, PhD, the co-founders and principals of Actionable Insights. Actionable Insights helps organizations discover and act on data-driven insights. The firm specializes in research and evaluation in the areas of health, housing, STEM (science, technology, engineering, and math) education, youth development, and community collaboration. AI conducted community health needs assessments for seven hospitals during the 2021–2022 CHNA cycle.

In addition, Packard Children's has partnered with Actionable Insights to provide strategic planning support to ensure that its community benefit investments are addressing identified community health needs. This has become especially important in the most recent CHNA cycles, as the community focuses more on health care access and social determinants of health. They have also worked with our grantees to improve the rigor of reporting for purposes of including information about the impact of those grants in this CHNA.

More information about Actionable Insights is available on the company's website.²²

²² <https://www.actionablellc.com>



5. Process and Methods

The hospitals and health systems listed in Section 4 formed an informal collaborative to work on the primary and secondary data requirements of the CHNA. The members of this collaborative contracted Actionable Insights (AI) to collect primary qualitative data—through key informant interviews and focus groups—and secondary qualitative and statistical data. Together, AI and the members of the informal collaborative (“the study team”) conducted the assessment. The CHNA data collection process took place over 10 months in 2021 and culminated in this report, written in late 2021 and early 2022. The phases of the CHNA process are depicted below and described in this section.



Secondary Data Collection

Data sources were selected to understand general county-level health, to examine specific underserved and/or underrepresented populations, and to fill previously identified information gaps. Data was also sought out about children, youth, and pregnant mothers, Packard Children’s Hospital’s target populations. For this reason, particular attention was paid to disaggregated data by age whenever available. Also, data on potential health disparities by subcounty geographic area and ethnicity were analyzed. These data were used to inform our health needs lists.

The teams collected and analyzed over 250 quantitative health indicators from existing sources using the public Community Health Data Platform sponsored by Kaiser Permanente and other online sources, such as KidsData.org, the California Department of Public Health, and the U.S. Census Bureau, as well as the two county public health departments. Findings from the previous community health needs assessment (2019), reports from Joint Venture Silicon Valley, and available subcounty data (cities and neighborhoods) were also used whenever available to increase understanding of the health

needs in San Mateo and Santa Clara counties and to assess priorities in the community.

For the CHNA, local data were compared with state benchmarks (California averages and rates) to help determine the severity of a health problem and to identify disparities. The following questions were asked:

- How do these indicators perform against accepted benchmarks?
- What are the inequitable outcomes and conditions for people in our community?

Primary Data Collection (Community Input)

The study team designed three strategies for collecting community input: key informant interviews with health experts and community service experts, focus groups with professionals who represented and/or served the community or residents, and a dual-county focus group with community members. Individuals representing high-need populations (low-income, minority, medically underserved) were included.²³

23 The IRS requires that community input include the low-income, minority, and medically underserved populations.

To ensure consistency across every interview and focus group, the study team generated research protocols. The study team sought to build upon prior CHNAs by focusing the primary research on topics and subpopulations that are less well understood by the statistical data. For example, the experiences of the Black population in San Mateo and Santa Clara counties are often obscured by statistics that represent an entire county's population rather than the Black population as a particular subgroup. The 2022 study team specifically convened a focus group of Black professionals to better understand through this primary qualitative research.

Actionable Insights conducted the key informant interviews and focus groups for this assessment. AI recorded each interview and focus group. Recordings were transcribed and qualitative research software tools were used to analyze the transcripts for common themes. AI also tabulated how many times health needs were prioritized by each of the focus groups or described as a priority in a key informant interview. The study team used this tabulation to help assess community health priorities.

In all, the study team solicited input from nearly 100 community members, community leaders, and representatives of various organizations and sectors. These representatives work either in the health field or in a community-based organization that focuses on improving health and quality-of-life conditions by serving those from high-need populations.

KEY INFORMANT INTERVIEWS

In March and April 2021, Actionable Insights spoke with 15 experts from various organizations in San Mateo and Santa Clara counties. Interviews were conducted virtually via Zoom for approximately one hour. Prior to each interview, participants were asked to complete a short online survey, in which they were asked to identify the health needs they felt were the most pressing among the people they served. Interviewees could choose up to three needs from the list of needs presented to them, which had been identified in one or both counties in 2019, or could write in needs that were not on the combined

2019 list. Also in the survey, participants were advised of how their interview data would be used and were asked to consent to be recorded.²⁴ Finally, participants were offered the option of being listed in the report and were asked to provide some basic demographic information (also optional).

The discussions centered around four questions for each health need that was prioritized by interviewees:

1. How do you see this need playing out in the community?
2. Which populations are experiencing inequities with respect to this need?
3. How has this need changed in the past few years; how were things going prior to the pandemic, and how are they going now?
4. What is needed (including models/best practices) to better address this need?

AI sent a similar survey to focus group participants and asked focus groups the same questions during discussion (modified appropriately for each audience).²⁵ Focus group discussions centered on the needs that had received the most votes from prospective participants in the online pre-survey. (See Attachment 4: Qualitative Research Protocols for complete protocols and questions, including pre-surveys. See Attachment 3: Community Leaders, Representatives, and Members Consulted for a list of key informants and focus group or interview details.)

²⁴ Only individuals who consented to be recorded were interviewed.

²⁵ Only individuals who consented to be recorded were included in focus groups. To preserve their anonymity, community members who participated in the clinic patients focus group were not offered the option of being listed in the report.

FOCUS GROUPS

AI conducted eight focus groups in San Mateo and Santa Clara counties with a total of 76 professionals and four residents between April and June 2021.

Study group members and/or nonprofit hosts recruited participants for the groups. The questions were the same as those asked of key informants.

List of Focus Groups Conducted for CHNA 2022

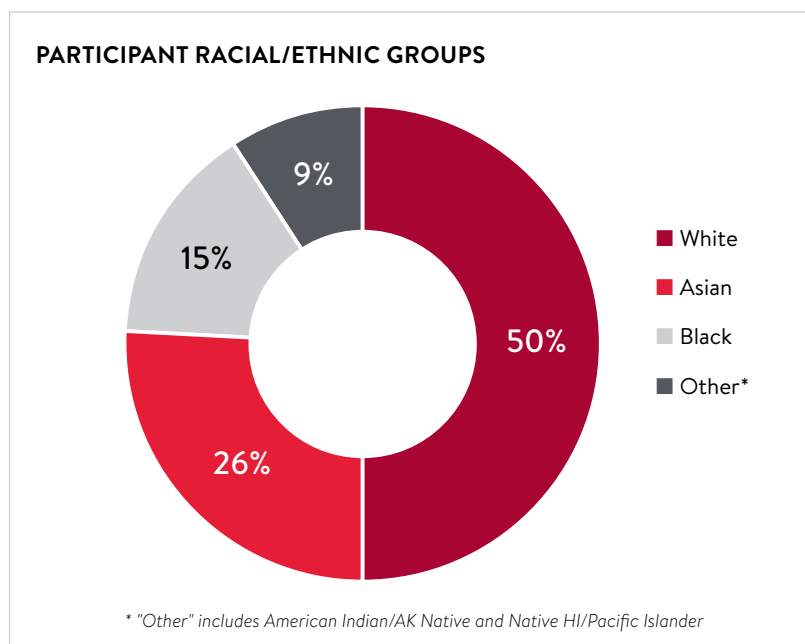
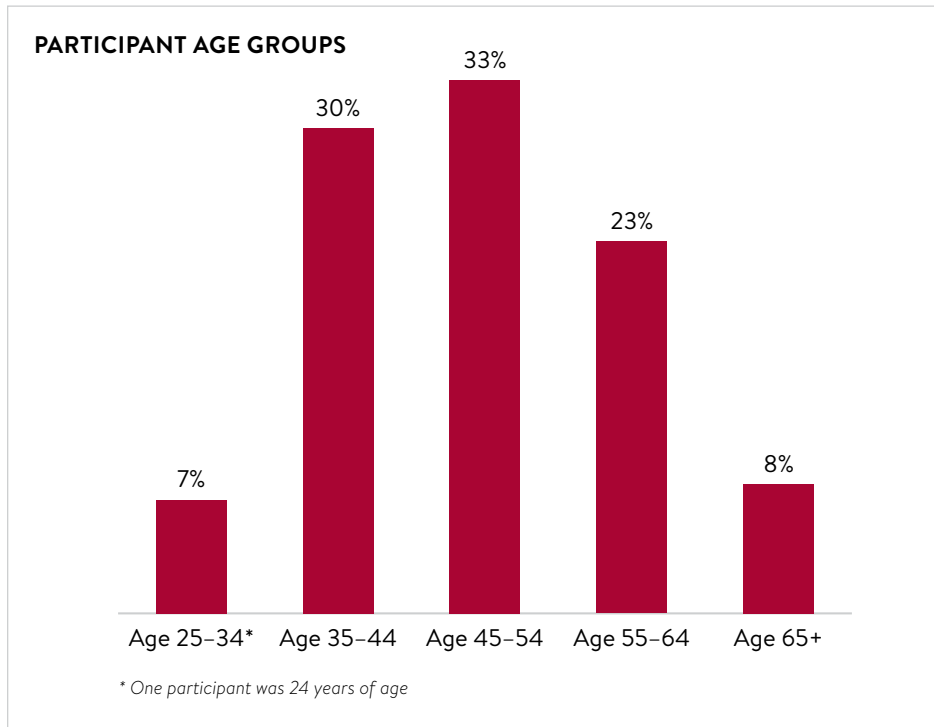
TOPIC	FOCUS GROUP HOST/PARTNER	DATE	NUMBER OF PARTICIPANTS
Adult mental/behavioral health	El Camino Health and Sutter Health	4/12/2021	13
Health equity	Stanford Health Care	4/14/2021	10
Santa Clara County social services	El Camino Health	4/19/2021	12
Safety net clinics and their patients	Stanford Health Care and Sutter Health	4/26/2021	12
Youth mental health	Lucile Packard Children's Hospital Stanford	4/29/2021	12
San Mateo County social services	Samaritan House	5/12/2021	10
Health of safety net clinic patients*	Gardner Health Services	6/7/2021	4
Black health	Bay Area Community Health Advisory Council (BACHAC)	6/14/2021	7

* Indicates resident/community member group

CHNA PARTICIPANT DEMOGRAPHICS

A total of 95 people participated in focus groups or interviews for the CHNA. More than three out of every five (62%) participated in dual-county research (i.e., represented both San Mateo and Santa Clara counties). The remainder represented either San Mateo County only (19%) or Santa Clara County only (another 19%).

The charts below show the age ranges of participants, as well as their race; note that individuals could choose more than one race (N=90). More than one in five (22%) of participants were of Hispanic/Latinx ethnicity (N=93). Two-thirds of participants (67%) identified as female, with almost all of the rest identifying as male (N=92). On average, participants were aged 48 (N=92).



INFORMATION GAPS AND LIMITATIONS

A lack of data limited our ability to fully assess some health issues that were identified as community needs during the 2022 CHNA process. Conducting the 2022 CHNA presented unique challenges for data collection:

- As was the case across the nation due to the COVID-19 pandemic, public health departments' epidemiologists lacked sufficient resources to conduct data analyses in the same way they had in years past. This affected our ability to assess data on infectious diseases, cancer, etc.
- Our CHNA, as it has since 2012, employed data from the publicly available Kaiser Permanente Community Health Needs Dashboard. As of 2021, the platform no longer provides data breakdowns by race/ethnicity and instead simply offers correlations between race and poor health outcomes (which are presented in this report).

In both cases, when current data were lacking, Actionable Insights relied on data from our previous CHNA.

- In years past, our CHNAs relied on the California Healthy Kids Survey (CHKS) for data about child and adolescent mental health and emotional well-being. However, Santa Clara County has not opted in to conduct the CHKS in recent years. Therefore, these data are lacking for Santa Clara County but not San Mateo County.
- Because of the pandemic, it was not safe to bring community members together in person. Moreover, while it was possible to conduct focus groups and interviews virtually (i.e., via Zoom), the most vulnerable community members often did not have access to the technology needed for a virtual meeting. Also, nonprofit partners advised that the community was severely stressed (financially and emotionally) by the pandemic and felt it was inappropriate to burden them with CHNA data collection requests. Although Actionable Insights was able to conduct one focus group with safety net

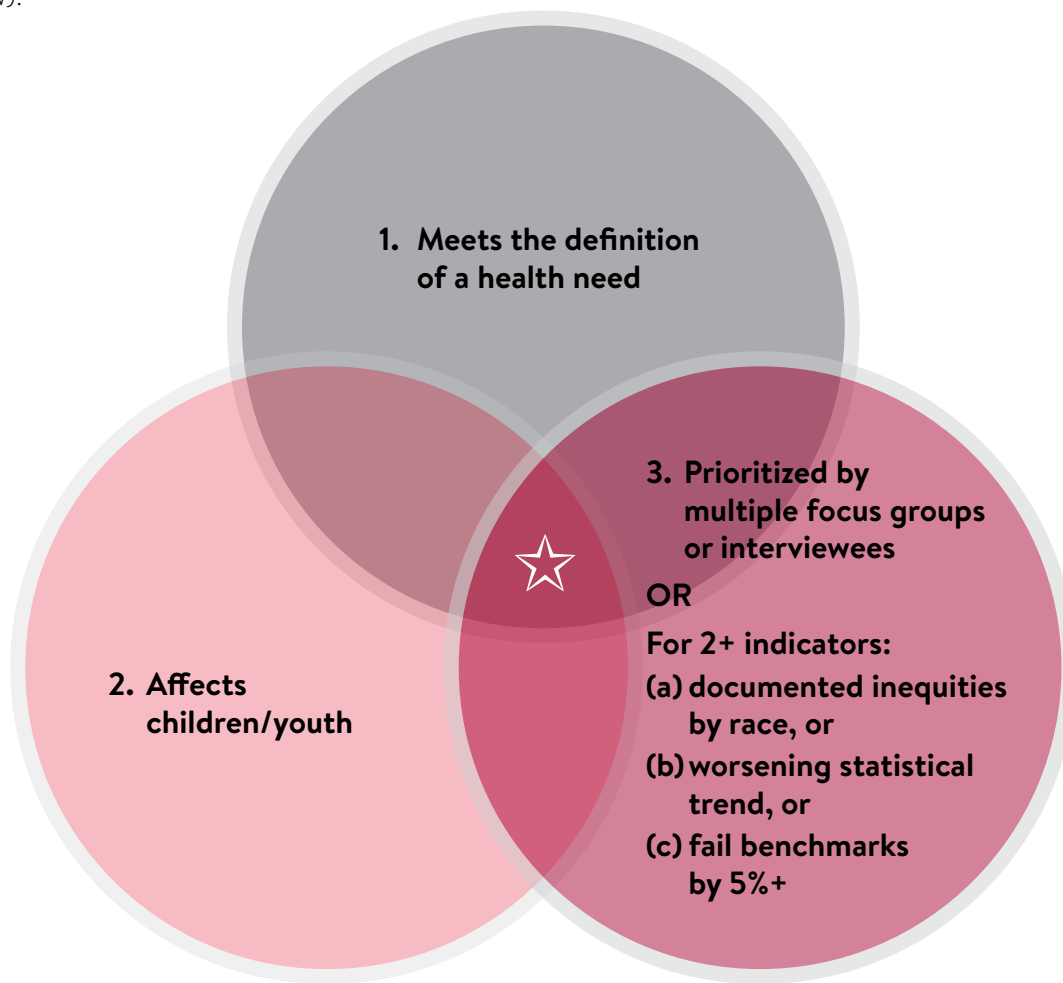
clinic patients, in order to best represent the perspectives and experiences of low-income, minority, and underserved community members during the pandemic, they spoke with a wide array of nonprofit staff who work with vulnerable populations. We acknowledge this as a limitation in our 2022 CHNA data.

Lastly, some indicators are difficult to measure or are just emerging. Statistical information related to these topics was scarce:

- Youth cigarette and e-cigarette use.
- Recent marijuana use and related behavioral health data.
- Domestic violence and related community safety data.
- Impact of social media on adolescent mental health.
- Cognitive decline data, including Alzheimer's disease prevalence rate and hospice admissions for dementia.
- Caregiver impact data (unpaid care, health effects).
- Oral health data.
- Data on experiences of discrimination.
- Data breakdowns by income/ socioeconomic status.
- Data on economic inequities within key zip codes.

Data Synthesis: Identification of Community Health Needs

In the analysis of quantitative and qualitative data, many health issues surfaced. To be identified as one of the community's prioritized health needs, an issue had to meet certain criteria (depicted in the diagram and detailed below).



To be identified as one of the community's prioritized health needs, an issue had to meet the following criteria:

1. Fits the definition of a "health need."
(See *Definitions box, next page.*)
2. Must affect children and/or youth.
3. Must be prioritized by multiple focus groups or key informants, or two or more direct indicators must:
 - exhibit documented inequities by race; or
 - show worsening trends; or
 - fail the benchmark by 5% or more.

Actionable Insights (AI) analyzed and synthesized the data for each issue and then applied those criteria to evaluate whether each issue qualified as a prioritized health need.

In 2022, this process led to the identification of 12 community health needs that fit all of the criteria. The list of needs, in priority order, appears on page 7.

See the health needs descriptions in Section 6: Prioritized 2022 Community Health Needs for further details about each of these health needs, and Attachment 2: Secondary Data Tables for detailed statistical data.



DEFINITIONS

Health indicator: A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

Health need: A poor health outcome and its associated risk(s), or a risk that may lead to a poor health outcome.

Health outcome: A snapshot of a disease/health event in a community that can be described in terms of both morbidity (illness or quality of life) and mortality (death).

Health risk: A behavioral, social, environmental, economic, or clinical care factor that impacts health. May be a social determinant of health.

Prioritization of Health Needs

Packard Children’s convened its Community Benefit Advisory Council (CBAC) on Feb. 16, 2022. AI described the CHNA process and findings, and the CBAC rated the needs via an online survey. The Packard Children’s CBAC used these criteria to determine the priority order:

- **Community priority.** We used the data from the qualitative research to ascertain the top priorities of the community, such as the high frequency with which the community prioritized the issue over others it expressed concern about during the CHNA primary data collection process. This criterion was rated by AI.
- **Disparities/inequities exist.** We used quantitative data to identify differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others. This criterion was rated by the CBAC.
- **Lacking sufficient community assets and/or resources.** Packard Children’s seeks to impact the well-being of the community at large beyond the traditional health services provided by our hospital. Additionally, the IRS requires that hospitals take into consideration whether existing assets/resources are available to address the issue. So, we used the list of assets and resources to consider to what extent community supports were lacking in health and wellness services or programs. This criterion was rated by AI.
- **Broad perspective.** The Packard Children’s Community Partnerships department convened its Community Benefit Advisory Committee to present the preliminary CHNA findings and solicit feedback, which was factored into the prioritization of the health needs list. We also used the knowledge gained from our participation on various boards of directors and health-focused coalitions, which include stakeholders from diverse sectors. This criterion was rated by the CBAC.

Based on the criteria described above, Packard Children’s prioritized 12 health needs, presented below in priority order (with 1 being the highest priority). (See Section 6: *Prioritized 2022 Community Health Needs for a summarized description of each.*)

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/Accidents
12. Sexually Transmitted Infections

COVID-19

In late 2019, a new coronavirus (SARS-CoV-2) appeared. It causes a respiratory illness that is now called COVID-19. The ensuing pandemic has been a health event of historic proportions. In absolute terms, the COVID-19 pandemic has surpassed the 1918 influenza (H1N1) pandemic, which killed 550,000 Americans (0.5% of the U.S. population at that time).²⁶

The COVID-19 pandemic shows signs of continuing for the foreseeable future. In San Mateo and Santa Clara counties, the numbers of COVID-19 cases and deaths peaked several times in 2020, 2021, and 2022. However, vaccinations—which began in early 2021—appear to be mitigating local hospitalizations and deaths. Below are the latest COVID-19 statistics for San Mateo and Santa Clara counties, as of mid-March 2022:

26 Noymer, A., and Garenne, M. (2000). The 1918 influenza epidemic’s effects on sex differentials in mortality in the United States. *Population and Development Review*, 26(3):565–81. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740912/>. And Centers for Disease Control and Prevention. (2019). 1918 Pandemic (H1N1 virus). Retrieved from <https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html>

San Mateo County^{27,28}

- Cases:
 - Cumulative total cases:²⁷ 119,845
 - Seven-day average number of daily cases:²⁸ 95
 - Seven-day average rate of daily cases:²⁸ 12 per 100,000 people
 - Seven-day average number of people hospitalized daily:²⁸ 118
- Infection and tests:
 - Rate of infection since January 2020:²⁸ 1 in 6 people
 - Current rate of spread (R-eff²⁹): 0.84 versus 0.81 statewide³⁰
 - 14-day average test positivity rate:²⁸ 2%
- Deaths:
 - Rate of deaths since January 2020:²⁸ 1 in 1,042 people
 - Cumulative total deaths:²⁷ 736
 - Seven-day average number of daily deaths:²⁸ 2
 - Seven-day average rate of daily deaths:²⁸ 0.22 per 100,000 people
- Vaccinations:²⁸
 - Fully vaccinated (all ages): 83%
 - Fully vaccinated (ages 5+): 88%
 - Fully vaccinated (ages 65+): 93%

Santa Clara County^{28,31}

- Cases:
 - Cumulative total cases:³¹ 306,473
 - Seven-day average number of daily cases:²⁸ 184
 - Seven-day average rate of daily cases:²⁸ 10 per 100,000 people
 - Seven-day average number of people hospitalized daily:²⁸ 193
- Infection and tests:
 - Rate of infection since January 2020:²⁸ 1 in 6 people
 - Current rate of spread (R-eff²⁹): 0.82 versus 0.81 statewide³⁰
 - 14-day average test positivity rate:²⁸ 2%
- Deaths:
 - Rate of deaths since January 2020:²⁸ 1 in 866 people
 - Cumulative total deaths:³¹ 2,158
 - Seven-day average number of daily deaths:²⁸ 3
 - Seven-day average rate of daily deaths:²⁸ 0.18 per 100,000 people
- Vaccinations:²⁸
 - Fully vaccinated (all ages): 86%
 - Fully vaccinated (ages 5+): 91%
 - Fully vaccinated (ages 65+): 95%

Because COVID is a new virus, many health effects and health care needs are still emerging. This CHNA report summarizes what the participating hospitals know so far about the health condition and its social determinants. To capture the effects of COVID on the community, the hospitals collaborating on the 2022 community health needs assessment conducted various focus groups and interviews, including a focus group dedicated to health equity.³² We also chose to add “documented ethnic and/or geographic disparities and inequities” to our criteria

27 San Mateo County Health. (2022). *County Data Dashboard*. Data retrieved from <https://www.smchealth.org/data-dashboard/county-data-dashboard>.

28 *New York Times*. (2022). California Coronavirus Tracker. *New York Times*. Data retrieved from <https://www.nytimes.com/interactive/2021/us/california-covid-cases.html>.

29 “R-eff is the average number of people an infected person will infect....Value less than 1 means decreasing spread. Value greater than 1 means increasing spread.” San Mateo County Health. (2022). *County Data Dashboard*.

30 CalCAT. (2022). *California COVID Assessment Tool*. Data retrieved from <https://calcat.covid19.ca.gov/cacovidmodels/>.

31 Santa Clara County Public Health. (2022). *COVID-19 Data and Reports*. County of Santa Clara Emergency Operations Center. Data retrieved from <https://covid19.sccgov.org/dashboards>.

32 CHNA participants, including those in the health equity focus group, are listed in Attachment 3: Community Leaders, Representatives, and Members Consulted.

for identifying community health needs in 2022. The hospitals will continue to monitor and address health effects, trends, and health care needs of COVID-19 as they learn more about the disease, its progression, and its short- and long-term impacts.

The pandemic has exacerbated existing inequities in the health and welfare of vulnerable populations in the U.S., causing disproportionate illness and mortality for people in minority racial and ethnic groups (i.e., Black, Indigenous, and people of color: BIPOC), people with certain preexisting health conditions, people living in crowded conditions, and people who are classified as “essential workers” (at higher risk of workplace exposure).³³ Approximately one in 10 people who were infected experience “long COVID,” a set of lingering symptoms including “fatigue, body aches, shortness of breath, difficulty concentrating” that last a year or more.³⁴

Perhaps the most far-reaching impacts of COVID-19 are socioeconomic. The government mandates shutting down or limiting activities in major industries (tourism, hospitality, brick-and-mortar retail and services, etc.) exacerbated the inequities experienced by many of the vulnerable populations identified above. Women, BIPOC, young people (ages 16–24), and those with low income (usually defined as less than 80% of the area median income) or without college degrees have also been impacted by job loss, housing insecurity, food insecurity, and other difficulties, all of which are likely to persist. Women in particular left the workforce in large numbers in 2020 and 2021, when school closures created a need for child care, a responsibility much more likely to fall on their shoulders than men’s.

While the hospitals acknowledge the negative health effects of COVID-19 itself, this CHNA report focuses

on identifying the broader health inequities and socioeconomic consequences of COVID-19 in San Mateo and Santa Clara counties.

HEALTH DISPARITIES AND INEQUITIES

Inequitable health and economic outcomes can be attributed, in part, to structural and institutional racism.³⁵ BIPOC community members may cope with toxic stress due to their experiences of discrimination. The physical toll this can take on their bodies has no equivalent among white Americans. The inflammation from toxic stress contributes to greater comorbidities among the BIPOC population in the U.S. compared with whites.³⁶ BIPOC individuals are also more likely to work in higher-risk and/or low-wage jobs, in part due to employment discrimination,³⁷ and to live in crowded or substandard conditions and impoverished neighborhoods, in part due to historical redlining policies and present-day housing discrimination.³⁸ All of these issues contribute to poorer health outcomes for BIPOC community members than for white people for nearly all health conditions, including COVID-19 infection.

With regard to economic outcomes, people of color are more likely to have less formal schooling than whites, in part due to education discrimination³⁹

35 Garcia, M.A., Homan, P.A., Garcia, C., and Brown, T.H. (2020). The color of COVID-19: structural racism and the pandemic’s disproportionate impact on older racial and ethnic minorities. *The Journals of Gerontology: Series B*. Retrieved from <https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1735&context=sociologyfacpub>.

36 Adler, N.E., and Rehkopf, D.H. (2008). U.S. Disparities in Health: Descriptions, Causes and Mechanisms. *Annual Review of Public Health*, 29:235–52.

37 See meta-analysis: Neumark, D. (2018). Experimental research on labor market discrimination. *Journal of Economic Literature*, 56(3):799–866. Retrieved from https://www.nber.org/system/files/working_papers/w22022/w22022.pdf.

38 Acevedo-Garcia, D., Noelke, C., and McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org; Institute for Child, Youth and Family Policy; The Heller School for Social Policy and Management; Brandeis University; Waltham, MA. Retrieved from https://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2.pdf.

39 Adair, J.K. (2015). *The impact of discrimination on the early schooling experiences of children from immigrant families*. Washington, DC: Migration Policy Institute. Retrieved from <https://www.migrationpolicy.org/research/impact-discrimination-early-schooling-experiences-children-immigrant-families>.

33 Campbell, J. (2020). “What Are Essential Services and Jobs During the Coronavirus Crisis?” *Huffington Post*. Retrieved from: https://www.huffpost.com/entry/what-are-essential-services-jobs_l_5e74eaacc5b6f5b7c543370c.

34 Komaroff, A.L. (2021). *The tragedy of long COVID*. Weblog, Harvard Health Publishing, Harvard Medical School. Retrieved from <https://www.health.harvard.edu/blog/the-tragedy-of-the-post-covid-long-haulers-202010152479>.

and in part because they are more likely to attend segregated, underperforming schools.⁴⁰ This, combined with possible employment discrimination, makes it more likely that they'll earn less, too.

This CHNA centered health disparities and inequities in the following ways:

- Compared data by race/ethnicity when available (see *Attachment 2: Secondary Data Tables*).
- Compared data by subcounty geographies when available (see *maps in Section 6: Prioritized 2022 Community Health Needs*).
- Asked every single key informant and focus group to identify local populations they felt were experiencing inequities related to each need that the informant or focus group prioritized (see *Attachment 4: Qualitative Research Protocols*).
- Conducted a special focus group specifically on the topic of health equity (see *Primary Data Collection subsection above*).
- Among other criteria, identified an issue as a health need if two or more direct indicators associated with the need exhibited documented inequities by race/ethnicity (see *Data Synthesis: Identification of Community Health Needs subsection above*).
- Among other criteria, the Packard Children's CBAC scored the list of needs by the extent to which there were differences in outcomes by subgroups, including by geography, language, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or other categories (see *Prioritization of Health Needs subsection above*).

6. Prioritized 2022 Community Health Needs

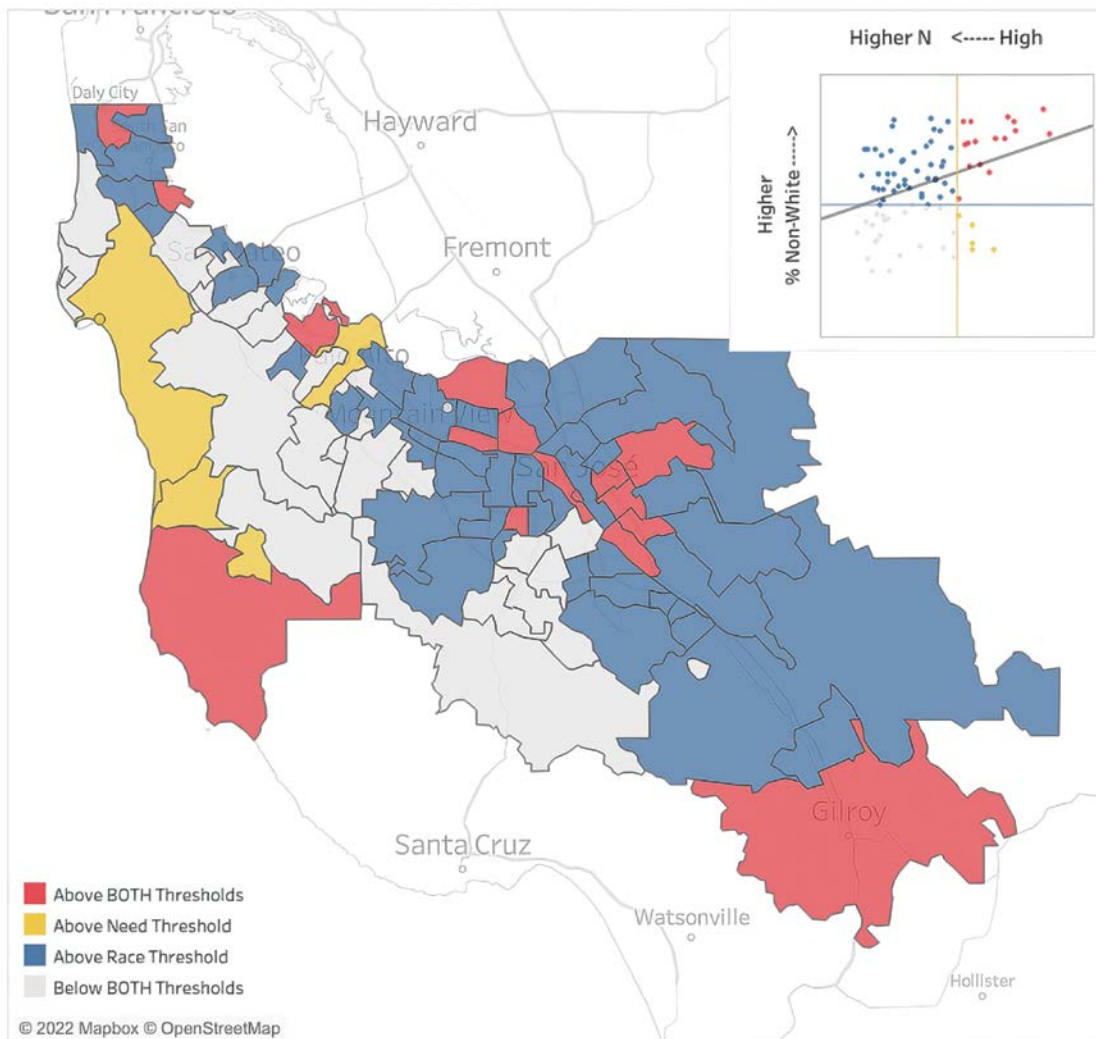
The processes and methods described in Section 5: Process and Methods resulted in the prioritization of 12 community health needs (see list on page 7). The descriptions of each need below summarize the data, statistics, and community input collected during the community health needs assessment. COVID-19 illness is treated separately in this report; see pages 23-25.

1. ECONOMIC STABILITY

Nearly all focus groups and over three-quarters of all key informants identified economic stability as a top community priority. 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.

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 with 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

⁴⁰ Reardon, S.F., Weathers, E.S., Fahle, E.M., Jang, H., and Kalogrides, D. (2019). *Is Separate Still Unequal? New Evidence on School Segregation and Racial Academic Achievement Gaps*. Retrieved from <https://cepa.stanford.edu/content/separate-still-unequal-new-evidence-school-segregation-and-racial-academic-achievement-gaps>.



Correlation Between Free- and Reduced-Price Lunch Enrollment and Nonwhite 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, nonwhite 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% nonwhite. Source: Community Health Data Platform, 2021.

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 with high school graduates statewide. The high school dropout rate is particularly high among Santa Clara County’s Latinx youth, about double compared with all California youth. In our 2019 CHNA report, we described similar inequities in educational attainment.

Qualitative data 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.⁴¹ 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.

41 Bohn, S., Cuellar Mejia, M., and 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/>.

“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

2. HOUSING AND HOMELESSNESS

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 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.

Most feedback about housing from key informants and focus group participants concerned housing

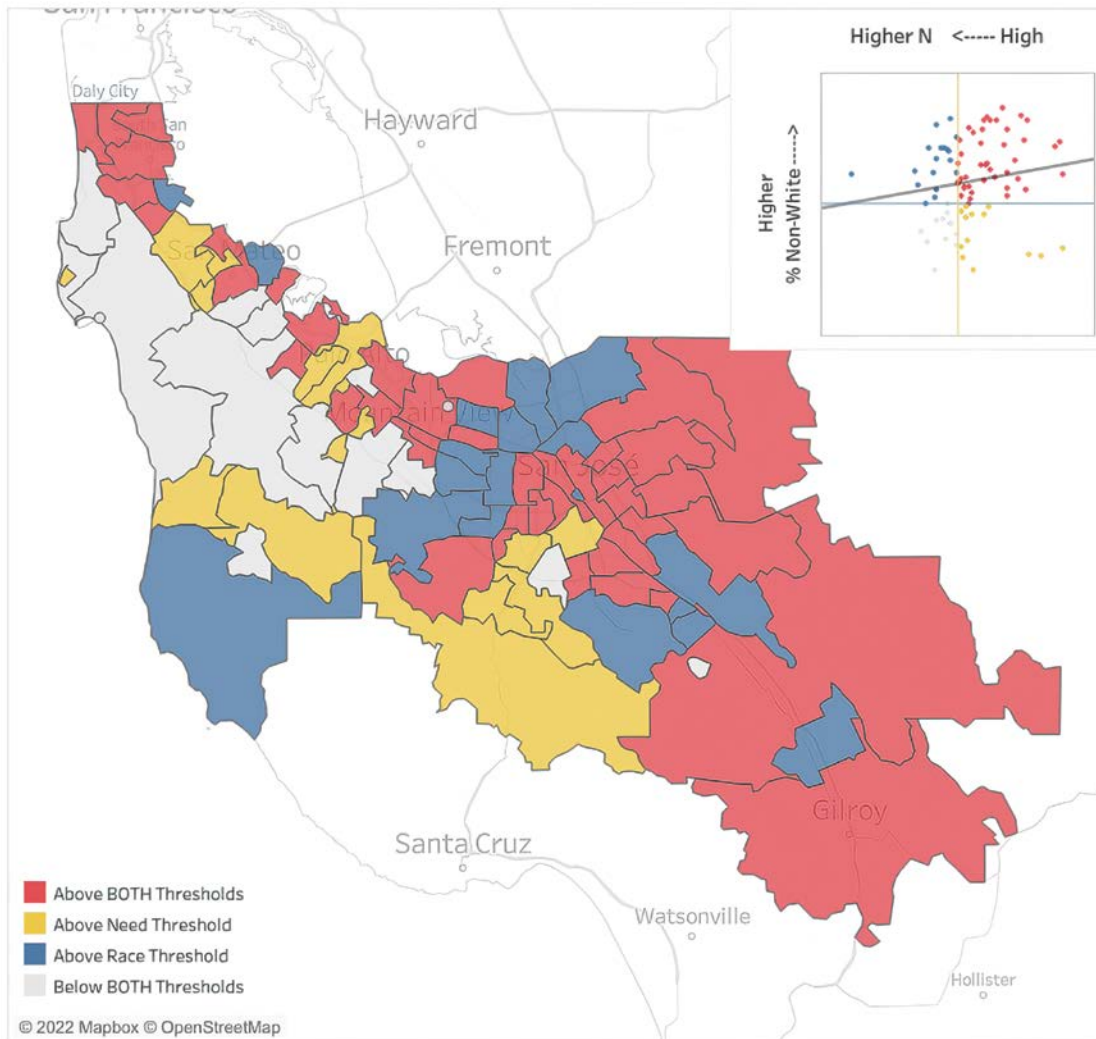
affordability. The housing affordability indices⁴² for both counties are lower (i.e., worse) than for the state of California. CHNA participants reported the difficulty that individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. In both counties, homelessness rose in 2019 (the most recent homeless count). Experts noted that during COVID, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

“It’s 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 of the Bay Area because it’s more affordable to live.”

—Behavioral Health Focus Group Participant

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

42 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*, Dec. 14, 2018. Retrieved from <https://www.esri.com/arcgis-blog/products/esri-demographics/analytics/the-delicate-balance-between-housing-affordability-growth-and-income>.



Correlation Between Severe Housing Cost Burden and Nonwhite 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, nonwhite 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% nonwhite.

3. HEALTH CARE ACCESS AND DELIVERY

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” ancestries⁴³ in both counties were significantly less

43 “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

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.

“I personally have a problem accessing health care because I'm a single parent, I don't earn [only] the minimum wage. And for that reason, I don't qualify by their standards, because according to them, I'm making so much money that I don't qualify. And it's not worth it for me to pay \$500 for health insurance or dental insurance where the individual plan—it has a lot of exclusions.”

—Clinic Patient Focus Group Participant

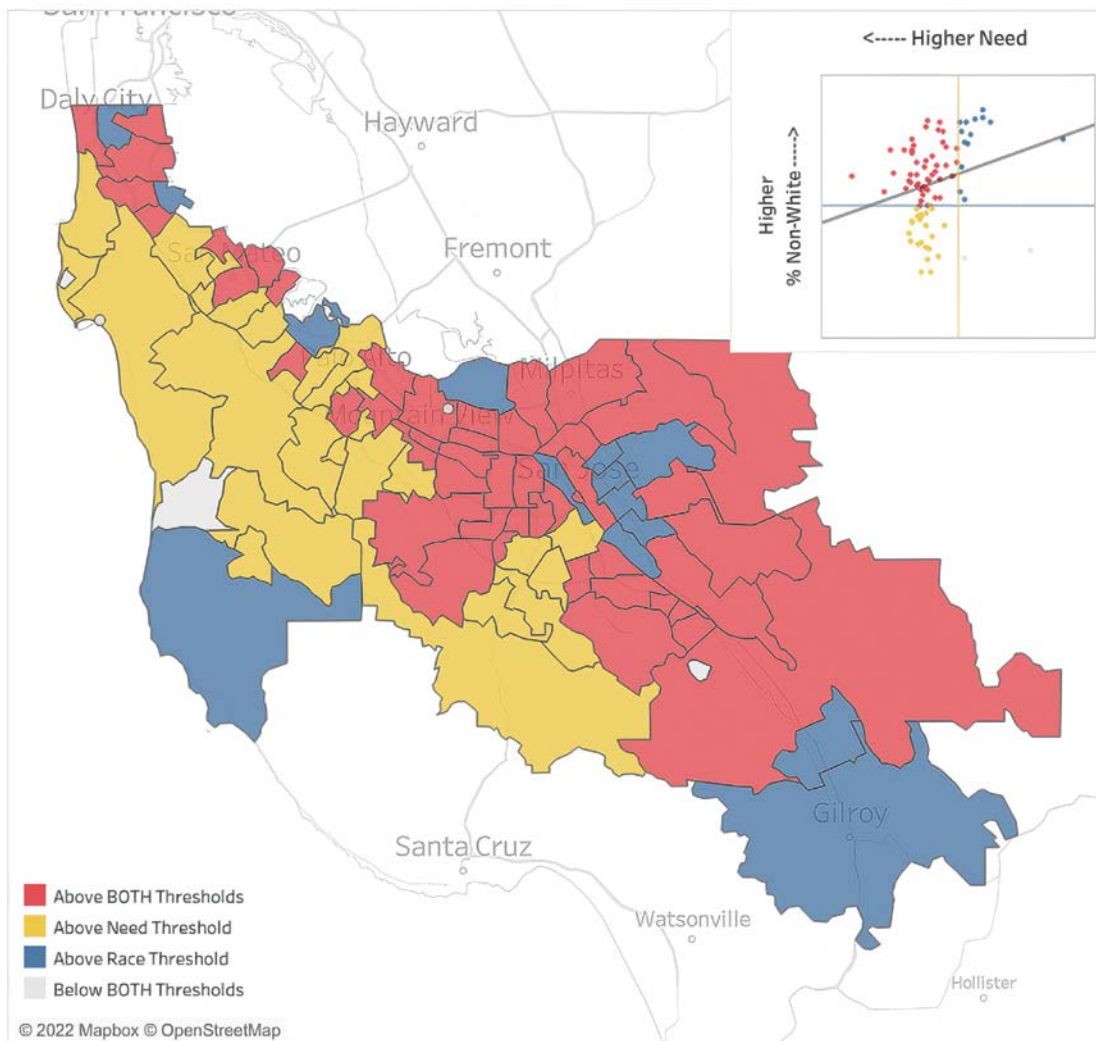
Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. They also expressed concern about the lower reimbursement rate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

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 1 in 10 Santa Clara County residents speak limited English, compared with fewer than 1 in 10 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 reverify their eligibility to retain coverage were specific concerns. Experts expressed concern about the use of the emergency department for nonemergent 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 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 with 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 nontraumatic 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.



Correlation Between Medicaid/Public Insurance Enrollment and Nonwhite 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, nonwhite 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% nonwhite. Source: Community Health Data Platform, 2021.

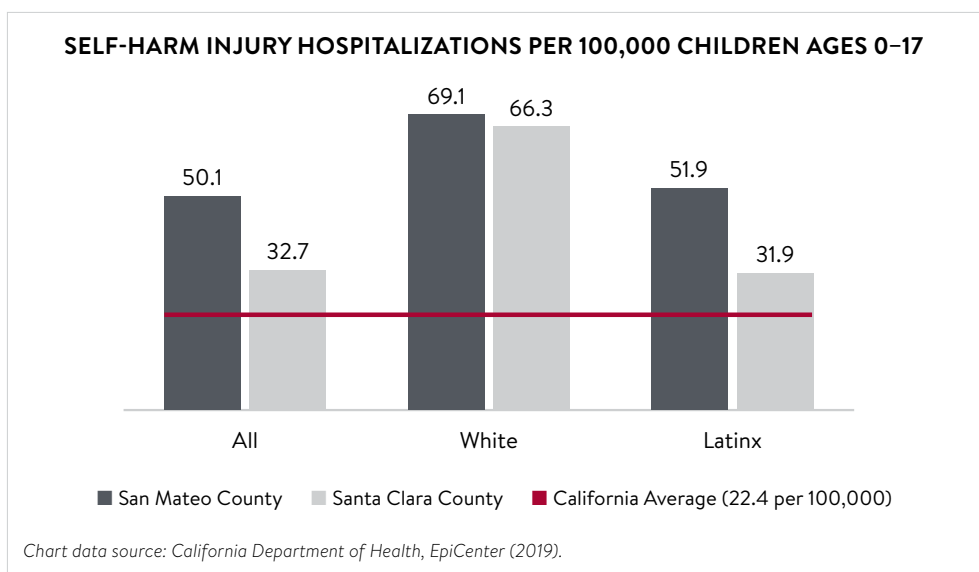
4. BEHAVIORAL HEALTH

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 less 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.

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."⁴⁴ 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."⁴⁵ Among the statistical data

44 McGuire, T.G., and Miranda, J. (2008). Racial and ethnic disparities in mental health care: evidence and policy implications. *Health Affairs (Project Hope)*, 27(2):393-403. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/>.

45 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/>.

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.

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.

FIFTH-, SEVENTH-, AND NINTH-GRADE STUDENTS MEETING ALL FITNESS STANDARDS

Grade	CA	San Mateo County (SM)	Santa Clara County (SC)	Asian		Black		Latinx		Pacific Islander		White	
				SM	SC	SM	SC	SM	SC	SM	SC	SM	SC
5th	24%	32%	27%	41%	33%	33%	20%	18%	14%	—	19%	41%	32%
7th	30%	37%	32%	51%	41%	20%	26%	23%	19%	20%	25%	48%	37%
9th	34%	35%	39%	51%	51%	—	29%	24%	25%	24%	25%	46%	45%

Table data source: California Department of Education, Physical Fitness Testing Research Files (2018).

5. DIABETES AND OBESITY

More than one-quarter of key informants and one focus group identified diabetes and obesity as top health needs. Two experts in Santa Clara County specifically called out diabetes as a rising problem in the community, while in San Mateo County, diabetes deaths appear to be trending down. The trend for adult obesity remains flat in Santa Clara County while worsening in San Mateo County.⁴⁶ Key informants and focus group participants identified the need for nutrition education, particularly from a young age. Some key informants further noted the cost of healthy food as a barrier to good nutrition.

The lack of physical activity was cited as a driver of obesity by multiple key informants, primarily in the context of the pandemic's interference with regular activities. Associated with this concern, the walkability index in both counties is worse than the state's. Both counties' Black, Latinx, and Pacific Islander middle- and high school students are much less likely to meet healthy body composition and fitness standards than middle- and high school students statewide.⁴⁷

Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. Data show that, among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores,

which sell fresh produce, in both counties than the state rate. Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2–11 in both counties eat adequate amounts of fruits and vegetables daily compared with children statewide. Multiple residents made the connection between unhealthy eating and mental health.

“Until we can help people get in touch with what's going on in their head and their heart when they put something in their mouths, [diabetes] is going to continue to be a big issue.”

—Clinic Patient Focus Group Participant

Our 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates than the state, and Santa Clara County's Black population also experiencing higher rates of diabetes. Although key informants and focus group participants did not connect diabetes and obesity with health disparities or inequities, experts writing on behalf of the American Diabetes Association describe placing “socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations.”⁴⁸

46 Robert Wood Johnson Foundation. (2021). *County Health Rankings*. Trend from San Mateo County public health department.

47 With one exception: Black middle schoolers in Santa Clara County generally meet body composition standards but not fitness standards.

48 Ogunwale, S.M., and Golden, S.H. (2021). Social Determinants of Health and Structural Inequities—Root Causes of Diabetes Disparities. *Diabetes Care*, Jan. 2021, 44(1):11–13. Retrieved from <https://care.diabetesjournals.org/content/44/1/11>.

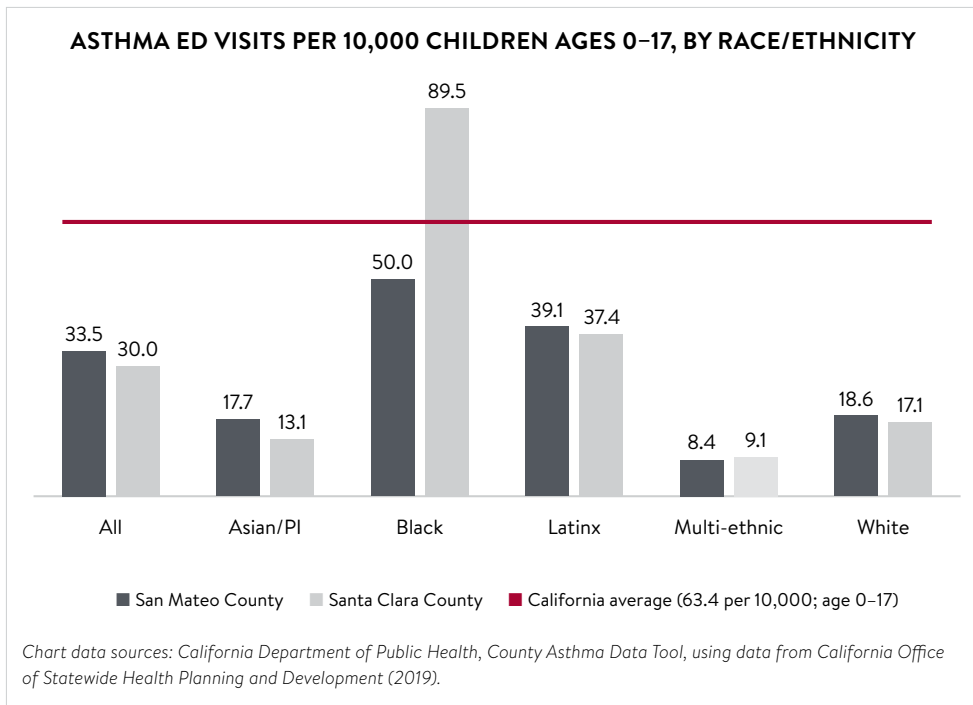
6. ASTHMA

Statistics suggest that asthma prevalence among people of all ages is higher in both counties than in the state, although the figure is trending higher only in Santa Clara County, as corroborated by a key informant from the county. Child asthma diagnoses are higher in San Mateo County than for all California children and, according to the county’s public health department, are trending up. San Mateo County’s public health department also suggested that drivers of asthma, such as obesity, are also worsening.

An expert in Black health cautioned about high rates of asthma in areas with poor air quality. Asthma emergency department visits are much higher for Black and Latinx children than other children in San Mateo and Santa Clara counties, although only Black

Santa Clara County children have a rate higher than the state’s. Our 2019 CHNA report indicated that the prevalence of asthma was higher for Black and Latinx community members in San Mateo County. Also, in 2019, we reported that Santa Clara County’s Black population was more likely to be hospitalized for asthma. These place-based inequities are, in part, related to the neighborhoods in which low-income and BIPOC community members live, which are in turn related to historical systemic discrimination such as redlining.⁴⁹

49 Iton, A., and Ross, R.K. (2017). Understanding How Health Happens: Your Zip Code Is More Important Than Your Genetic Code. In *Public Health Leadership*, Callahan, R.F., and Bhattacharya, D., eds. New York, NY: Routledge, pp. 83–99. Retrieved from https://zums.ac.ir/files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84. See also: Duncan, D.T., and Kawachi, I. (Eds.). (2018). *Neighborhoods and Health*. Oxford, UK: Oxford University Press.



7. MATERNAL AND INFANT HEALTH

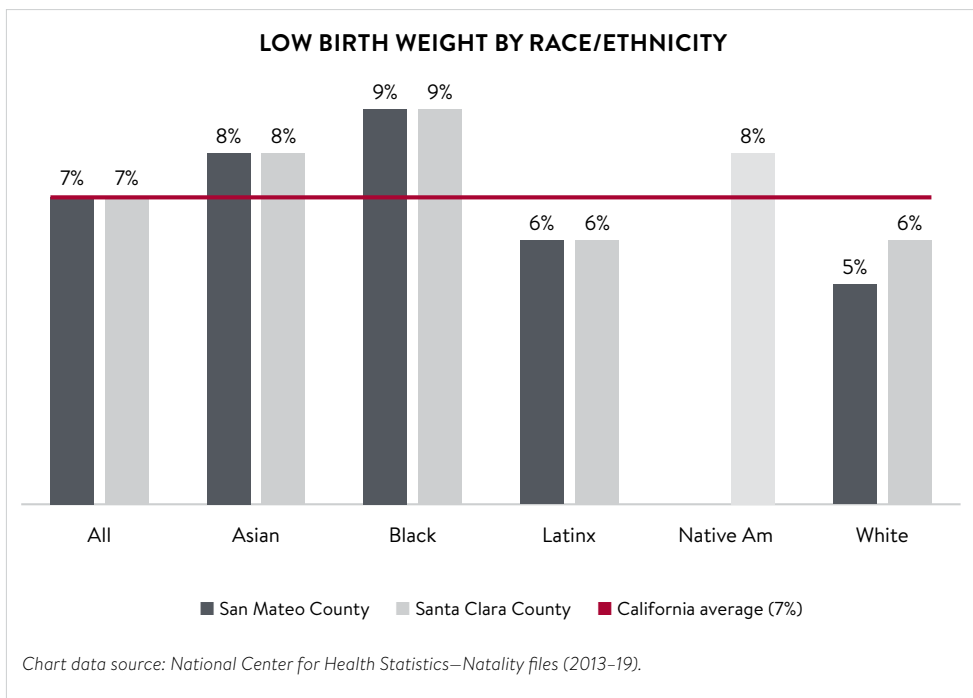
Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinas in both counties and young Black women in San Mateo County than in all females ages 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 in 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.”

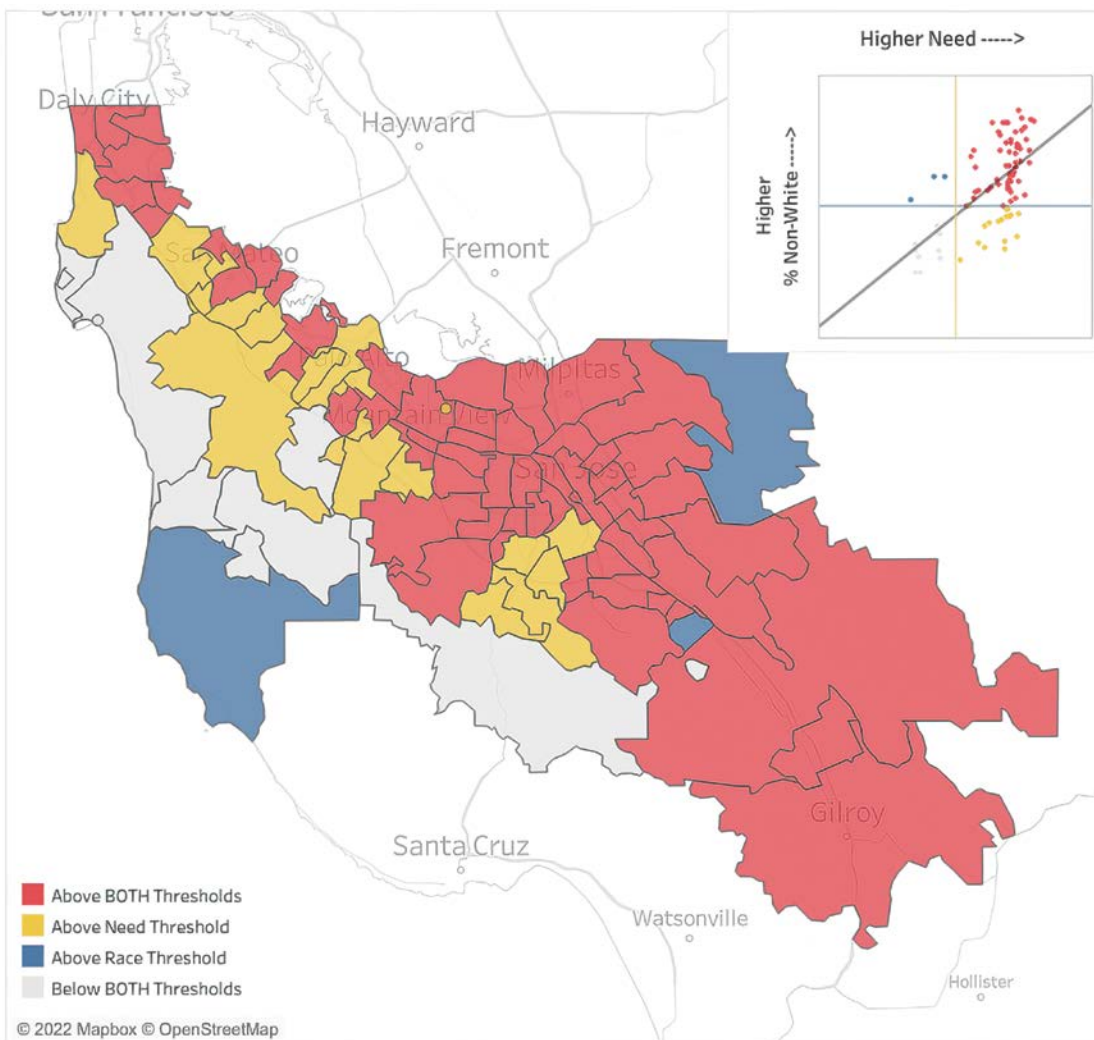
—Public Health Expert



8. CLIMATE/NATURAL ENVIRONMENT

Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. Both counties are at significantly greater risk of heat waves as well as coastal and river flooding than the state as a whole. Santa Clara County is also at greater risk of drought than the state overall. Public health experts cited lack of tree canopy cover in Santa

Clara County, which is reflected in the statistical data as less than the state average. Both focus group participants and key informants mentioned the adverse effects of environmental issues, particularly on low-income and BIPOC individuals, not only related to physical health but also with regard to the mental and financial stress of evacuation due to floods or wildfires.



Correlation Between Air Pollution and Nonwhite Population, by ZIP Code

Notes: Air quality is poor in many parts of both counties (red and yellow areas). In many places where air quality is poor, nonwhite community members are also in the majority (red areas). "Need Threshold" is air pollution PM2.5 concentration of 7.8 parts per million (U.S. average). "Race Threshold" is 50% nonwhite. Source: Community Health Data Platform, 2021.

“Some [coastal] communities not only had to go through the epidemic, but also fires—evacuations for days, if not weeks. There’s people that were going through a fire evacuation while as a result, someone in their family also ended up with COVID because people had to go to hotels [as evacuation shelters]....And also there was the flooding, too. There were more evacuations because of that. So you have communities that have been hit, not one, not twice, but three times. And so now we’re going to have communities that are going to be struggling not only financially, but emotionally as well.”

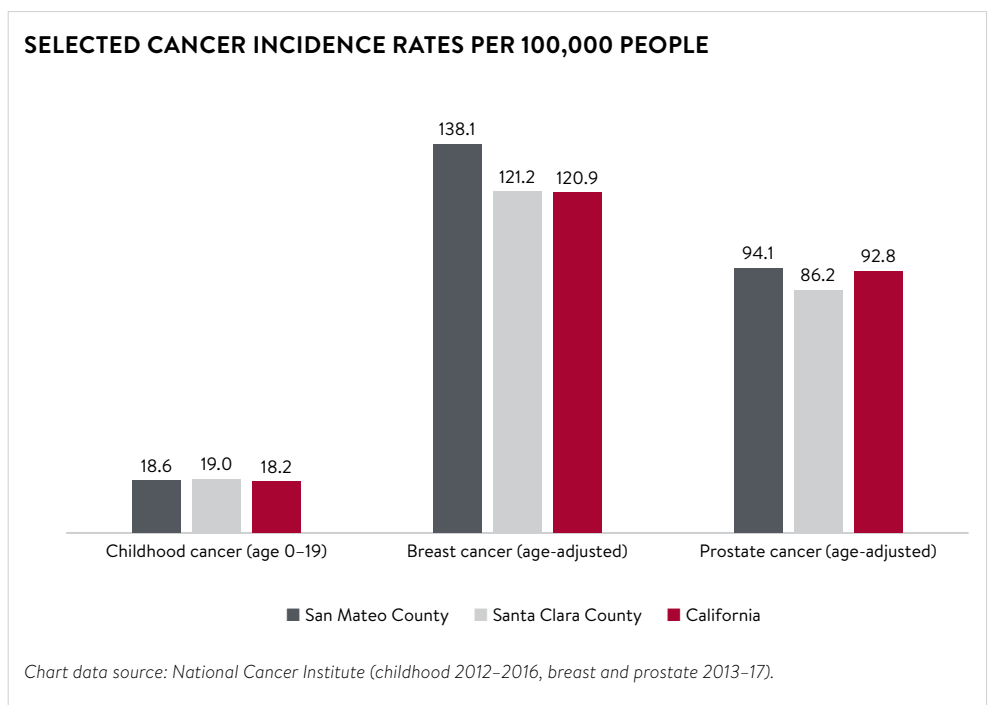
—Coastside Expert

Road network density and traffic volume were both significantly higher in San Mateo and Santa Clara counties than state averages. The environmental cost of high traffic volume includes air pollution, which can aggravate asthma. One Santa Clara County key informant noted that asthma rates have been worsening, and an expert in Black health cautioned about high rates of asthma in areas with poor air quality (see the “Asthma” subsection above for more information). Such place-based inequities may be related to historical systemic housing

discrimination (e.g., redlining).⁵⁰ Statistics suggest that asthma prevalence among people of all ages is higher in both counties than in the state, although the figure is trending higher only in Santa Clara County. Child asthma diagnoses are higher in San Mateo County than for all California children. Overall, the number of unhealthy air days has been rising in Silicon Valley.

9. CANCER

Mortality rates for cancer in both counties are better than state benchmarks. However, indicators of concern include the breast cancer incidence rate among Santa Clara County women compared with California women overall, the prostate cancer incidence rate among San Mateo County men compared with California men overall, and rising prostate cancer mortality rates in San Mateo County. In addition, the rate of cancer incidence



50 Iton, A., and Ross, R.K. (2017). Understanding How Health Happens: Your Zip Code Is More Important Than Your Genetic Code. In *Public Health Leadership*, Callahan, R.F., and Bhattacharya, D., eds. New York, NY: Routledge, pp. 83–99. Retrieved from https://zums.ac.ir/files/socialfactors/files/Public_Health_Leadership-Strategies_for_Innovation_in_Population_Health_and_Social_Determinants-2.pdf#page=84. See also: Duncan, D.T., and Kawachi, I. (Eds.). (2018). *Neighborhoods and Health*. Oxford, UK: Oxford University Press.

among children ages 0–19 is slightly higher in both counties than in the state and highest among white and Asian/Pacific Islander children. Our 2019 CHNA report indicated that, compared with California residents, Black residents of both counties have a higher incidence of breast cancer, lung cancer, and prostate cancer, and a higher prevalence of cancer of all sites combined, while Latina residents have a substantially higher incidence of cervical cancer. Finally, mammography screening levels, an early cancer detection measure, are lower for Santa Clara County’s Black and Native American women and Latinas, and San Mateo County’s Black women, than for California’s women overall.

The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, residents are more likely to be obese, which is a cancer risk factor). The Institute states, “Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy

changes to overcome systemic social, racial, and/or institutional inequalities.”⁵¹

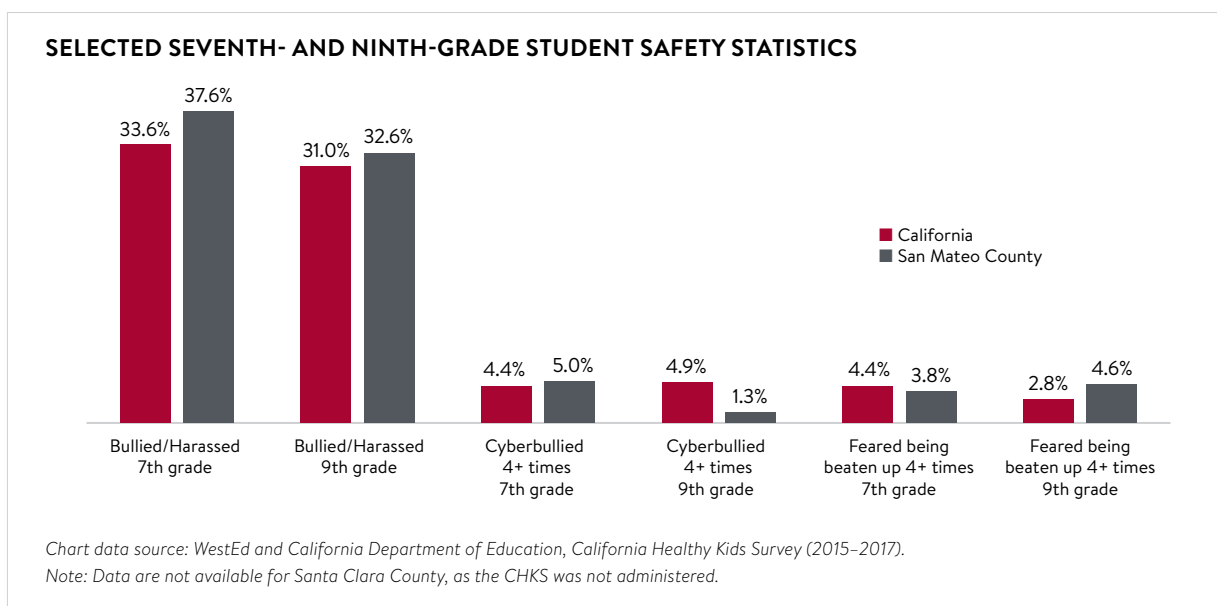
10. COMMUNITY SAFETY

While many community safety statistics are better in both counties than in the state, the rate of rape in Silicon Valley is rising. In addition, the homicide rate is significantly higher among the Black population in both counties than the state rate. This latter difference may, in part, be attributed to residential segregation,⁵² which has been shown to be related to structural discrimination (see the “Housing and Homelessness” subsection above).

In San Mateo County, bullying and harassment, including cyberbullying, are worse for seventh and ninth graders than for all California students in those grades.⁵³ San Mateo County’s ninth graders are also nearly twice as likely to fear being beaten up at school

51 National Cancer Institute. (2020). *Cancer Disparities*. Retrieved from <https://www.cancer.gov/about-cancer/understanding/disparities>.
 52 Knopov, A., Rothman, E.F., Cronin, S.W., Franklin, L., Cansever, A., Potter, F., Mesic, A., Sharma, A., Xuan, Z., Siegel, M., and Hemenway, D. (2019). The role of racial residential segregation in black-white disparities in firearm homicide at the state level in the United States, 1991–2015. *Journal of the National Medical Association*, 111(1):62–75. Retrieved from https://www.researchgate.net/profile/Anita-Knopov/publication/326323244_The_Role_of_Racial_Residential_Segregation_in_Black-White_Disparities_in_Firearm_Homicide_at_the_State_Level_in_the_United_States_1991-2015/links/5bee3267299bf1124fd5e3f3/The-Role-of-Racial-Residential-Segregation-in-Black-White-Disparities-in-Firearm-Homicide-at-the-State-Level-in-the-United-States-1991-2015.pdf.

53 Note, comparable data are not available for Santa Clara County.



than all California ninth graders.⁵⁴ Two experts noted that the shift to virtual education during the pandemic benefited youth who had been bullied at school and said that some did not want to return when schools reopened. Indeed, rates of bullying and harassment at school are higher for most nonwhite youth in San Mateo County versus the state. In addition, cyberbullying rates are higher for the county's Black, Latinx, and Native American middle schoolers than middle schoolers in California overall.⁵⁴

Some experts expressed concern about COVID-related stress contributing to domestic violence and/or sexual abuse; one mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety. There are disparities in domestic violence: Black children ages 0–17 in both counties and Latinx children in Santa Clara County are more likely to be the subject of a substantiated child abuse case than children statewide. Researchers attribute these disparities to differences in family circumstances that put children at greater risk of abuse (e.g., being young and/or single parents, experiencing poverty).⁵⁵ Building on the differences in child abuse statistics, both counties' Black children (ages 0–20) are also more likely to be in foster care than are California children on average. Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.⁵⁴ Statistics show that juvenile felony arrests (ages 10–17) are higher in Santa Clara County than the state and, specifically, higher for Black and Latinx youth in

both counties. In Santa Clara County, Latinx youth are substantially overrepresented in the county's juvenile detention center population.⁵⁶ These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.⁵⁷

“...especially for our patients who are in situations with violent partners it was great to have the in-person encounter as a sort of legitimate reason for that patient to get away from the partner, to be able to speak with a provider confidentially. And now with virtual visits, it's really hard to be able to discreetly ensure that confidentiality; that person has to do that visit from a home or someplace where it's a little harder for you to directly ask if it's a safe place to talk, and also for them to really be as inclined to set up visits for check-ins for safety.”

—Health Equity Focus Group Participant

54 See, for example, Cutuli, J.J., Goerge, R.M., Coulton, C., Schretzman, M., Crampton, D., Charvat, B.J., Lalach, N., Raithel, J., Gacitua, C., and Lee, E.L., 2016. From foster care to juvenile justice: Exploring characteristics of youth in three cities. *Children and Youth Services Review* 67(2016):84–94. Retrieved from <https://www.aisp.upenn.edu/wp-content/uploads/2020/11/From-Foster-Care-to-Juvenile-Justice.pdf>. See also Yi, Y., and Wildeman, C. (2018). Can foster care interventions diminish justice system inequality? *The Future of Children*, 28(1):37–58. Retrieved from <https://files.eric.ed.gov/fulltext/EJ1179175.pdf>.

55 Font, S.A., Berger, L.M., and Slack, K.S. (2012). Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review*, 34(11):2188–2200. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3439815/>. See also: Black Child Legacy Campaign. (2021). *Child Abuse and Neglect*. Retrieved from <https://blackchildlegacy.org/resources/child-abuse-and-neglect/>.

56 County of Santa Clara. (2020). *Santa Clara County Juvenile Justice Annual Report*. Retrieved from https://probation.sccgov.org/sites/g/files/exjcpb721/files/documents/2021_09_17_Juvenile%20Justice%20Annual%20Report_2020_Final.pdf.

57 Gallegos, A.H., and White, C.R. (2013). Preventing the School-Justice Connection for Youth in Foster Care. *Family Court Review*, 51(3):460–68. See also: Foster, M., and Gifford, E. (2004). “The Transition to Adulthood for Youth Leaving Public Systems: Challenges to Policies and Research,” in *On the Frontier of Adulthood: Theory, Research, and Public Policy*, eds. Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., and Rubén G. Rumbaut. Chicago, IL: University of Chicago Press.

11. UNINTENDED INJURIES/ACCIDENTS

Road network density and traffic volume were both significantly higher in San Mateo and Santa Clara counties than state averages. One consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents, especially in Santa Clara County. In particular, the rate of emergency department visits for bicycle accidents among children ages 0–12 is higher in Santa Clara County than the state rate. Two of the county’s public health experts discussed high traffic volume and the need to prevent accidents and make roads safe for pedestrians and cyclists.

By race, among children ages 0–12 in Santa Clara County, ED visits for bicycle accidents are highest among whites; for motor vehicle crashes, they are highest among Blacks and Latinxs; and for pedestrian accidents, they are highest among Latinxs. In our

2019 CHNA report, San Mateo County Latinxs of all ages were at higher risk for pedestrian accident deaths than individuals of other ethnicities, and their pedestrian accident mortality rate was higher than the benchmark. Racial inequities in accident rates have been found nationwide and are attributed in part to unequal access to safe transportation.⁵⁸ The absence of sidewalks in low-income neighborhoods is another factor related to inequities in pedestrian accident rates nationally.⁵⁹

58 Hamann, C., Peek-Asa, C., and Butcher, B. (2020). Racial disparities in pedestrian-related injury hospitalizations in the United States. *BMC public health*, 20(1):1–7. Retrieved from <https://link.springer.com/article/10.1186/s12889-020-09513-8>.

59 Lu, W., McKyer, E.L.J., Lee, C., Ory, M.G., Goodson, P., and Wang, S. (2015). Children’s active commuting to school: an interplay of self-efficacy, social economic disadvantage, and environmental characteristics. *International Journal of Behavioral Nutrition and Physical Activity*. 12(1):29. Retrieved from <https://ijbnpa.biomedcentral.com/articles/10.1186/s12966-015-0190-8>.

SELECTED EMERGENCY DEPARTMENT VISIT RATES FOR ACCIDENTS AMONG CHILDREN AGES 0–12, BY RACE/ETHNICITY

Item	CA	San Mateo County (SM)	Santa Clara County (SC)	Asian/PI		Black		Latinx		White	
				SM	SC	SM	SC	SM	SC	SM	SC
Falls	3,084.2	2,578.7	2,498.5	1,518.6	1,424.3	2,295.8	2,841.5	2,673.0	3,175.9	3,817.5	3,533.7
Poisonings	137.5	127.4	99.1	115.2	54.3	–	–	109.1	114.8	181.7	157.5
Bicycle accidents	12.2	–	13.5	–	–	–	–	–	–	–	27.6
Motor vehicle crashes	249.9	140.8	166.1	97.2	78.1	–	387.5	213.0	258.9	120.3	168.0
Pedestrian accidents	18.3	–	12.9	–	–	–	0.0	–	19.3	–	–

Table data source: California Department of Health, EpiCenter (2015).

12. SEXUALLY TRANSMITTED INFECTIONS

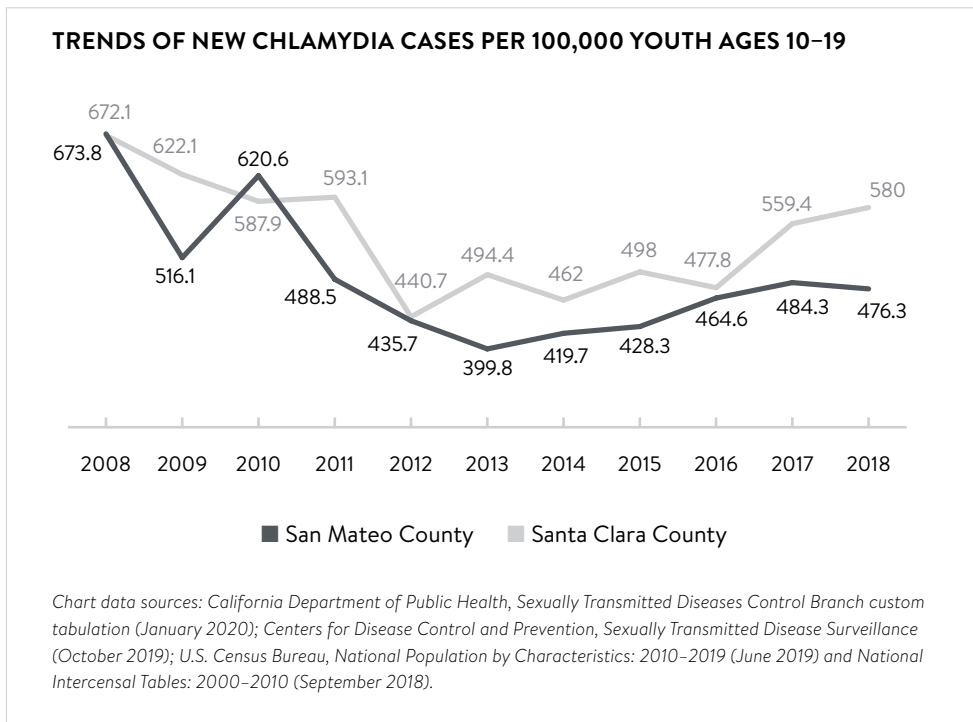
Although statistics on sexually transmitted infections are better than the state for both counties, there are concerning trends. HIV diagnoses among younger men (ages 13–24 and 25–44) are on the rise in Santa Clara County, while rates of early syphilis are increasing in San Mateo County. In both counties, chlamydia is on the rise among youth as well. In our 2019 CHNA report, we found that the proportion of people who were not screened for HIV was higher in Santa Clara County than statewide.

Additionally, there are disparities; for example, Black and Latinx men ages 13 and older in Santa Clara County are more than twice as likely to be diagnosed with HIV than California men overall. In

our 2019 CHNA report, statistics showed that the Black population in Santa Clara County was also more likely to be diagnosed with early syphilis than all Californians. The Centers for Disease Control and Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the health care system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to “stay sexually healthy.”⁶⁰

For additional statistical data, see Attachment 2: Secondary Data Tables.

60 Centers for Disease Control and Prevention. (2020). *STD Health Equity*. Retrieved from <https://www.cdc.gov/std/health-disparities/default.htm>.



7. Evaluation Findings from 2020–2022 Implemented Strategies

2019 Prioritized Health Needs

In 2018–2019, Lucile Packard Children’s Hospital Stanford participated in a Community Health Needs Assessment similar to our collaborative 2022 effort. Our 2019 CHNA report is posted on the Community Benefits page of our public website. As noted in that report, Packard Children’s met in February 2019 and prioritized the health needs listed below. Our hospital chose to address the top three as well as Maternal and Infant Health in subsequent years through implementation strategies.

1. Health Care Access and Delivery
2. Behavioral Health
3. Diabetes and Obesity
4. Unintentional Injuries
5. Economic Stability
6. Housing and Homelessness
7. Transportation
8. Oral/Dental Health
9. Cancer
10. Communicable Diseases
11. Asthma
12. Natural Environment

Implementation Strategies for Fiscal Years 2020 and 2021

The 2019 CHNA formed the foundation for Packard Children’s Hospital’s implementation strategies for fiscal years 2020 through 2022, which were initiated in fiscal year 2020 (FY 2020). The IRS requires hospitals to report on the impact of implementation strategies. The following sections describe the evaluation of community benefit programs put forth in the implementation strategies. Due to timing constraints that require the adoption and public

posting of this report by the end of the fiscal year, evaluation results for FY 2022 (Sept. 1, 2021–Aug. 31, 2022) were not yet available for inclusion. For more information, see the “Community Benefits Reports and Health Assessment” page of our public website.⁶¹

Community Benefit Investments in Fiscal Years 2020 and 2021

Lucile Packard Children’s Hospital Stanford is dedicated to meeting the health needs of our community’s most vulnerable. As a nonprofit organization, Lucile Packard Children’s Hospital Stanford is dedicated to improving the health of our community. As part of that commitment, we provide direct services to some of our community’s most vulnerable members, and we partner with government and local community-based organizations on programs and funding.

The following program guidelines drive our community work:

- Meaningful and sustainable community investment
- Services that meet the needs of vulnerable populations
- Partnering to build stronger, healthier communities
- Continued advocacy for children’s health issues

At Lucile Packard Children’s Hospital Stanford we believe that every family is deserving of quality, nurturing care. As part of that commitment, we provide financial assistance to families who qualify. We’re proud to be part of the safety net that provides care to our community’s most vulnerable.

Lucile Packard Children’s Hospital Stanford’s most recent previous CHNA was conducted between September 2018 and January 2019. The 2019 CHNA, which identified significant community health needs, formed the foundation for Lucile Packard Children’s

⁶¹ <https://www.stanfordchildrens.org/en/about/government-community/benefits-reports>

Hospital Stanford’s implementation strategies for fiscal years 2020–2022.

The following are highlights of Lucile Packard Children’s Hospital Stanford’s community benefit strategies and their implementation. Due to time constraints that require adoption and public posting of this report by the end of the fiscal year, evaluation results for fiscal year 2022 are not yet fully available. For more information, visit our website.⁶²

FY 2020–FY 2022 COMMUNITY BENEFIT (CB) INVESTMENT HIGHLIGHTS

- More than \$4 million in charity care excluding uncompensated Medicare.
- More than \$50 million to train the next generation of physicians and other health care professionals.
- More than \$5.5 million in community investment grants to CBOs, such as support for community emergency management programs and advocacy for children’s health issues.

COMMUNITY INVESTMENT GRANTS

Lucile Packard Children’s Hospital Stanford seeks to meet community benefit standards through multiple initiatives specifically addressing identified community health needs. These initiatives range from services and activities conducted by the hospital organization itself to programs funded by the hospital and conducted by community nonprofits and government agencies in the community we serve. The results section of this evaluation specifically addresses Lucile Packard Children’s Hospital Stanford’s funding of externally conducted programs.

Lucile Packard Children’s Hospital Stanford conducts a yearly grant program that funds nonprofit organizations and government agencies working on shared unmet health needs. Our Community Investment Grant program allows Lucile Packard Children’s Hospital Stanford to provide support for community-based organizations with programs or services that align with our Community Health Initiatives:

- Improve Access to Care
- Prevent and Treat Pediatric Obesity
- Improve the Social, Emotional, and Mental Health of Children and Youth
- Improve the Health of Infants and New Mothers
- Improve Food Security

Our FY 2020–FY 2022 Community Investment Grant recipients are listed in the table below.

⁶² <https://www.stanfordchildrens.org/en/about/community-benefit>

List of Community Investment Grants, FY2020–FY2022

INITIATIVE	ORGANIZATION	FY 2020	FY 2021	FY 2022	TOTAL INVESTMENT
Access	Legal Aid Society, Peninsula Family Advocacy Program (FAP)	\$75,000	\$75,000	\$75,000	\$225,000
Access	MayView Community Health Center	\$75,000			\$75,000
Access	Puente de la Costa Sur, Medical Access Program	\$85,000	\$85,000	\$85,000	\$255,000
Access	Ravenswood Family Health Center, Pediatric Services Program	\$300,000	\$300,000	\$300,000	\$900,000
Access	Santa Cruz Community Health Centers	\$85,000	\$85,000	\$85,000	\$255,000
Access	Sonrisas Dental Health, Children’s Access to Care and School Dental Screening Outreach and Education Program	\$40,000	\$40,000	\$40,000	\$120,000
Access	Stanford Pediatric Advocacy Program	\$70,000	\$66,000	\$75,000	\$211,000
Access	Stanford Strengthening Connections for Families to County Home Visiting Programs	\$20,000			\$20,000
Food Insecurity	Fresh Approach	\$25,000			\$25,000
Food Insecurity	Jacob's Heart	\$25,000			\$25,000
Food Insecurity	Packard Food Program	\$150,000		\$150,000	\$300,000
Food Insecurity	Stanford School of Medicine		\$100,000		\$100,000
Maternal Health	Roots Community Health Center—Hey Sis, Let’s Chat program		\$50,000	\$50,000	\$100,000
Maternal Health	Teen Success Program	\$50,000	\$50,000	\$50,000	\$150,000
Obesity	Fresh Approach, Connecting Hunger Relief with Health and Nutrition Programming	\$60,000	\$60,000	\$60,000	\$180,000
Obesity	Gardner Packard Children’s Health Center, GOALS		\$88,300	\$90,000	\$178,300
S/E	Adolescent Counseling Services	\$90,000	\$90,000	\$90,000	\$270,000
S/E	Acknowledge Alliance	\$40,000	\$40,000	\$40,000	\$120,000
S/E	Early Life Stress Program, Addressing Disparities Through a Mental Health Dissemination and Innovation Initiative	\$110,000	\$100,000	\$75,000	\$285,000
S/E	My Digital TAT2	\$40,000	\$40,000	\$40,000	\$120,000
S/E	Project Safety Net/HEARD Alliance	\$110,000	\$100,000	\$75,000	\$285,000
S/E	Stanford Center for Youth Mental Health and Wellbeing	\$110,000	\$120,000	\$120,000	\$340,000
TOTAL		\$1,510,000	\$1,489,300	\$1,500,000	\$4,499,300

EVALUATION OF GRANTS PROGRAM OVERALL

Lucile Packard Children’s Hospital Stanford has engaged Actionable Insights for support with a robust evaluation of the Community Investment Grants program overall. Together, the team worked to identify strategies to address needs, used criteria to make choices about strategic investments, and improved grantmaking policies and procedures for alignment with the CHNA. Additionally, the team sought to improve the capacity of its nonprofit partners to assess the impact of their own programs for improved reporting and provided individual technical assistance for some existing grantees. Together, these efforts have improved Packard Children’s Hospital’s own reporting to its stakeholders and increased transparency and accountability about how it provides community health benefits.

INITIATIVES AND RESULTS

Health Initiative 1: Improve Access to Primary Health Care Services for Children, Teens, and Expectant Mothers

FUNDED GRANTEES – ACCESS	
GRANTEE	IMPACT
<p>Legal Aid Society—Peninsula Family Advocacy Program (FAP)</p> <p>FAP improves the health and welfare of expectant mothers, low-income children, and their families. FAP provides no-cost legal representation, advocacy, and education to help address underlying causes of poor health among low-income children receiving care. FAP assists community members with medical insurance and financial issues, housing problems, enrolling in public benefits, domestic violence, and enrolling in educational programs; it also provides assistance for teen parents and family caregivers. Families gain the tools necessary to advocate for themselves and their children.</p>	<ul style="list-style-type: none"> Served over 100 low-income families each year with legal services. At least 94% of legal cases each year had a favorable outcome for clients. Completed a study of efficacy of the dyslexia reading program in the Redwood City School District. 17–21 low-income families per year received medically necessary outpatient therapies as a result of legal intervention. Provided 183 “curbside consults” to social workers, physicians, and other health providers to help with identifying legal barriers to health in their clients/patients. In FY 2020, two school districts worked with FAP to improve learning disability program served from partners. Received referrals from about 500 health providers.
<p>MayView Community Health Center</p> <p>This health center increases the availability of health care services for vulnerable children.</p>	<p>Merged with Ravenswood Family Health Centers—see Ravenswood evaluation section.</p>
<p>Puente de la Costa Sur—Medical Access to South Coast Residents program</p> <p>Puente is the only community resource center in the San Mateo County South Coast communities of Pescadero, La Honda, Loma Mar, and San Gregorio. Puente advocates for its community and leverages resources that promote individual and community health and wellness.</p>	<p>In FY 2021:</p> <ul style="list-style-type: none"> Made 639 of referrals to SMC Health. 92% of those referred saw a provider. 186 enrolled in health insurance. 89% of the newly enrolled sought care. 1,321 tested for COVID-19. 186 vaccinated against COVID-19 (almost 1,800 doses). 181 participated in health workshops.

FUNDED GRANTEES – ACCESS	
GRANTEE	IMPACT
<p>Ravenswood Family Health Center Pediatric Services Program</p> <p>The program’s overall goals are to increase access to a comprehensive health home for pediatric patients and improve maternal health outcomes.</p>	<ul style="list-style-type: none"> • An average of 1,958 kids received primary care annually. • At least 160 kids per year received integrated behavioral health services. • An average of 3,375 kids received oral health care annually. • Measured BMI for at least 1,800 kids and provided nutrition and physical activity counseling. • 29% of CenteringParenting kids were screened using Modified Checklist for Autism in Toddlers. • 86% of CenteringParenting kids were screened using Ages and Stages Questionnaire. • Screened CenteringParenting mothers for depressive symptoms.
<p>Santa Cruz Community Health Centers</p>	<ul style="list-style-type: none"> • Increased patient care plan completion by 37%. • Increased number of Complex care registry patients with up-to-date WCC by 21%.
<p>Sonrisas Dental Health (SDH), Children’s Access to Care and School Dental Screening Outreach and Education Program</p> <p>SDH seeks to break the cycle of poverty and dental problems for low-income families. While risk of dental decay does not discriminate by race or gender, affecting all children equally, some children face great challenges in accessing care due to financial and other concerns. Many children enter kindergarten with untreated tooth decay, and a portion of those require urgent or emergency dental interventions. Many of SDH’s patients are Latino, are low-income, and live in crowded housing settings. SDH accepts Medi-Cal Dental insurance and provides essential care and screenings in elementary schools.</p>	<ul style="list-style-type: none"> • 394 children screened in two years. • Provided a dental home for 39 new pediatric Medi-Cal patients in FY 2021 (at least two visits per year). • Distributed 944 oral health kits over two years. • Distributed oral health education videos in Spanish for 12 schools (over 750 students) in grades 3–5 to San Mateo County Schools. • In FY 2021, 300 students (primarily from Allen and Belle Air elementary schools) participated in Healthy Smiles Across the Miles virtual oral health education. • Distributed oral health information to 100% of parents.
<p>Stanford Pediatric Advocacy Program</p> <p>Program staff direct two key training programs for Stanford pediatric residents—the Community Pediatrics and Child Advocacy and the StAT (Stanford Advocacy Track) Training Program—with the purpose of training the next generation of health care providers in community engagement and advocacy. The program also provides mini-grants to StAT residents to apply their training through community engagement projects.</p> <p>Program staff also engaged in collaborative service projects and research projects that address local health disparities.</p>	<ul style="list-style-type: none"> • Trained 34 Community Pediatric Residents. • Trained 23 StAT Residents since 2019, impacting delivery to approximately 2,500 patients. • 14 StAT abstracts funded by mini-grants accepted to PAS or APA Regional in FY 2020. • Provided anti-racism resources for iMPACT providers and led anti-racism rally. • Worked with seven Stanford clinical partners and 15 community partners on collaborative projects.

FUNDED GRANTEES – ACCESS	
GRANTEE	IMPACT
<p>Stanford Strengthening Connections for Families to County Home Visiting Programs</p> <p>The grant focuses on increasing referrals and fostering stronger connections between community pediatric clinics and County home visiting programs.</p>	<p>In FY 2020, developed plan to launch “Family Connects” in partnership with Packard Children’s Hospital and in coordination with San Mateo County Family Health Service and secured 70% of its funding.</p>

Health Initiative 2: Prevent and Treat Pediatric Obesity

FUNDED GRANTEES – PEDIATRIC OBESITY	
GRANTEE	IMPACT
<p>Fresh Approach, Connecting Hunger Relief with Health and Nutrition Programming</p> <p>Fresh Approach serves low-income or food-insecure families in San Mateo and Santa Clara counties. They provide VeggieRx Nutrition and Cooking Workshops, increase access to healthy food through farmers’ markets, provide nutrition education and healthy food incentives (VeggieRx vouchers and matching nutrition incentives), and provide gardening resources at the Collective Roots Community Garden in East Palo Alto. The long-term goal is to reduce the risk of developing diet-related chronic diseases.</p>	<ul style="list-style-type: none"> • Over 200 households served each year, reaching over 700 people each year. • \$27,930 in VeggieRx vouchers distributed. • \$61,532 in matching nutrition incentives distributed. • Over 6,700 reached through East Palo Alto farmers’ markets and Mobile Farmers’ Market. • 35 garden plots in use in FY 2021. • 83% of participants who attend classes regularly ate one additional serving of fruits and vegetables compared with before the program. • 68% of participants learned how to shop on a budget/afford healthy food. • 36% increase in voucher redemption at participating farmers’ markets from the previous year.
<p>Gardner Packard Children’s Health Center, GOALS</p> <p>This obesity treatment intervention program is provided in English and Spanish, and was adapted to a telehealth model during the pandemic.</p>	<ul style="list-style-type: none"> • 35–40 families enrolled annually. • More than 100 virtual home visits/calls in FY 2021. • Measurement of BMI improvement in progress.

Health Initiative 3: Improve the Social, Emotional and Mental Health of Children and Youth

FUNDED GRANTEES – SOCIAL/EMOTIONAL AND MENTAL HEALTH	
GRANTEE	IMPACT
<p>Adolescent Counseling Services (ACS)</p> <p>ACS helps students through challenges of adolescence, including life-threatening issues such as depression, suicidality, and self-harm. They provide mental health therapy and support services at local middle and high schools and in the community, and provide Substance Abuse Treatment (ASAT) to break the cycle of drug/alcohol use and strengthen the effectiveness of the family. ACS also provides Outlet services to LGBTQ+ youth (support, education, and advocacy).</p>	<ul style="list-style-type: none"> • Almost 800 served through individual or family therapy, support groups, crisis intervention. • 78% achieved treatment plan goals. • 73%–76% increase in functioning and coping skills. • 263 people received ASAT treatment. • 75% successfully completed the 10-week ASAT program. • 404 people served through Outlet support groups. • 89%–97% of Outlet participants increased comfort with identifying as LGBTQ+. • 89%–100% of Outlet participants feel more connected to the community. • Over 11,500 educated and trained about the issues LGBTQ+ youth face. • 89%–97% of those trained increased understanding of the issues that LGBTQ+ youth face.
<p>Acknowledge Alliance, Resilience Consultation Program</p> <p>This program provides three services: social/emotional learning for educators, consultation for educators, and student counseling. School staff improve educator-student relationships, build awareness of student social and emotional issues, and build empathy and understanding in the lives of their students. School staff also use strength-based strategies to engage and reach their students, collaborating with colleagues on behalf of their students, and use strategies to promote their own personal and professional resilience. As a result, students improve their functioning at home, at school, and with peers, and make positive behavioral choices. As a result, the program will improve school climate, academic performance, and pro-social character building.</p>	<ul style="list-style-type: none"> • Over 1,900 students and 480 school staff trained each year on positive school climate. • Eight in 10 students improved social and emotional competencies. • Eight in 10 students increased understanding of their feelings. • 91% of teachers increased awareness of student social and emotional needs. • Improvement in student assessment of social/emotional capacity.

FUNDED GRANTEES – SOCIAL/EMOTIONAL AND MENTAL HEALTH	
GRANTEE	IMPACT
<p>Stanford Early Life Stress Program (SELSP), Addressing Disparities Through a Mental Health Dissemination and Innovation Initiative</p> <p>The program provides Cue-Centered Therapy (CCT) training to mental health providers locally and internationally. In FY 2021, SELSP launched the training online. SELSP is also active in local provider collaboration efforts, including the Ravenswood Wellness Partnership, the CHC Mental Health Leadership Collaborative, and the Bay Area Health and Legal Partnership for Immigrant Families (BAHLI). These partners work on partnership strategy, service delivery, resource coordination, and mutual support for provider stress related to the pandemic. SELSP works to increase the capacity of service providers across multiple disciplines, to inform policy, and to advocate for child-friendly and trauma-informed immigration procedures and systems in the U.S. They do this by producing reports, resource materials, training, and testimony for courts, policy makers, and service providers. They have been active in providing Stress and Resilience Intervention (SRI) training to interdisciplinary audiences (namely, attorneys, advocates, and mental health providers) on traumatic stress experienced by immigrant children and related implications for engaging with this population.</p>	<ul style="list-style-type: none"> • Successful completion and launch of comprehensive interactive online CCT training course. • Over 100 mental health professionals trained in CCT online. • 38 mental health professionals completed live one-day intensive CCT training. • Five mental health professionals received weekly supervision. • Highly rated trainings (e.g., 4.8 average score (on a scale of 1 to 5) for contribution to their professional growth). • Produced and disseminated informational resources (e.g., webinars, written reports, and recommendations) on the mental health impact of the COVID-19 pandemic. • Trained nine California counties in SRI (381 trainees). • SRI facilitators (i.e., trainees) reduced psychological distress.
<p>My Digital TAT2</p> <p>Program offers a two-part, 45-minute “Personal Responsibility in the Digital Age” intervention to fourth and fifth graders in San Mateo and Santa Clara counties with the goal of improving online media literacy and mental health.</p>	<ul style="list-style-type: none"> • 124 interventions. • Every child offered at least one solution to make the internet a kinder place. • In FY 2021, 92% of students learned strategies to deal with managing inappropriate content and push back on toxicity. • In FY 2021, 84% of students said they would think about the impact of their interactions before they engage in social media.

FUNDED GRANTEES – SOCIAL/EMOTIONAL AND MENTAL HEALTH	
GRANTEE	IMPACT
<p>Project Safety Net and Health Care Alliance for Response to Adolescent Depression (HEARD)</p> <p>Engages with school districts and charter schools to assist them in their efforts to improve student mental well-being. Offers training, such as recognizing and referring students exhibiting concerning behavioral health issues, and materials such as tools/protocols.</p>	<ul style="list-style-type: none"> • 11 school districts. • Assisted school mental health professionals with the creation of new methods in the distance learning environment to identify and work with students who were struggling. • Districts educated staff, parents, and students about student mental health. • An evidence-supported postvention response protocol was implemented, including identification and support for at-risk students, support for grieving students, and prevention of contagion efforts among other ongoing efforts. • A pilot program for integrating social/emotional learning (SEL) into two districts was successfully launched. • Parents who participated in presentations about valuing SEL in schools showed a 70% increase in understanding.
<p>Stanford Center for Youth Mental Health and Wellbeing</p> <p>Delivers implementation assistance for the Allcove model across the state, which are places for youth to access a range of emotional, physical, and social support services; delivers community presentations addressing mental health stigma and suicide prevention; facilitates multiple youth advisory groups; and collaborates with organizations in both San Mateo County and Santa Clara County for Allcove development.</p>	<ul style="list-style-type: none"> • Collaborated with Santa Clara County Behavioral Health Services on implementation. • Coordinated monthly Youth Advisory Board meetings. • Contributed to development of the Community Consortium for SCC. • Opened the first center in the U.S. in 2021. • Distributed guidance documents to key stakeholders in designated communities. • Established learning community for pilot sites. • 15 events held during planning year. • Promoted mental health awareness through 18 presentations to public audiences.

Health Initiative 4: Improve the Health of Infants and New Mothers

FUNDED GRANTEES – MATERNAL HEALTH	
GRANTEE	IMPACT
<p>Roots Community Health Center, “Hey Sis, Let’s Chat” program</p> <p>This program serves African American women by providing videos related to maternal health. The program’s objectives are to increase the number of women who are inspired to take control of their own health and instill lifestyle changes that support positive birth outcomes, to increase the number of African American women who have expanded on their knowledge of key components of physical and mental health for maternal health, and to increase the number of women who can confidently identify their mental and emotional needs.</p>	<ul style="list-style-type: none"> • The proportion of participants who improved knowledge of foods with necessary nutrients for a healthy pregnancy increased from 54% to 90%. • The proportion of participants who improved understanding of how nutrients contribute to positive birth outcomes increased from 72% to 99%. • The proportion of participants who are confident in their ability to identify the signs of nutrient deficiencies increased from 54% to 90%. • 100% of participants are now able to recognize the physical, mental, and emotional effects of stress on their bodies and to make lifestyle changes that satisfy their emotional and mental health needs. • 100% of participants felt empowered to apply the information from the videos to their own diet and self-care routines.
<p>Teen Success</p> <p>The program provides education and support for teen parents. Teen pregnancy is both a symptom and a cause of poverty, and it creates significant barriers for both mothers and their children to prosper. Research shows that young mothers face numerous challenges to their successful completion of high school and postsecondary education, and that they are much more likely to maltreat their children.</p>	<ul style="list-style-type: none"> • At least 81% of parents made academic progress each year. • 75% of parents graduated from high school are enrolled in post-secondary education. • 85% of children are on track developmentally. • In FY 2020, 80% of children met linguistic milestones. • 75% of parents experienced decreased stress.
<p>Fresh Approach</p> <p>Jacob’s Heart</p> <p>Packard Food Program</p> <p>Stanford School of Medicine</p>	<p>Packard Children’s partnered with these four organizations to deliver more than 31,000 pounds of food to the community. Serving 6,800 families, the program provided 3,600 meal vouchers and 3,400 grocery bags.</p>

8. Conclusion

Lucile Packard Children's Hospital Stanford worked with local hospital and health system partners, pooling expertise and resources, to conduct the 2022 Community Health Needs Assessment. By gathering secondary data and conducting new primary research as a team, the partners were able to understand the community's perception of health needs as well as prioritize health needs with an understanding of how each compares against benchmarks. Packard Children's further prioritized health needs in its area based on a set of defined criteria.

The 2022 CHNA, which builds upon prior assessments dating to 1995, meets federal (IRS) and California state requirements.

Next steps for our hospital:

- Make the CHNA report, adopted by our hospital board on April 19, 2022, publicly available on our website by Aug. 31, 2022.⁶³
- Monitor community comments on the CHNA report (ongoing).
- Select priority health needs to address using a set of criteria.
- Develop strategies to address priority health needs.
- Strategies are adopted by our hospital board and filed with the IRS by Jan. 15, 2023.

9. List of Attachments

1. Secondary Data Indicators List
2. Secondary Data Tables
3. Community Leaders, Representatives, and Members Consulted
4. Qualitative Research Protocols
5. Community Assets and Resources, San Mateo County
6. Community Assets and Resources, Santa Clara County
7. IRS Checklist

⁶³ <https://www.stanfordchildrens.org/en/about/government-community/benefits-reports>

