Lucile Packard
Children's Hospital
at Stanford

2012-13 Community Health Needs Assessment

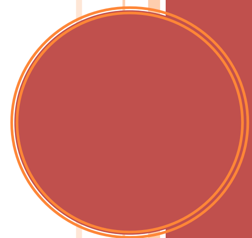

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TABLE OF CONTENTS

Acknowledgements 1
Acknowledgements, Continued 2
Executive Summary 1
Community Health Needs Assessment (CHNA) Background 1
Community Served 1
Process & Methods 2
Prioritized Needs 3
Conclusion 4
1. Introduction/Background 5
Purpose of CHNA Report and Affordable Care Act Requirements 5
SB 697 and California's History with Past Assessments 5
2. About Lucile Packard Children's Hospital at Stanford 6
Community Served 6
About Packard Children's Community Benefits 7
3. Process and Methods 9
Baseline Data Gathering 9
Qualitative Research (Community Input) 10
Information Gaps & Limitations 12
4. Identification and Prioritization of Community Health Needs 14
Identification of Community Health Needs 15
Summarized Descriptions of Prioritized Community Health Needs 15
Prioritization of Health Needs 19
5. Community Assets and Resources 20
Hospitals and community clinics 20
Community collaboratives, coalitions and committees 22
Major organizations that promote and fund health initiatives 22
6. Collaborative Partners and Consultants 23
Hospitals and Other Partner Organizations 23
Identity and Qualifications of Consultants 23
7. Conclusion 25
8. List of Appendices 26
Appendix 1: Secondary Data Sources 27
Appendix 2: IRS Checklist 32

Appendix 3: Persons Representing the Broad Interests of the Community 34
Appendix 4: List of Infant/Child/Adolescent/Maternity Indicators Gathered 40
Appendix 5: Cross-Cutting Drivers Mentioned During Primary Data Gathering 44
Appendix 6: 2013 Implementation Strategy 45
2013 Implementation Strategy 45
9. List of Attachments 53
Attachment 1: Health Need Profile, Access to Health care 53
Attachment 2: Health Need Profile, Asthma 53
Attachment 3: Health Need Profile, Birth Outcomes 53
Attachment 4: Health Need Profile, Mental Health 53
Attachment 5: Health Need Profile, Pediatric Obesity 53

EXECUTIVE SUMMARY

Lucile Packard Children's Hospital at Stanford conducted a community health needs assessment (CHNA) between September 2012 and January 2013. This assessment meets all of the new federal requirements of the Affordable Care Act (ACA), and was approved by Packard Children's Board of Directors on June 5, 2013. In accordance with federal requirements, this report is made widely available to the public on our website at www.lpch.org.

Community Health Needs Assessment (CHNA) Background

The Affordable Care Act, enacted by Congress on March 23, 2010, stipulates that non-profit hospital organizations complete a community health needs assessment every three years, by the last day of its first taxable year beginning after March 23, 2012. For Packard Children's, that tax year is September 2012 – August 2013. Packard Children's fulfilled this requirement by conducting the assessment between September 2012 - March 2013 and documenting it in May 2013.

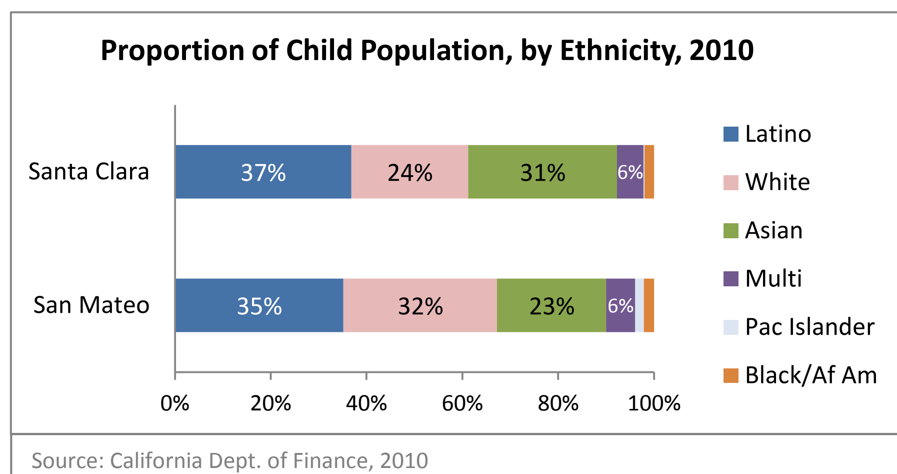
Per IRS requirements, Packard Children's CHNA included feedback from the community and experts in public health and clinical care and took into account the health needs of vulnerable populations, including minorities, those with chronic illness, low-income populations, and medically underserved populations.

The CHNA, and the resulting list of identified health needs, are to serve as the basis for future community benefit investments. The IRS requires that the hospital also adopt an implementation strategy for each of its facilities by the last day of the fiscal year (August 31, 2013.)

This report documents how the CHNA was conducted and describes the related findings.

Community Served

Packard Children's is located on the Stanford University campus in Palo Alto, California. Palo Alto is located on the northern end of Santa Clara County (SCC), bordering the San Mateo County (SMC) cities of East Palo Alto to the east and Menlo Park to the north. Because of our international reputation for outstanding care to babies, children, adolescents, and expectant mothers, Packard Children's serves patients and their families around the entire San Francisco Bay Area. However, with 89% of obstetrics patients and 52% of pediatric patients



Source: California Dept. of Finance, 2010

residing in San Mateo and Santa Clara counties, the primary community we serve can be defined as these two counties.

Our community is very diverse; more than a third of the child (age 0-18) population is Hispanic/Latino. As shown in the chart on Page 2, white children make up about another third of the SMC population, and a quarter of the SCC population. There is only a small proportion of black/African Americans in our service area (2%).

Process & Methods

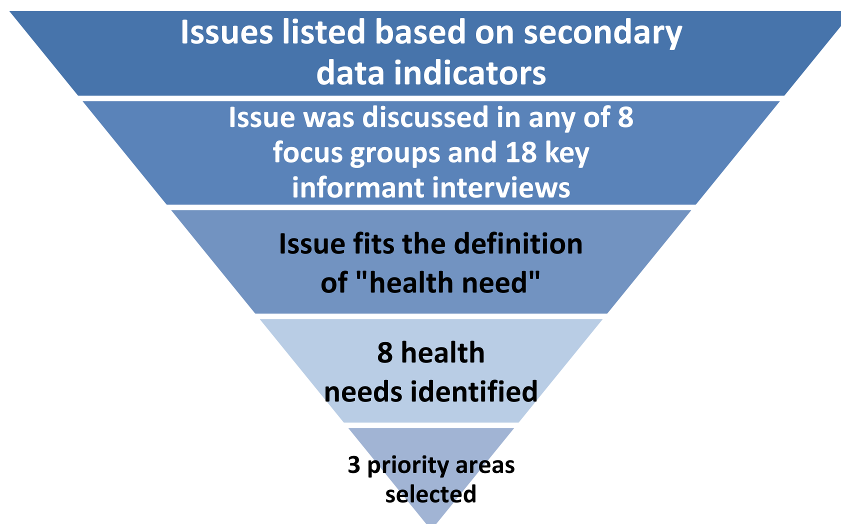
Packard Children's contracted with Applied Survey Research (ASR) to analyze baseline health indicator data, collect a range of community feedback, and to facilitate and document the CHNA process and its results.

In Fall 2012, Packard Children's commissioned the creation of a custom data compendium that focused on infants, children, adolescents, and pregnant mothers in SCC and SMC. ASR reviewed this compendium, along with thousands of other pieces of local community health data, in order to gain an understanding of local health needs as they compared with state averages and national targets. Secondary data were obtained from a variety of sources – see Appendix 1 for a complete list.

During the Fall of 2012 and Winter 2013, ASR conducted key informant interviews with local health experts, focus groups with community service providers, and separate focus groups with residents.

In March 2013, health needs were identified by synthesizing community input with secondary data described above, and then filtering the result against a set of criteria. The most pressing health needs were then prioritized by Packard Children's Community Advisory Council (CAC) using a second set of criteria.

The diagram below depicts the refining process that Packard Children's used to identify health needs.



Prioritized Needs

Packard Children's CAC reviewed the list of health needs and, in April 2013, prioritized them via a multiple-criteria scoring system. These needs are listed below in priority order, from highest to lowest.

Health Needs Identified by CHNA Process, in Order of Priority

1. **Poor mental health** in the community is evidenced by reports that more than one-fourth of youth in middle and high school reported that they felt sad or hopeless almost every day. Youth of color have higher rates of depression and suicidal thoughts. In 2008 and 2009 our community saw a rash of youth suicides. Community input indicates specific concerns about stress and depression. Known root causes of mental health disorders in children and youth include adverse childhood experiences such as being abused or neglected, or witnessing violence or substance abuse. Drivers of poor mental health include poor coping skills, lack of education about stress and depression, and lack of treatment/access to care.

2. **Obesity** rates among children and youth fail to meet Healthy People 2020 (HP2020) targets in both counties. Measures of risk for body composition indicate that 2-5 year-olds, 5th graders, and 9th graders are at risk for poor health outcomes. Even infant weight is increasing, with more than 10% of SMC newborns considered at high birth-weight. In all child and adolescent age groups, Hispanic/Latino children have some of the highest rates of obesity compared with other ethnicities. However, Pacific Islanders have the highest rates of overweight and obesity among fifth graders (e.g., 65% in SMC). Drivers of obesity are poor nutrition, lack of exercise, and physical environment such as low availability of fresh food and high prevalence of fast food.

3. **Violence and abuse** are health needs because the rate of youth homicide (7.4) in SCC is higher than the target of 5.5. In addition, the county has seen a large increase in homicides overall in the years 2011 and 2012. Domestic violence and child abuse rates for some ethnic subgroups also fail against targets in both counties. Drivers of this health need include poor mental health and social determinants of health such as poverty and unemployment.

4. **Diabetes** among children is of growing concern nationally and locally. The American Diabetes Association estimates that about 1 in every 400 American children and adolescents has diabetes. In SCC, 4% of adults surveyed reported that they had been diagnosed with diabetes between the ages of 0-10. Although county-level child/adolescent diabetes data are generally lacking, community leaders expressed great concern about young patients being diagnosed with diabetes or pre-diabetes, especially those who are overweight. Given high rates of children who are overweight or obese, the community wishes to be vigilant about this condition.

5. **Health care access and delivery** are cross-cutting drivers that impact nearly all health needs, from prevention to treatment. Health experts and community members alike expressed concern about various aspects of access, including having sufficient health care insurance, having adequate finances for copays and medicines, and having sufficient transportation to health care services. Health care workforce development issues are also a concern since a lack of primary care and specialty physicians impact a patient's access to care, and the scarcity of physicians who speak a language other than English make this more acute for non-English speakers. Access and delivery are driven by socioeconomic conditions (e.g., unemployment, poverty, linguistic isolation, and low levels of

education) and the availability of physicians who can serve these populations. Although our community has higher rates of insured children than the state, ethnic disparities exist when it comes to health care insurance and access to a medical home.

❻ **Substance abuse** was of high concern to the community and health professionals alike. Youth in our community have higher rates of binge drinking (12%-13% of 11th graders) compared with the target (9%). Youth marijuana use is also high. For example, 40% of SMC 11th graders reported that they had tried marijuana. Community input from teens indicates that they generally have easy access to both legal and illegal drugs. Drivers of substance abuse include poor coping skills, poor mental health, lack of education about addiction, and lack of both treatment resources and access to care.

❼ **Asthma** prevalence in SMC is higher than the state average (18% compared with 14%). Also, the asthma hospitalization rate of SCC children ages 0-4 is 24.5 per 10,000, which is higher than the target of 18.1. The health need is likely being impacted by smoking as well as poor air quality levels. Community input demonstrated a concern about the costs of asthma treatment due to lack of medical insurance, and mentioned additional environmental factors such as mold and overcrowded housing.

❽ **Infant/birth outcomes** are of concern based on the high percentage of babies born to mothers at advanced maternal age in our community (about 26% of all births), which increases the risk for poor birth outcomes. Although the proportion of low birth-weight babies meets the target of 8%, black/African American babies fare worse than babies of other ethnicities by every known measure of infant health, including infant mortality. A driver of this health need is inadequate early prenatal care.

Conclusion

Packard Children's conducted a thorough community health needs assessment in Santa Clara and San Mateo Counties and took into consideration existing health indicator data, community (resident) input, and input from professionals, including public health and clinical health experts.

Primary research with health experts and professionals mirrored the secondary data, but gave a much richer picture of the drivers of various health conditions, especially as they pertained to health care access and delivery issues. Community residents also made the connection between physical environment, cultural norms, messages from the media, and health behaviors that impact their mental and physical health.

A synthesis of the quantitative and qualitative data resulted in a list of eight of the most pressing health needs in our community. Packard Children's Community Advisory Council (CAC) was then able to rank those needs and select priorities for upcoming community benefit investment.

Packard Children's investments from September 2013-August 2016 will be based on the identified health priorities of: **Pediatric Obesity, Mental Health,** and **Access to Care.**

1. INTRODUCTION/BACKGROUND

Purpose of CHNA Report and Affordable Care Act Requirements

Enacted on March 23, 2010, federal requirements included in the Affordable Care Act (ACA) stipulate that hospital organizations under 501(c)(3) status must adhere to new regulations, one of which is conducting a community health needs assessment (CHNA) every three years. The CHNA report must document how the assessment was done, including 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.

As part of the tri-annual CHNA assessment, hospitals must:

- Collect and take into account input from public health experts as well as community leaders and representatives of high-need populations including: minority groups, low-income individuals, medically underserved populations and those with chronic conditions.
- Identify and prioritize community health needs.
- Document a separate CHNA for each individual hospital.
- Make the CHNA report widely available to the public.
- Adopt an Implementation Strategy to address selected health needs identified through the CHNA.
- Submit the Implementation Strategy with the IRS Form 990.
- Pay a $50,000 excise tax for failure to meet CHNA requirements for any taxable year.

> A **health condition** is a disease, impairment, or other state of physical or mental health that contributes to a poor health outcome, e.g., asthma.
>
> A **health outcome** is a result of health conditions in a community that can be described in terms of both morbidity (quality of life) and mortality (death rates), e.g., hospitalizations or deaths due to asthma.

SB 697 and California's History with Past Assessments

Compared to SB 697, which is the California-specific legislation requiring a community health needs assessment, the ACA regulations are more stringent on how to conduct and document the needs assessment. A comparison is shown in the table below.

Comparison of ACA and SB 697 CHNA Requirements

Activity or Requirement	Required by ACA	Required by SB 697
Conduct community health needs assessment at least once every 3 years	Yes	Yes
CHNA identifies and prioritizes community health needs	Yes	Yes
Input from specific groups/individuals are gathered	Yes	No
CHNA findings are made widely available to the public	Yes	No
Implementation strategy is adopted to meet selected needs	Yes	Yes
File an Implementation Plan with IRS	Yes	No (OSHPD)
$50,000 excise tax for failure to meet CHNA requirements	Yes	No

Lucile Packard Children's Hospital at Stanford plans to align these two report requirements starting with the Community Health Needs Assessment conducted in 2012-13.

2. ABOUT LUCILE PACKARD CHILDREN'S HOSPITAL AT STANFORD

Community Served

Packard Children's is a world-class, non-profit hospital devoted entirely to the care of babies, children, adolescents, and expectant mothers. The hospital is located on the Stanford University campus in Palo Alto, California. Palo Alto is located on the northern end of Santa Clara County (SCC), bordering San Mateo County (SMC) cities of East Palo Alto to the east and Menlo Park to the north. In addition to our main facility in Palo Alto, Packard Children's also operates licensed beds in satellite units at three local area hospitals: a special-care nursery at Washington Hospital in Fremont (9 beds), a special-care nursery at Sequoia Hospital in Redwood City (6 beds), and adolescent and general pediatrics inpatient units at El Camino Hospital in Mountain View (30 beds).

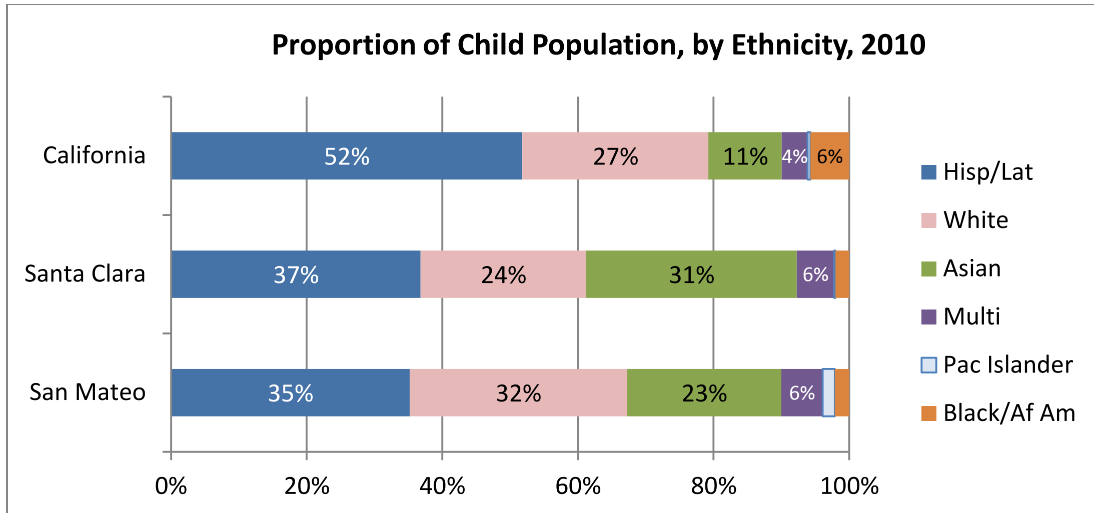
Because of our international reputation for outstanding care to babies, children, adolescents, and expectant mothers, we serve patients and their families around the entire San Francisco Bay Area. In the 10-county Northern California area, Packard Children's ranks third for pediatrics, with 11% market share, and sixth for obstetrics, with 4% market share (OSHPD 2011).

However, since our 2012 discharge data shows that over half (52%) of Packard Children's inpatient pediatric cases (excluding normal newborns) and 89% of obstetrics cases came from SCC and SMC, the primary community we serve can be defined as SCC and SMC. Packard Children's ranks first in market share (26%) for pediatrics and fourth for obstetrics (12%) in our primary service area.

Demographic Profile of Community Served

Packard Children's service area is very diverse and is becoming increasingly so over time. More than a third of the community is foreign-born (SCC: 37%, SMC: 34%). Of the overall child (age 0-18) population, Hispanic/Latinos make up the largest ethnic group, with 35% in SMC and 37% in SCC. Proportionally, there is a larger population of Hispanic/Latino children in Packard Children's service area than in the state overall, and fewer blacks/African Americans (2% compared with 6% statewide). SMC is unique in that it has a larger proportion of Pacific Islander children (2%) and multi-ethnic children (6%) than in SCC or the state. The majority of the local and state multi-ethnic population (including adults) are those who are both white and Asian.

The 2012 federal poverty guideline is defined as an annual income of $23,050 for a family of four. Based on this figure, the latest data available show the percentage of children 0-18 living in poverty in SCC at 10% and in SMC at 9%. However, the federal poverty guidelines used to compile these numbers do not reflect the actual cost of living in these two counties, so the percentages would be higher if this were to be taken into consideration.



Source: California Dept. of Finance, 2010; cited by Lucile Packard Community Benefits Report 2012.
Note: American Indian population was less than 1% of children in all geographies represented.

A better measure for the Bay Area is the Self-Sufficiency Standard for California, calculated by the Insight Center of Community Economic Development (2011). The self-sufficiency standard measures how much income is needed, by county, for a family to adequately meet its minimal basic needs: housing, food, child care, out-of-pocket medical expenses, transportation and other necessities. For example, a family of two adults and two school-aged children requires an income of $69,526 in SMC and $70,129 in SCC. According to the United Way of the Bay Area (2009), 22% of families in both counties fall below the self-sufficiency standard.

Another indicator of poverty is the percentage of public school children eligible to receive free or reduced-price lunch. In 2010, 38% in SCC and 37% in SMC qualified for free or reduced-price lunch.

About Packard Children's Community Benefits

A community benefit investment is a service, program, or project provided or funded by the hospital, which either directly or indirectly fulfills an ongoing need or service delivery gap that has been identified through the hospital's needs assessment processes. The primary purpose of a community benefit investment is to improve the health status of the community in general or the health status of a group of community members for whom disparities exist. Services that benefit only a single patient or a group of patients in the hospital are generally not considered community benefit, with a few exceptions discussed below.

Community benefit categories:

Benefits for economically disadvantaged populations: These services and programs target at-risk or underserved populations that have been identified through the needs assessment process. They include inpatient and outpatient medical services to patients that are partially reimbursed by means-tested government programs and to patients who qualify for charity care.

Benefits for the broader community: These services and programs are designed to maintain or improve the health of the community-at-large or specific populations that do not necessarily meet the definition of "economically disadvantaged." This category includes community health education programs, child safety programs, referral programs, advocacy, regional perinatal networks, and other programs that contribute to the community's health knowledge.

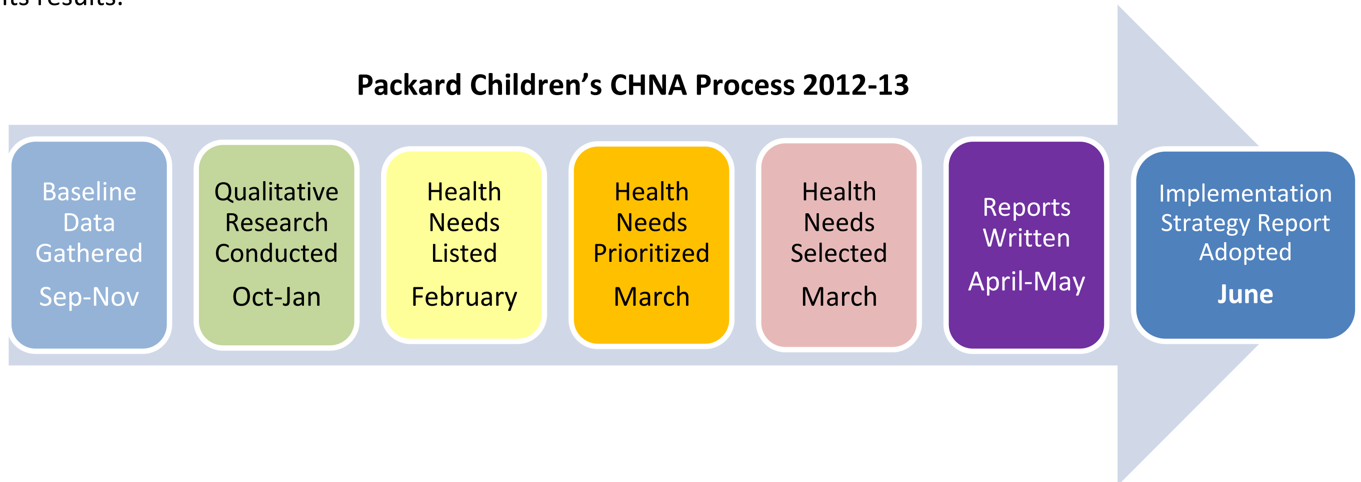
Health research, education, and training programs: These services and programs contribute to the supply of health professionals in the community and the body of medical knowledge. This category includes the direct financial support that Packard Children's contributes to the research and teaching programs of Stanford University, internship and clinical experience programs for nurses and allied health-care professionals, and support for research and projects addressing community health issues.

In sum, Packard Children's community benefit investments include:

- Undercompensated costs of medical services to government-sponsored patients
- Charity care
- Subsidized health services
- Education of health professionals
- Health improvement services in the community, including health education
- Financial and in-kind contributions to community-based organizations
- Community-building activities

3. PROCESS AND METHODS

The CHNA process took place over seven months, and culminated in this report in May 2013. Packard Children's contracted with Applied Survey Research (ASR) to analyze baseline health indicator data, collect professional and resident community input, and facilitate and document the CHNA process and its results.



Baseline Data Gathering

Packard Children's contracted with Resource Development Associates (RDA) to create a compendium of secondary **data indicators** related to infants, children, adolescents, and pregnant mothers. Packard Children's made available to RDA a selection of recent and comprehensive public health reports and demographic data.

RDA used the following **questions** to frame the report:

- What health areas offer the most current and consistent data?
- What are the most salient/meaningful indicators?
- How do these indicators perform against Healthy People 2020 targets or state/national averages?
- What health disparities are seen among different populations?
- Are there opportunities to positively impact outcomes to improve the health and quality of life for residents?

A **health data indicator** is a characteristic of an individual, population, or environment which is subject to measurement and can be used to describe one or more aspects of the health of an individual or population, e.g., the rate of children 0-5 hospitalized for asthma in 2010 is a health indicator.

ASR reviewed and synthesized this Packard Children's compendium with other **secondary data sources** that were contributed by, or prepared on behalf of, collaborative partners in SCC and SMC, including:

- CARES online data platform (contributed by Kaiser Permanente)
- 2013 Community Health Needs Assessment; Health and Quality of Life in San Mateo County (Healthy Community Collaborative of San Mateo County)
- San Mateo County Health & Quality of Life Study (Professional Research Consultants, Inc., 2013)
- Santa Clara County CHNA compendium report (RDA, 2012)

Please see Appendix 1 for a list of all data sources utilized.

Qualitative Research (Community Input)

Packard Children's contracted with Applied Survey Research (ASR) to collect community input via primary qualitative research in SCC and SMC. This research focused on our target population of babies, children, adolescents, and expectant mothers. ASR used three strategies for collecting community input: key informant interviews with health experts, focus groups with community service providers, and focus groups with county residents.

Each group and interview was recorded and summarized as a stand-alone piece of data. When all groups had been conducted, the team used qualitative research software tools to analyze the information and tabulate all health conditions that were mentioned, along with health drivers discussed. ASR then analyzed the list of conditions that had been mentioned in multiple focus groups and key informant interviews, with special attention to those that had been listed by a focus group as a top need.

Input from Health Experts and Community Service Providers Overall

In all, ASR consulted with almost 100 professionals who represented various organizations and sectors in our service area. These representatives either work in the health field or improve health conditions by serving those from the target populations.

The health experts and community service providers who were consulted came from the following types of organizations:

- Public health departments
- County health & hospital systems
- Private hospital systems
- Health insurance providers
- Mental/behavioral health or violence prevention providers
- School system representatives
- Community center representatives
- Non-profit agencies providing basic needs
- Other non-profit agencies serving children and families

See Appendix 3 for the names, titles, and expertise of these professionals along with the date and mode of consultation (focus group or key informant interview).

Key Informant Interviews

ASR conducted interviews with five experts in child, adolescent, or maternal health on behalf of Packard Children's. Packard Children's CHNA was also informed by an additional 13 key informant interviews conducted on behalf of the Santa Clara County Community Benefit Coalition (of which Packard Children's is a member) and Kaiser Permanente San Mateo Area (a collaborative partner of the Hospital Consortium of San Mateo County). These experts included public health officers, community clinic

managers, and clinicians who have countywide experience and expertise. The experts are named in Appendix 3.

Health experts were interviewed by telephone for approximately one hour. Informants were asked to discuss in detail one of the areas of focus for the CHNA: quality of life (morbidity), mortality, and health drivers of delivery, access to care, socio-economic factors, health behaviors, and the environment.

Community Service Provider Focus Groups

Four focus groups with community service providers were conducted for Packard Children's in November 2012 and January 2013. The discussion centered around four questions:

1. How healthy is our community (on a scale of 1-5)?
2. What are the health needs (conditions) that you see in the community?
3. What are the most pressing health needs on this list? (three selected)
4. What are the drivers of these prioritized conditions?

Health Needs and Drivers

A **health need** is a poor health outcome and its associated health drivers, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need, e.g., asthma.

A **health driver** is a behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health, e.g., poor air quality is a health driver related to asthma.

Groups were encouraged to discuss drivers from multiple domains: health access, health delivery, socio-economic factors, environmental factors, and health behaviors.

Details of Community Service Provider Focus Groups

Focus	Date	Number of Participants
1. Child-Serving Organizations (SCC)	11/9/2012	8
2. Youth Organizations (SCC)	11/9/2012	4
3. Child-Serving Organizations (SMC)	1/24/2013	4
4. Youth Organizations (SMC)	1/24/2013	7

An additional 11 focus groups with professionals, using the same four discussion questions, were conducted on behalf of Packard Children's collaborative partners (the SCC Coalition and SMC Consortium) and these groups also informed Packard Children's CHNA, especially since many included discussions about drivers of all health conditions, such as health education and access to care. Appendix 3 includes the names and credentials of the professionals who attended.

Resident Input

Resident focus groups were conducted in October and November 2012. The discussion centered around the same four questions listed above, which were modified appropriately for the audience.

In order to provide a voice to the community we serve in SCC and SMC, Packard Children's targeted participants who were medically underserved, in poverty, socially or linguistically isolated, or those who had chronic conditions. Four focus groups were held with community members; one of the groups was conducted in Spanish.

Resident Focus Groups

Population Focus	Location	Date	Number of Participants
1. Young Children (SCC)	Mayview Community Center (Sunnyvale)	10/23/2012	6
2. Young Children (SMC, Spanish)	Hoover Elementary School (San Mateo)	11/27/2012	13
3. Youth (SCC)	Fresh Lifelines for Youth (Milpitas)	10/22/2012	9
4. Youth (SMC)	Terra Nova High School (Pacifica)	10/18/2012	9

Resident Participant Demographics

Thirty-seven community members participated in the Packard Children's resident focus group discussions across SCC and SMC. We received thirty-three anonymous demographic surveys, the results of which are described below.

- Community residents lived in ten cities within SCC and SMC, with the largest number coming from Redwood City (8).
- Three-quarters of participants (76%) were Hispanic/Latino.
- About half (15) of the residents were under 20 years old, seven were in their twenties, and seven were between 30-49 years old. Adult respondents spoke to the health needs of infants, children, teens, and expectant women in their families and communities.
- The majority of participants (65%) had benefits through Medi-Cal, Medicare or another public health insurance program. (Health insurance information is missing for 10 of the participants.)
- Almost all households were comprised of multiple adults over age 25 and at least one child under 18.
- Of those who answered the question regarding annual household income, all but one reported incomes of under $45,000 per year. The vast majority (71%) earned under $25,000 per year, which is near the federal poverty guideline for a family of four, and well below the California Self-Sufficiency Standard for two adults with two school-age children ($69,828 on average in SCC and SMC). This demonstrates a high level of need among participants in an area where the cost of living is extremely high compared to other areas of California.

Information Gaps & Limitations

ASR and Packard Children's were limited in our ability to assess some of the identified community health needs due to a lack of secondary data. Such limitations included data on oral/dental health, substance abuse (particularly, use of illegal drugs), and mental health. More specific limitations included lack of county data on LGBTQ youth mental health, diabetes among children, and lack of extended data on breastfeeding once mothers have left the hospital.

There were also limitations on how we were able to understand the needs of special populations, including LGBTQ, undocumented immigrants, and blacks/African Americans. Due to the small numbers and/or, for some of these populations, the likely undercount of these community members, many data are statistically unstable and do not lend themselves to predictability.

4. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY HEALTH NEEDS

The diagram below displays the process that ASR and Packard Children's used to identify the community's health needs:

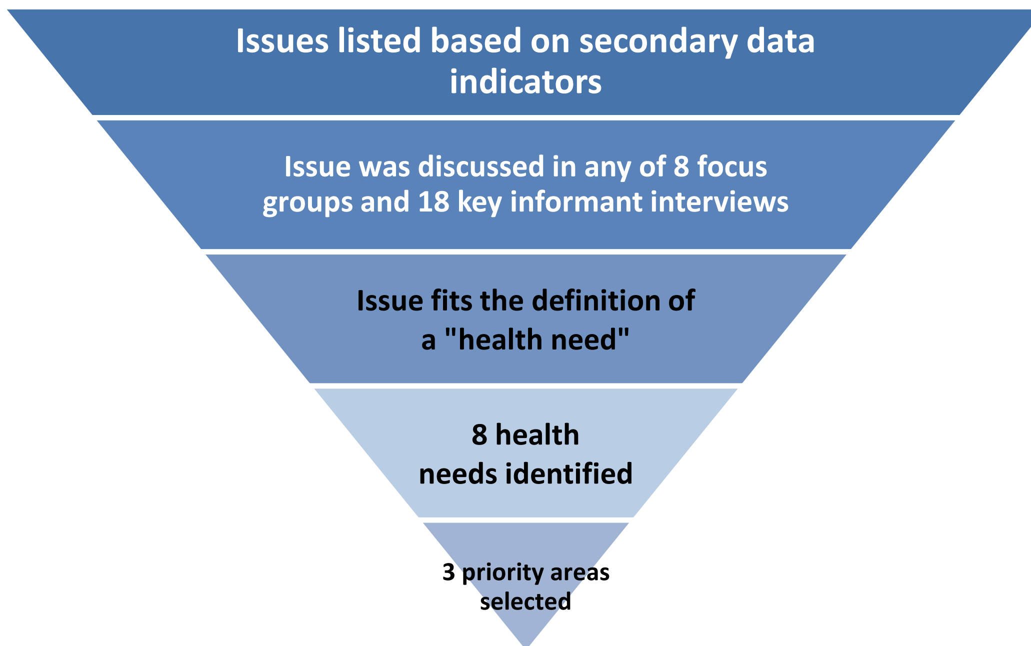
1. Gathered secondary health data. (See Section 3 and Appendices 1 and 4 for a list of sources and indicators on which data were gathered.)

2. Gathered primary, qualitative data. (See Section 3 and Appendix 3 for a list of the sources from which the data were gathered.)

3. Narrowed the list to "health needs" by applying criteria (described on next page).

4. Used criteria to prioritize the health needs.

These steps are further defined below.



Identification of Community Health Needs

As described in Section 3, a wide variety of experts and community members were consulted about the health of the community.

Collectively, residents and professionals identified a diverse set of health conditions and demonstrated a clear understanding of the health behaviors and other drivers (environmental and clinical) that affect health outcomes. They spoke about prevention, access to care, clinical practices that work and do not work, and their overall perception of the community's health. Community members were frank and forthcoming about their personal experiences with health challenges and their perceptions about the needs of their families and community.

Cross-cutting drivers that frequently arose during primary data collection are listed in Appendix 5.

In order to generate a list of health needs, ASR used a spreadsheet (known as the "data culling tool") to list indicator data and evaluate whether they were "health needs." In order to be categorized as a health need, all three of the following criteria needed to be met:

1. The issue must fit the definition of a "health need:" a poor health outcome and its associated health drivers, or a health driver associated with a poor health outcome, where the outcome itself has not yet arisen as a need.
2. The issue is suggested or confirmed by more than one source of secondary and/or primary data.
3. At least one related indicator performs poorly compared with HP2020 targets or state averages.

Eight health conditions or drivers fit all three criteria and were retained as community health needs. The list of needs, in alphabetical order, is found below.

Summarized Descriptions of Prioritized Community Health Needs

"Targets" referenced below refer to Healthy People 2020 targets. Examples of indicators are shown as bullet points below each summarized description. Data sources identified by number in superscript can be found in Appendix 1.

❶ **Access and delivery of health care** are cross-cutting drivers that impact nearly all health needs, from prevention to treatment. Health experts and community members alike expressed concern about various aspects of access, including having sufficient health care insurance, having a medical home or primary care physician, having adequate finances for copays and medicines, and having sufficient transportation to health care services. Aspects of delivery issues include care in a patient's native language and the ability to get appointments in a timely manner. The lack of primary care and specialty physicians are reported to have an impact on a patient's access to care. Access and delivery are driven by socioeconomic conditions such as poverty and low levels of education.

- SCC linguistically isolated population:[146] 22%| CA: 20%
- SMC Healthy Kids enrollees distance to primary care provider: [158] 65% of enrollees live more than 15 minutes from their usual source of care

❷ **Asthma** is a health need as marked by high asthma hospitalization rates of children ages 0-4 in SCC, and the prevalence of asthma in the children of SMC. The health need is likely being impacted by health behaviors such smoking, as well as poor air quality levels and mold in the home. Community input indicates that the health need is also affected by concerns about the costs and availability of treatment (including prescription medication and equipment) due to underinsurance or lack of insurance.

- SCC asthma hospitalization rate per 10,000 children ages 0-4:[20] 24.5 | Target: 18.1
- SMC child asthma prevalence:[20] 18% | CA: 14%

❸ **Infant/birth outcomes** are of concern based on the high percentage of babies born to mothers of advanced maternal age (35 years and older), which increases the chances for poor birth outcomes, including genetic disorders. Overall, the proportion of low birth-weight babies is not particularly high, but ethnic disparities exist. Black/African American babies fare worse than babies of other ethnicities as measured by every infant health indicator, including infant mortality. The health need is likely being impacted by certain social determinants of health, and by a lack of early prenatal care. The majority of pregnant mothers in our service area receive prenatal care, but smaller proportions of American Indian and black/African American women receive early prenatal care compared with other ethnic groups. Community feedback indicates concerns about the cost of care, and poor access to primary care providers and specialists due to lack of insurance. In addition, community input suggested that limited prenatal visits may be driven by lack of knowledge of the importance of prenatal care, language barriers, and cultural issues such as body modesty.

- SCC & SMC births to mothers of advanced maternal age: [28] 26%| CA: 18%
- SMC low birth-weight babies:[28] Overall: 6.9% | SMC African Americans: 18.4% | Target: 7.8%
- SCC infant mortality rate per 1,000 live births:[25] Overall: 2.8 | African Americans, 6.9| Target: 6.0

❹ **Diabetes** among children is of growing concern nationally and locally. The American Diabetes Association estimates that about 1 in every 400 American children and adolescents has diabetes. Although county-level child/adolescent diabetes data are generally lacking, community leaders expressed great concern about young patients being diagnosed with diabetes or pre-diabetes, especially those who are overweight. Given high rates of children who are overweight or obese, the community wishes to be vigilant about this condition. Community input about diabetes was strong, and expressed the connection between the disease and related health behaviors such as poor diet and lack of physical activity. The health need is also likely being impacted by physical environment such as the proximity and profusion of fast food establishments, and a relative lack of fresh grocers and WIC-Authorized food sources.

- SCC child diabetes prevalence:[126] 4% (adults reporting having been diagnosed at age 0-10)

❺ **Poor mental health** was among the top concerns of the community. Over one-fourth of youth in middle and high school experience depression, and youth of color report being depressed at higher proportions than white youth.[36] Known root causes of mental health disorders in children and youth include adverse childhood experiences such as being abused or neglected, or witnessing violence or substance abuse. Youth in focus groups talked about stress and depression driven by family economic concerns and the pressure to perform academically. Also, the lack of education about how to cope with stress, stigma about mental illness, and poor access to mental health care contributes to this need. Related to poor mental health are the health needs around violence and substance abuse.

- Youth who reported feeling sad or hopeless almost every day.[36] Asian: 26%, Pacific Islander: 33-34%, Hispanic/Latino: 31%, African-American: 27-30%, American Indian: 25-26%, White: 24%
- In 2009 there were a record 10 suicides of youth 0-19 in SCC followed by only two in 2010.[26]
  Note that the 2000-2010 average is fewer than 8 suicides among youth 0-19 across both counties. Suicide rates (especially by gender or ethnicity) are difficult to rely upon because of this small number.

❻ **Obesity** rates for children and youth fail against HP2020 targets.[94] High rates of overweight and obese children are seen as early as two years of age. Even infant weight is increasing, with over 10% of SMC newborns considered at high birthweight.[42] Hispanic/Latino children of all ages have the highest rates of overweight and obesity,[15,42,94] and there is concern in the community about Pacific Islander and Filipino overweight and obese youth. The health need is likely being impacted by health behaviors such as low fruit and vegetable consumption, high soda consumption, the proximity and profusion of fast food establishments, and a relative lack of grocery stores and WIC-Authorized food sources.

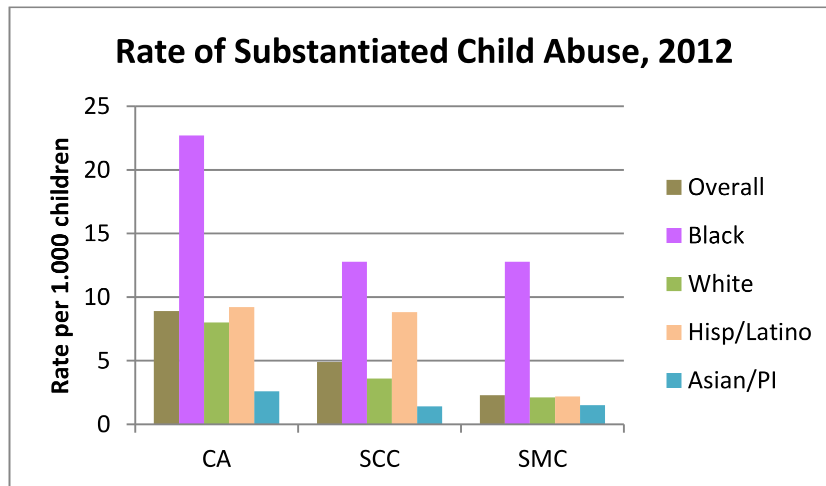
- In SCC, 18% of low-income 2-5 year-olds are in the 95th percentile for weight based on age/height.[42]
- 5th graders "at risk" for obesity based on BMI for their age/gender: Nearly 30% (SCC and SMC)[15]
- 9th graders "at risk" for obesity based on BMI for their age/gender: 22% (SCC) and 25% (SMC)[15]

❼ **Substance abuse** is a health need as marked by relatively high levels of binge drinking among youth. Youth marijuana use is also high compared to the state, especially for Hispanic/Latino and Black/African American youth.[36] Community feedback indicates that the health need is impacted by stress and poor coping skills across all populations, concerns about the cost of treatment, avoidance of treatment due to fear of being stigmatized, and poor access to primary care providers, specialists, and other support options due to lack of insurance or underinsurance. In addition, community input suggested greater concern for adolescents developing alcohol or drug dependency, which is driven by peer pressure, curiosity, media portrayals, accessibility of substances (including tobacco), and parental permissiveness.

- SCC & SMC binge drinking:[36] 12%-13% of 11th graders | Target: 9% of youth age 12-17
- SMC: 40% of 11th graders reported that they had tried marijuana[36]

❽ **Violence and abuse** have direct and indirect impacts on physical and mental health. Youth are often the victims of violence, including homicide.[128] SCC has seen a record number of homicides in the years 2011 and 2012.[113] More than one in four middle and high school students report having been physically bullied in SCC.[36] Disparities are seen in rates of domestic violence and child abuse among ethnic groups in both counties.[(35,140)] The health need is likely being impacted by health behaviors such as binge drinking and gang membership. Community input indicates that the health need is also affected by the lack of (affordable) activities for youth, economic stress, lack of policy enforcement, poor family models, and unaddressed mental and behavioral health issues among perpetrators. Residents also suggested that violence is underreported by victims, possibly due to stigma and/or cultural norms.

- Youth homicide rate:[33] SCC: 7.4| CA: 1.8 | Target: 5.5 (for all ages)
- SCC physical bullying: [36] 28% of middle/high school students
- Gang identification highest among African-American, Native American, and Hispanic/Latino youth[36]
- SMC 2012 substantiated child abuse allegations rate per 1,000 children: [140]
  Overall: 2.3 | Black: 12.8 |CA overall: 8.9 | CA Black: 22.7



Please consult the Health Needs Profiles (Attachments 1-5) for more information about access to care, asthma, birth outcomes, mental health, and pediatric obesity.

Prioritization of Health Needs

Before beginning the prioritization process, Packard Children's chose the following set of criteria:

1. Issue is getting worse over time and/or not improving
2. A successful solution to the issue has the potential to solve multiple problems
3. Opportunity to intervene at the prevention level
4. Community prioritizes the issue over other issues (determined by ASR's primary data collection)

How Criteria 1-3 were scored: The score levels for the prioritization criteria were:

1: Does not meet criteria, or is not of concern	2: Meets criteria, or is of some concern	3: Strongly meets criteria or is of great concern

Packard Children's Community Advisory Committee (CAC) rated the eight health needs using the first three criteria via an electronic survey. CAC members' ratings were combined and averaged by ASR to obtain a combined CAC score for each criterion.

How Criteria 4 was scored: ASR assigned community prioritization scores based on the results of the primary data gathering process. The score levels for the fourth prioritization criterion were:

1: Health need was mentioned by at least one key informant or focus group, but not prioritized by any	2: Health need was prioritized by half or fewer of key informants and focus groups	3: Health need was prioritized by more than half of the key informants and focus groups

Combining the Scores: ASR calculated the mean of the four criterion scores, resulting in an overall prioritization score for each health need.

Packard Children's Community Health Needs by Prioritization Score

Health need/condition	Overall average score	CAC Prioritization Criteria and Scores			Community Priority Score Based on Primary Data
		No Positive Trend	Multiplier Effect	Prevention/ Intervention Opportunity	
Mental health	**2.6**	2.1	2.8	2.6	3.0
Obesity, including poor nutrition	**2.6**	2.0	2.8	2.6	3.0
Violence/abuse	**2.4**	2.4	2.8	2.5	2.0
Diabetes, including poor nutrition	**2.4**	2.5	2.5	2.5	2.0
Access/delivery	**2.2**	1.7	2.6	2.4	2.0
Substance abuse	**2.1**	1.8	2.6	2.1	2.0
Asthma	**2.1**	2.0	1.8	2.7	2.0
Prenatal/birth/infant care	**2.0**	1.2	2.6	2.4	2.0

5. Community Assets and Resources

Hospitals and community clinics

SMC Hospitals:

- Kaiser Foundation Hospital – Daly City
- Kaiser Foundation Hospital – Redwood City
- Kaiser Foundation Hospital – San Mateo
- Kaiser Foundation Hospital – South San Francisco
- Kaiser Permanente Regional Cancer Treatment Center
- Mills Peninsula Hospital
- San Mateo County Medical Center
- Sequoia Hospital
- Seton Hospital

SCC Hospitals and Hospital Programs:

- Kaiser Foundation Hospital – Santa Clara
- Kaiser Foundation Hospital – San Jose
- Lucile Packard Children's Hospital at Stanford
- O'Connor Hospital
- Santa Clara Valley Health & Hospital System
- Stanford Hospital & Clinics

SMC Community Clinics by City:

Daly City:

- Clinic by the Bay
- Daly City Youth Health Center
- RotaCare Free Clinic

Menlo Park:

- Ravenswood Belle Haven Clinics
- San Mateo Medical Center Methadone Clinic
- Willow Clinic

Redwood City:

- Fair Oaks Children's Clinic
- Fair Oaks Clinic
- Planned Parenthood Mar Monte
- Samaritan House
- Sequoia Teen Wellness Center
- South County Mental Health

SCC Community Clinics by City:

Central San Jose:

- Asian Americans for Community Involvement
- Franklin McKinley Neighborhood Health Clinic
- Gardner Health Center (Virginia)
- Gardner Health Center (E. Santa Clara)
- Indian Health Center (Meridian)
- Planned Parenthood Mar Monte (The Alameda)
- Planned Parenthood Mar Monte (Washington School)
- RotaCare Bay Area
- San Jose High Neighborhood Health Clinic
- St. James Health Center
- Washington Neighborhood Health Clinic

Continued on next page…

SMC Community Clinics by City (continued):

San Mateo**:**

- Edison Clinic
- Mobile Health Clinic
- Planned Parenthood Mar Monte
- Samaritan House

Other:

- Mobile Dental Van
- Ravenswood Family Health Center and Dental Clinics, a.k.a. South County Health Center (East Palo Alto)
- RotaCare Coastside Clinic (Half Moon Bay)
- South San Francisco Clinic (South San Francisco)

SCC Community Clinics by City (continued):

East San Jose:

- CompreCare Health Center (Alum Rock)
- Foothill Community Health Center (Story)
- Foothill Health Center (Montpelier)
- Independence High School Pediatric Clinic
- Indian Health Center (Silver Creek)
- Lundy Clinic (Berryessa)
- Mar Monte Community Clinic (Alvin)
- Mount Pleasant High School Pediatric Clinic
- Pacific Free Clinic (Overfelt High School)
- Planned Parenthood Mar Monte (Alum Rock)
- Yerba Buena High School Pediatric Clinic

Other San Jose:

- Asian Americans for Community Involvement (Moorpark)
- Indian Health Center at O'Connor Hospital
- Planned Parenthood Mar Monte (Blossom Hill)
- Valley Connection (South Bascom)

Gilroy:

- Gardner Health Center
- Gilroy Neighborhood Health Clinic
- Planned Parenthood Mar Monte
- RotaCare Bay Area

Sunnyvale:

- Mayview-Columbia Neighborhood Center
- Planned Parenthood Mar Monte

Mountain View:

- Mayview Community Health Center
- Planned Parenthood Mar Monte at El Camino Hospital
- RotaCare Bay Area

Other:

- Alviso Health Center (Alviso)
- Mayview Community Health Center (Palo Alto)
- Planned Parenthood Mar Monte (Los Altos)

Community collaboratives, coalitions and committees

Silicon Valley has a unique climate when it comes to collaboration. SCC and SMC are both known for their strength and inclusive nature. Packard Children's participates in a number of collaboratives and coalitions in each county, as listed below. Additional collaboratives can be found across both counties, including those that focus on specific health outcomes (such as various obesity collaboratives) and others that focus on overall health and wellness (such as Kids in Common.)

San Mateo County

- BANPAC (Bay Area Nutrition and Physical Activity Collaborative)
- Get Healthy San Mateo County Task Force
- HEARD (Health Care Alliance for Response to Adolescent Depression)
- Hospital Consortium of San Mateo County
- Project Safety Net
- Ravenswood Family Health Center board of directors
- SafeKids Coalition of Santa Clara and San Mateo Counties
- San Mateo County Children's Health Initiative, Oversight Committee
- San Mateo County Healthy Communities Collaborative
- Youth Health Literacy Collaborative

Santa Clara County

- BANPAC (Bay Area Nutrition and Physical Activity Collaborative)
- Palo Alto Unified School District Health Council
- Project Cornerstone Advisory Council
- Putting Healthcare Back into the Schools Initiative
- SafeKids Coalition of Santa Clara and San Mateo Counties
- Santa Clara County Children's Agenda 2015 Vision Council
- Santa Clara County Community Benefits Coalition
- Santa Clara County Health Plan
- Santa Clara County Office of Education's Coordinated School Health Advisory Council
- Silicon Valley Youth Health Literacy Collaborative
- Somos Mayfair Wellness Initiative
- Sunnyvale Collaborative

Major organizations that promote and fund health initiatives

- San Mateo County Health Services Agency
- San Mateo County Human Services Agency
- San Mateo Health & Hospital System
- San Mateo Health System
- San Mateo Public Health Department
- Santa Clara County Health & Hospital System
- Santa Clara County Public Health Department
- Santa Clara County Social Services Agency
- The Health Trust (SMC and SCC)

6. COLLABORATIVE PARTNERS AND CONSULTANTS

Hospitals and Other Partner Organizations

Packard Children's worked collaboratively with two groups that serve the broad community in our service area. In SCC, we are a member of the Santa Clara County Community Benefit Coalition ("the SCC Coalition"), a group of six local non-profit hospitals, public health experts, and other partners, who have been working together to address health needs in the South Bay for several years. Packard Children's also sits on the Hospital Consortium of San Mateo County ("the SMC Consortium"), which also includes health and hospital system representatives and SMC's public health officer. *For a complete list of participating partners in both counties, please see the Acknowledgements section.*

Both of these groups approached the new federal regulations with a collaborative spirit, followed similar processes to use countywide data to understand the health needs, and also discussed and prioritized the needs as a group. In addition to conducting our own primary and secondary data research, Packard Children's was able to leverage these partnerships to share costs; Packard Children's shared resources with the SCC Coalition and SMC Consortium to identify key populations for focus groups, recruit participants, and share the costs of focus groups centered on children and adolescents in each county.

Identity and Qualifications of Consultants

The community health needs assessment was completed by **Applied Survey Research** (ASR), a non-profit social research firm. For this assessment ASR conducted primary research, synthesized primary and secondary data, facilitated the process of identification and prioritization of community health needs and assets, and documented the process and findings in this report.

ASR was uniquely suited to provide Packard Children's and the SCC Coalition with consulting services relevant to conducting the CHNA. The team that participated in the work – Lisa Colvig-Amir, Dr. Jennifer van Stelle, Angie Aguirre, and Melanie Espino – brought together diverse, complementary skill sets and various schools of thought (public health, anthropology, and sociology).

ASR's expertise in **community assessments** is well-recognized. ASR won first place in the Community Indicators Consortium Innovation Awards sponsored by the Brookings Institution in 2007 for having the best community assessment project in the nation. It accomplishes successful assessments by using mixed research methods to help understand needs, and puts the research into action through designing and facilitating strategic planning efforts with stakeholders.

In addition to their research and academic credentials, the ASR team has a 32-year history of working with vulnerable and **underserved populations** such as young children, teen mothers, seniors, low-income families, immigrant families, families who have experienced domestic violence and child maltreatment, the homeless, and children and families with disabilities.

Communities recently assessed by ASR include Arizona (six regions), Alaska (three regions), the San Francisco Bay Area including San Mateo, Santa Clara, Santa Cruz, and Monterey Counties, San Luis Obispo County, the Central Valley area including Stanislaus and San Joaquin Counties, Marin County, Nevada County, Pajaro Valley, and Solano and Napa Counties.

Packard Children's and the SCC Coalition contracted with **Resource Development Associates** (RDA) to create compendia of secondary data (described in Section 3). RDA is a 28-year-old Bay Area consulting firm supporting government agencies and community-based organizations through assessment, planning, evaluation, data system development and analysis, and grant writing. Located in Oakland, California, RDA is a privately-held, woman-owned consulting firm. It employs professionals with credentials in public health, clinical services, social welfare, organizational development, and planning.

Since its inception, RDA has served some of the largest and most innovative human service initiatives in the nation. It targets its efforts towards the improvement of outcomes for public health and behavioral health agencies, school districts, early childhood programs, adult and juvenile justice organizations, and community-based organizations. RDA consults with a wide array of organizations ranging from federal agencies (e.g., Center for Substance Abuse Prevention [CSAP], Centers for Disease Control and Prevention [CDC], the Department of Housing and Urban Development [HUD], and the Office of Juvenile Justice and Delinquency Prevention [OJJDP]) to smaller, community-based organizations. It conducts comprehensive assessments and evaluations for local cities, public health departments, Maternal, Child and Adolescent Health (MCAH) divisions, and First 5 commissions, as well as alcohol and drug services, juvenile justice initiatives, violence prevention efforts, and educational initiatives. RDA has established and proven competencies in assembling and interpreting large amounts of public data to inform and structure its efforts in community needs profiling.

7. CONCLUSION

Lucile Packard Children's Hospital at Stanford worked collaboratively with our hospital partners, public health experts, and other partners in San Mateo and Santa Clara Counties to meet the requirements of the new federally-required CHNA by pooling expertise, guidance, and resources for a shared assessment. By gathering secondary data and doing primary research as a team, Packard Children's and our partners in the Santa Clara County Community Benefit Coalition and the Hospital Consortium of San Mateo County were able to collectively understand the community's perception of health needs, and prioritize those needs with an understanding of how each need compares against respective targets.

From this platform of shared understanding, Packard Children's then embarked on our own process of secondary data collection and primary qualitative research in order to understand, in greater depth, the needs of infants, children, adolescents, and expectant mothers. Eight of the most pressing health needs in our service area were then prioritized by our Community Advisory Council (CAC).

The CAC selected three priority areas for implementation. Packard Children's investments between September 2013 - August 2016 will be based on these priorities:

- Pediatric Obesity
- Mental Health
- Access to Health Care

These priority areas guided our next step: identifying strategies that have the potential to make the biggest impact on the identified health needs. For more information about the selected priorities and investments, please find Packard Children's 2013 Implementation Strategy in Appendix 6.

8. LIST OF APPENDICES

1. Secondary Data Sources
2. IRS Checklist
3. List of Community Leaders and Their Credentials
4. Indicator List
5. Cross-Cutting Drivers
6. 2013 Implementation Strategy

Appendix 1: Secondary Data Sources

1. American Academy of Pediatrics. Policy statement: Breastfeeding and the use of human milk. 2012. Pediatrics,129(3).
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Appendix 2: IRS Checklist

CHNA Federal Requirements Checklist	IRS Notice	CHNA Reference
A. Pre-Assessment		
☑ Identifies organizations with which the facility collaborated in preparing the CHNA(s)	Notice 3.03	Sec. 6
☑ Identifies qualifications of any third parties contracted to assist in conducting a CHNA	Notice 3.03	Sec. 6
☑ Defines community served and a description of how the community was determined	Notice 3.03	Sec. 2
☑ Describes demographics and other descriptors of the hospital service area	Form 990/H Part V 1.b	Sec. 2
B. Data Collection		
Secondary Data		
☑ Sources and dates of data and other information used	Notice 3.03	Sec. 3, App. 1
☑ Information gaps that impact the ability to assess health needs	Notice 3.03	Sec. 3
Primary Data		
Documents individuals consulted:	Notice 3.03	
☑ Name, Title and Affiliation		Appendix 3
☑ Brief description of individual's special knowledge or expertise		Appendix 3
☑ Persons with special knowledge of or expertise in public health		Appendix 3
☑ For **non-**public health experts, name and title of at least one individual in each organization who was consulted		Appendix 3
CHNA includes input from persons who represent the broad interests of the community:	Notice 3.06	Sec. 3, App 3
☑ Federal, tribal, regional, state, or local health or other departments or agencies with current data or other relevant information		Appendix 3
☑ Leaders, representatives, or members of medically underserved populations		Appendix 3
☑ Leaders, representatives, or members of low-income populations		Appendix 3
☑ Leaders, representatives, or members of minority populations		Appendix 3
☑ Leaders, representatives, or members of populations with chronic disease needs		Appendix 3
☑ Report describes when the organization consulted with these persons	Notice 3.03	Appendix 3
☑ Report describes the mode of consultation (focus groups/key informant interviews)		Appendix 3
☑ Leader/representatives' names		Appendix 3
☑ Leader/representatives' leadership or representative roles		Appendix 3
C. CHNA Methodology	Notice 3.03	
☑ Criteria and analytical methods applied to identify the community health needs		Sec. 4
☑ Prioritized description of all health needs identified		Sec. 4
☑ A description of process and criteria used to prioritize the health needs		Sec. 4

CHNA Federal Requirements Checklist	IRS Notice	CHNA Reference
D. Facilities and Resources	Notice 3.03	
"A description of the existing health care facilities and resources within the community available to meet community health needs identified through CHNA" Revised per guidance to be "known resources."		
☑ Existing health care facilities		Sec. 5
☑ Other known available resources		Sec. 5
E. Publicizing the CHNA	Notice 3.07	
☑ Written report(s) posted visibly on **facility** website		
☑ If facility has no website, report(s) posted visibly on website for the organization		
☑ Instructions for accessing CHNA report are clear		
☑ Posted reports exactly reproduce an image of each report		
☑ Individuals with Internet access can access and print reports without special software and without payment of a fee		
☑ Individuals requesting a copy of the report(s) are provided the URL		
☑ Reports remain widely available until a subsequent CHNA is made widely available to the public		

Appendix 3: Persons Representing the Broad Interests of the Community

The following professionals were consulted for their expertise in the community. They were identified based on their professional expertise and knowledge of target groups including children, youth, expectant women, low-income populations, minorities, the medically underserved, and those living with chronic conditions. Included are leaders from health systems in both SCC and SMC, and their respective departments of public health, non-profit hospital representatives, local government employees, health care consumer advocate organizations, and nonprofit organizations. **Bold formatting** indicates that the expert/community service provider was consulted on behalf of Packard Children's for their specific expertise with children and adolescents (youth).

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATIO N METHOD	DATE CONSULTED
1. Alexi Arvanitidis	Insights Clinician	StarVista	Mental Health	SMC Children/Youth	Focus Group	9/17/12
2. Sharon Dolan	Executive Director	Boys & Girls Club – North SMC	Health Behaviors	SMC Children/Youth	Focus Group	9/17/12
3. Sharon Ranals	Director	City of So. San Francisco Parks and Rec	Health Behaviors	SMC Children/Youth	Focus Group	9/17/12
4. Ofr. Bill Gablin	Police Officer	City of So. San Francisco Police Dept.	Health Behaviors	SMC Health Behaviors	Focus Group	9/17/12
5. Madeline Houghton	Stay Safe Supervisor	Asian American Recovery Services	Health Behaviors	SMC Minority (Asian)	Focus Group	9/17/12
6. Mary Bier	Coordinator	Partnership for a Safe & Healthy Pacifica	Health Behaviors	SMC underserved	Focus Group	9/17/12
7. Emily Schwartz	Family Therapist	Pyramid Alternatives	Health Behaviors	SMC Youth	Focus Group	9/17/12
8. Tony Ortiz	Senior Program Manager	SMC Probation Office	Health Behaviors	SMC Youth	Focus Group	9/17/12
9. Louise Rogers	Deputy Chief	SMC Health System	Public Health	SMC residents	Interview	9/18/12
10. Dr. Anand Chabra	Director, Maternal, Child and Adolescent Health	SMC Health System	Public Health	SMC Adolescents	Interview & Focus Group	9/19/12, 2/20/13
11. Melissa Moss	Health Case Manager	Safe Harbor Shelter	Health Access/Delivery	SMC Low SES (Homeless)	Focus Group	9/19/12
12. Wendy Goldberg	Dir., SMC Center for Homelessness	SMC Human Service Agency	Health Access/Delivery	SMC Low SES (Homeless)	Focus Group	9/19/12
13. Scott Cuyjet	Family Nurse Practitioner	Daly City Youth Health Center	Health Access/Delivery	SMC Youth	Focus Group	9/19/12
14. Regina Cruz	Administrator	RotaCare Clinic - Daly City	Health Access/Delivery	SMC Low SES	Focus Group	9/19/12
15. Audrey Magnasen	Executive Director	North Peninsula Neighborhood Services	Health Access/Delivery	SMC residents	Focus Group	9/19/12

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATION METHOD	DATE CONSULTED
16. James Gibboney, MD	Internal Medicine	Kaiser Permanente	Health Access/Delivery	SMC residents	Focus Group	9/19/12
17. Lynne Siracusa	Social Work Manager	Kaiser Permanente	Health Access/Delivery	SMC residents	Focus Group	9/19/12
18. Scott Tsunehara, MD	Physician - Internal Medicine	Kaiser Permanente	Health Access/Delivery	SMC residents	Focus Group	9/19/12
19. Srija Srinivasan	Dir., Strategic Operations	SMC Health System	Public Health	SMC residents	Interview	9/20/12
20. Jaime Chavarria, MD	Chief Medical Officer	Ravenswood Family Health Center	Morbidity/Mortality	SMC Low SES	Focus Group	9/24/12
21. Jason Wong, MD	Medical Director	Samaritan House	Morbidity/Mortality	SMC Low SES	Focus Group	9/24/12
22. Karen Larson	Site Administrator	RotaCare Clinic Half Moon Bay	Morbidity/Mortality	SMC Low SES/underserved	Focus Group	9/24/12
23. Susan Houston	Director of Older Adult Services	Peninsula Family Service Agency	Morbidity/Mortality	SMC Older Adults	Focus Group	9/24/12
24. Kathleen Steele	Social Services Manager	Kaiser Permanente	Morbidity/Mortality	SMC residents	Focus Group	9/24/12
25. Fatima Soares	Executive Director	Coastside Hope	Morbidity/Mortality	SMC Underserved	Focus Group	9/24/12
26. René Santiago	Deputy County Executive	SCC County Health & Hospital System	Public Health	SCC residents	Interview	10/2/12
27. Shamima Hasan	CEO	Mayview Community Health Center	Community Health	SCC Underserved (uninsured)	Interview	10/2/12
28. Dan Peddycord	Director	SCC Public Health Dept	Public Health	SCC residents	Interview	10/3/12
29. Dr. Marty Fenstersheib	Health Officer	SCC Health & Hospital System	Public Health	SCC residents	Interview	10/3/12
30. Michelle Lew	Executive Director	Asian Americans for Community Involvement (AACI)	Community Health	SCC Minority (Asian)	Interview	10/4/12
31. Reymundo Espinoza	CEO	Gardner Health Center	Community Health	SCC Underserved (uninsured)	Interview	10/4/12
32. Dr. Chester Kunnappilly	Chief Medical Officer	SMC Health System	Public Health	SMC residents	Interview	10/4/12
33. Dr. Susan Ehrlich	CEO	SMC Health System	Public Health	SMC residents	Interview	10/5/12
34. Peter Eirhorn	Clinician & Medical Billing Administrator	Star Vista – Insights	Health Behaviors	SMC Children	Focus Group	10/15/12

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATION METHOD	DATE CONSULTED
35. Kerry Lobel	Executive Director	Puente de la Costa Sur	Health Behaviors	SMC Coastal residents	Focus Group	10/15/12
36. Clara Boyden	Special Programs Manager	Behavioral Health & Recovery Services	Health Behaviors	SMC residents	Focus Group	10/15/12
37. Dan Young	Deputy Sheriff	SMC Sheriff's Office	Health Behaviors	SMC residents	Focus Group	10/15/12
38. Sr. Christina Heltsley	Executive Director	Saint Francis Center of Redwood City	Health Behaviors	SMC residents	Focus Group	10/15/12
39. Hemal Mehta, MD	Pediatrician	Healthy Weight Collaborative	Morbidity/Mortality	SMC children	Focus Group	10/16/12
40. Christina Ugaitafa	Aging & Adult Services Program Analyst	SMC Health System	Public Health	SMC older adults	Focus Group	10/16/12
41. Anne Marie Silvestri	Director – Dental Services	San Mateo Medical Center	Morbidity (oral health)	SMC residents	Focus Group	10/16/12
42. Beverly Johnson	Director – Human Service Agency	SMC Health System	Public Health	SMC residents	Focus Group	10/16/12
43. Cathleen Baker	Community Health Planner	SMC Health System	Public Health	SMC residents	Focus Group	10/16/12
44. Jonathan Messinger	Clinics Manager	SMC Health System	Public Health	SMC residents	Focus Group	10/16/12
45. Steve Kaplan	Dir., Behavioral Health	SMC Health System	Public Health	SMC residents	Focus Group	10/16/12
46. Dolores Alvarado	Executive Director	Community Health Partnership	Health Insurance	SCC underserved (uninsured)	Interview	10/17/12
47. Celia Shanley	Health Services Manager	Rebekah's Children Services	Mental Health	SCC Children/Youth	Focus Group	11/1/12
48. Lillian Castillo	Nutritionist	SCC Public Health Dept	Public Health	SCC residents	Focus Group	11/1/12
49. Lynn Magruder	Grants Administrator	Community Solutions	Mental Health	SCC residents	Focus Group	11/1/12
50. Art Barron	Chair, Advisory Board	CARAS	Non-Profit	SCC Underserved & Low SES	Focus Group	11/1/12
51. Eileen Obata	District Nurse	Gilroy Unified School District	Public Health	SCC underserved & Low SES	Focus Group	11/1/12
52. Marilyn Roaf	HCD Grants Coordinator	City of Gilroy	Community Services	South SCC underserved, low SES	Focus Group	11/1/12
53. Maureen Drewniany	Community Services Manager	City of Morgan Hill	Community Services	South SCC underserved, low SES	Focus Group	11/1/12

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATION METHOD	DATE CONSULTED
54. Sister Rachela Silvestri	Director, Community Health	Saint Louise Hospital	Community Health	South SCC underserved, Low SES	Focus Group	11/1/12
55. Susan Valenta	President & CEO	City of Gilroy Chamber of Commerce	Community Services	South SCC underserved, low SES	Focus Group	11/1/12
56. Claudia Rossi	Trustee	Morgan Hill School Board	Education	South SCC underserved, Low SES	Focus Group	11/1/12
57. Dr. Kent Imai	Medical Director	Community Health Partnership	Health Insurance	SCC Underserved (uninsured)	Interview	11/6/12
58. Naomi Nakano-Matsumoto	Executive Director	West Valley Community Services	Community Health	SCC Low income	Focus Group	11/6/12
59. Carol Leigh-Hutton	President & CEO	United Way Silicon Valley	Non-Profit	SCC Low SES	Focus Group	11/6/12
60. Jill Dawson	Program Director	InnVision Shelter Network	Non-Profit	SCC Low SES	Focus Group	11/6/12
61. Marie Bernard	Executive Director	Sunnyvale Community Services	Non-Profit	SCC Low SES	Focus Group	11/6/12
62. Maureen Wadiak	Associate Director	Mountain View Community Services	Non-Profit	SCC Low SES	Focus Group	11/6/12
63. Patricia Gardner	Executive Director	Silicon Valley Council of Nonprofits	Non-Profit	SCC Low SES	Focus Group	11/6/12
64. Poncho Guevara	Executive Director	Sacred Heart Community Service	Non-Profit	SCC Low SES	Focus Group	11/6/12
65. Kathleen King	CEO	Santa Clara Family Health Foundation	Health Insurance	SCC Underserved (uninsured)	Focus Group	11/6/12
66. Ellen Corman	Supervisor, Injury Prevention & Community Outreach	Stanford Hospital & Clinics	Community Health	SCC & SMC Chronic Conditions	Focus Group	11/7/12
67. Sherri Terao	Division Director	SCC Mental Health	Mental Health	SCC Children	Focus Group	11/7/12
68. Bonnie Broderick	Director, Chronic Disease and Injury Prevention	SCC Public Health Dept	Public Health	SCC Chronic Conditions	Focus Group	11/7/12
69. Vivian Silva, MSW	Care Manager	City of Sunnyvale	Community Services	SCC Chronic Conditions	Focus Group	11/7/12
70. Fred Ferrer	Executive Director	The Health Trust	Community Health	SCC Chronic Conditions, Low SES	Focus Group	11/7/12
71. Cindy McGown	Senior Director	Second Harvest Food Bank	Non-Profit	SCC Low SES	Focus Group	11/7/12
72. Pam Gudiño	Program Manager	Somos Mayfair	Community Wellness Services	SCC Minority (Latino)	Focus Group	11/7/12

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATION METHOD	DATE CONSULTED
73. Aimee Reedy	SCC Division Director	SCC Public Health Dept	Public Health	SCC residents	Focus Group	11/7/12
74. Bruce Copley	Director	SCC Dept. Alcohol and Drug Services	Behavioral Health	SCC residents	Focus Group	11/7/12
75. Dr. Thad Padua	Medical Director	Santa Clara Family Health Plan	Health Insurance	SCC Underserved (uninsured)	Interview	11/9/12
76. Anne Ehresman	Executive Director	Project Cornerstone	Non-Profit	SCC Children	Focus Group	11/9/12
77. Dana Bunnett	Executive Director	Kids in Common	Non-Profit	SCC Children	Focus Group	11/9/12
78. Geraldo Cadenas	Senior Office Assistant	Columbia Neighborhood Center	Community Services	SCC Children	Focus Group	11/9/12
79. Melinda Landau	School Nurse	San Jose Unified School District	Education	SCC Children	Focus Group	11/9/12
80. Rho Henry Olaisen	Director	Abilities United	Community Wellness Services	SCC disabled youth	Focus Group	11/9/12
81. Susan Silveira	Program Director	SCC Public Health Dept	Public Health	SCC residents	Focus Group	11/9/12
82. Petra Riguero	Program Supervisor	City of San Jose Mayor's Gang Prevention Task Force	Community Services	SCC Violence Prevention	Focus Group	11/9/12
83. Dr. Dorothy Furgerson	Chief Medical Officer	Planned Parenthood	Community Health	SCC Youth	Focus Group	11/9/12
84. Elaine Glissmeyer	Executive Director	YMCA	Community Wellness Services	SCC Youth	Focus Group	11/9/12
85. Jodi Kazemini	Clinic Manager	Packard Children's Adolescent Medicine Clinic	Community Health	SCC Youth	Focus Group	11/9/12
86. Marlene Bjornsrud	Executive Director	Bay Area Women's Sports Initiative	Community Wellness Services	SCC Youth	Focus Group	11/9/12
87. Paul Schutz	Associate Director of Development	Community Health Awareness Council	Community Services	SCC Youth	Focus Group	11/9/12
88. Thea Runyan		Belmont-Redwood Shores School District	Public Health	SMC Children	Focus group	1/24/13
89. Bri Carpano-Seoane	Family Services Director	Ronald McDonald House at Stanford	Community Health	SMC Children	Focus group	1/24/13
90. Margot Rawlins	Pub Health and Early Childhood Specialist	Silicon Valley Community Foundation	Community Health	SMC Children	Focus group	1/24/13
91. Julie Wesolek	Executive Director	YMCA Silicon Valley	Community Wellness	SMC Children	Focus group	1/24/13

NAME	TITLE	AFFILIATION	EXPERTISE	TARGET GROUP(S)	CONSULTATIO N METHOD	DATE CONSULTED
92. Sarah Poulain	Interim Director	StarVista, Dept of Early Childhood and Fam Svc	Mental Health	SMC Youth	Focus group	1/24/13
93. John Yap, MSW	Director of Empowering Youth Initiative	Peninsula Conflict Resolution Center	Mental Health	SMC Youth	Focus group	1/24/13
94. Rachel DelMonte	Executive Director	San Mateo YMCA	Community Wellness	SMC Youth	Focus group	1/24/13
95. Daniela Torres	Health Education	Planned Parenthood Mar Monte	Sexual Health	SMC Youth	Focus group	1/24/13
96. Lizelle Lirio de Luna	Public Health Nurse, Adolescent Family Life Program	SMC Public Health Dept	Public Health	SMC Youth	Focus group	1/24/13
97. Mitchell Eckstein	Social Worker	SMC	Family Support	SMC Youth	Focus group	1/24/13
98. Kristen Dambrowski	Associate Executive Director	Peninsula YMCA	Community Wellness	SMC Youth	Focus group	1/24/13
99. Monique Kane	Executive Director	Community Health Awareness Council (CHAC)	Community Health	SCC Children	Interview	2/15/13
100. Marmi Bermudez	Program Manager, Health Coverage Unit	SMC Health System	Public Health	SMC Uninsured	Interview	2/19/13
101. Sue Lapp	Chief Executive Officer	School Health Clinics	Public Health	SCC Children & Adolescents	Interview	2/26/13
102. Dr. Scott Morrow	Health Officer	SMC Health System	Public Health	SMC residents	Interview	2/27/13

Appendix 4: List of Infant/Child/Adolescent/Maternity Indicators Gathered

Indicator	Data Source
Absence of Dental Insurance Coverage	California Health Interview Survey (CHIS), 2007
Access to Primary Care	U.S. Health Resources and Services Administration Area Resource File, 2009 (as reported in the 2012 County Health Rankings)
Adequate Fruit/Vegetable Consumption (Youth)	California Health Interview Survey (CHIS), 2009
Adequate Social or Emotional Support	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Alcohol Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Asthma Hospitalizations (Youth)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Asthma Prevalence	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Breastfeeding (Any)	CA only: California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011; Outside CA: National Survey of Children's Health, 2007
Breastfeeding (Exclusive)	CA only: California Department of Public Health, In-Hospital Breastfeeding Initiation Data, 2011; Outside CA: National Survey of Children's Health, 2007
Cancer Mortality	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Change in Total Population (from 2000 to 2010)	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1
Children in Poverty	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Chlamydia Incidence	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009
Dental Care Affordability	California Health Interview Survey (CHIS), 2007
Dental Care Utilization [Youth]	California Health Interview Survey (CHIS), 2009
Diabetes Hospitalizations (Youth)	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
Diabetes Management (Hemoglobin A1c Test)	Dartmouth Atlas of Health care, Selected Measures of Primary Care Access and Quality, 2003-2007
Diabetes Prevalence	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009
Facilities Designated as Health Professional Shortage Areas (HPSA)	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012
Fast Food Restaurant Access	CA only: U.S. Census Bureau, ZIP Code Business Patterns, 2009; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Federally Qualified Health Centers	U.S. Health Resources and Services Administration, Centers for Medicare & Medicaid Services, Provider of Service File, 2011
Free and Reduced Price School Lunch Eligibility	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2009-2010

Indicator	Data Source
Fruit/Vegetable Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Grocery Store Access	U.S. Census Bureau, County Business Patterns, 2010
Heavy Alcohol Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
High School Graduation Rate	U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Local Education Agency (School District) Universe Survey Dropout and Completion Data, 2008-2009
HIV Hospitalizations	California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010
HIV Prevalence	Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2008
HIV Screenings	CA only: California Health Interview Survey (CHIS), 2005; Outside CA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Homicide	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Inadequate Fruit/Vegetable Consumption (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2003-2009
Infant Mortality	Centers for Disease Control and Prevention, National Vital Statistics System, 2003-2009
Lack of a Consistent Source of Primary Care	CA only: California Health Interview Survey (CHIS), 2009; Outside CA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Lack of Prenatal Care	CA only: California Department of Public Health, Birth Profiles by ZIP Code, 2010; Outside CA: Centers for Disease Control and Prevention, National Vital Statistics Systems, 2007-2009. Accessed through CDC WONDER
Linguistically Isolated Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Liquor Store Access	CA only: California Department of Alcoholic Beverage Control, Active License File, April 2012; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Low Birth-weight	CA only: California Department of Public Health, Birth Profiles by ZIP Code, 2010; Outside CA: Centers for Disease Control and Prevention, National Vital Statistics Systems, 2003-2009. Accessed through the Health Indicators Warehouse
Lung Cancer Incidence	The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2004-2008
Median Age	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Motor Vehicle Crash Death	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2008-2010
Obesity (Youth)	CA only: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011; Outside CA: National Survey of Children's Health, 2007
Overweight (Youth)	CA only: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011; Outside CA: National Survey of Children's Health, 2007
Park Access	U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1; Esri's USA Parks layer (compilation of Esri, National Park Service, and TomTom source data), 2012.

Indicator	Data Source
Pedestrian Motor Vehicle Death	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2008-2010
Physical Inactivity (Youth)	California Department of Education, Fitnessgram Physical Fitness Testing Results, 2011
Poor Air Quality (Ozone)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008
Poor Air Quality (Particulate Matter 2.5)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008
Poor Dental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010
Poor General Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010
Poor Mental Health	California Health Interview Survey (CHIS), 2009
Population Below 200% of Poverty Level	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Population Living in a Health Professional Shortage Areas (HPSA)	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012
Population Living in Food Deserts	U.S. Department of Agriculture, Food Desert Locator, 2009
Population Receiving Medicaid	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Population with Any Disability	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Population with No High School Diploma	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Poverty Rate (< 100% FPL)	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Premature Death	Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (As Reported in the 2012 County Health Rankings)
Preventable Hospital Events	CA only: California Office of Statewide Health, Planning and Development (OSHPD), Patient Discharge Data, 2010; outside CA: Dartmouth Atlas of Health care, Selected Measures of Primary Care Access and Quality, 2003-2007
Recreation and Fitness Facility Access	CA only: U.S. Census Bureau, ZIP Code Business Patterns, 2009; Outside CA: U.S. Census Bureau, County Business Patterns, 2010
Soft Drink Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Student Reading Proficiency (4th Grade)	States' Department of Education, Student Testing Reports, 2011
Suicide	CA only: California Department of Public Health, Death Statistical Master File, 2008-2010; Outside CA: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2005-2009. . Accessed through CDC WONDER
Supplemental Nutrition Assistance Program (SNAP) Recipients	U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), 2009
Teen Births	Centers for Disease Control and Prevention, National Vital Statistics Systems, 2003-2009. Accessed through the Health Indicators Warehouse

Indicator	Data Source
Tobacco Expenditures	Nielsen Claritas SiteReports, Consumer Buying Power, 2011
Tobacco Usage (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-10
Total Female Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Male Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 0-4	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 5-17	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Total Population Age 18-24	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates
Unemployment Rate	U.S. Bureau of Labor Statistics, July, 2012 Local Area Unemployment Statistics
Uninsured Population	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates
Violent Crime	U.S. Federal Bureau of Investigation, Uniform Crime Reports, 2010
Walkability	WalkScore.Com (2012)
WIC-Authorized Food Store Access	U.S. Department of Agriculture, Food Environment Atlas, 2012

Appendix 5: Cross-Cutting Drivers Mentioned During Primary Data Gathering

- Access issues, including insurance/coverage issues (including Medi-Cal), lack of transportation/transportation issues, issues with location, and language barriers
- Accessing primary care providers and the supply of practitioners & specialists (workforce development)
- Being too busy
- Being unemployed
- Caregiver issues
- Concerns about delivery of prevention efforts
- Cultural issues
- Denial/fear
- Disabilities/existing medical conditions exacerbating other drivers
- Eating fast food
- Environmental issues, especially schools, neighborhoods (walkability & personal safety), housing, and lack of grocery stores or other places to buy fresh food
- Experiencing stigma
- Gangs, crime
- Having low income or being in poverty
- Health behaviors, including utilization of health care
- Heredity/genetic predisposition
- Issues of coordination of care
- Issues with prescription drugs (medication management, access to medication, sharing)
- Issues with treatment
- Lack of awareness
- Lack of health education
- Lack of knowledge
- Lack of motivation
- Lack of physical activity
- Lack of services
- Lack of/poor outreach
- Media
- Need for a patient-centered medical home/ care coordination / "warm handshake"
- Need for best practices to be employed
- Need for partnerships or more effective partnerships
- Poor nutrition, including too much sugar, not cooking at home or cooking unhealthy food, eating processed food
- Social issues, especially poor/no role models, parenting and family issues, peer pressure, and social isolation
- Special populations: Children; youth; older adults; LGBTQ; those of particular ethnicities (including being undocumented); adults
- Specific hospital-related delivery issues
- The cost of health care/insurance/prescriptions/activities/fresh food

Appendix 6: 2013 Implementation Strategy

2013 Implementation Strategy

This plan represents a multi-year strategic investment in community health. Lucile Packard Children's Hospital at Stanford (Packard Children's) believes that long-term funding of proven community partners yields greater success in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2012-2013 Community Health Needs Assessment (CHNA) process as well as process assessments, reports, and requests submitted by community partners that detail their progress toward mutually developed goals and objectives for improving community health. Please reference the attached Health Profiles for the status of these health needs, and others, in our service area.

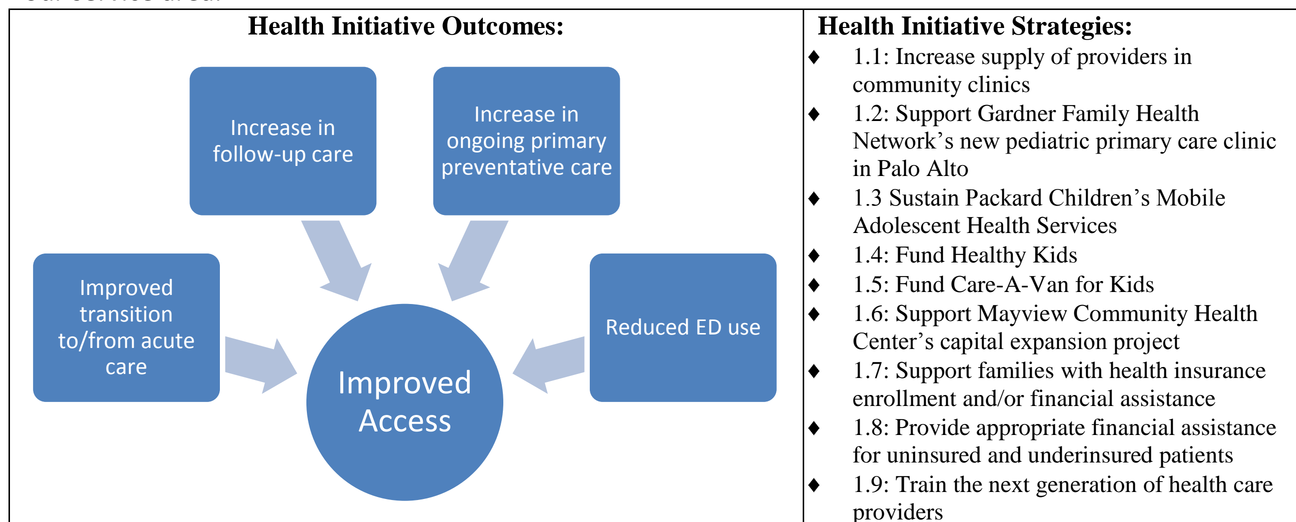
Three initiatives will serve as our priority areas for three fiscal years from September 2013 through August 2016:

1. Improve Access to Care
2. Prevention and Treatment of Pediatric Obesity
3. Improve the Social, Emotional, and Mental Health of Children and Youth

Health Initiative 1: Improve Access to Care

Goal: Improve access to a comprehensive medical home to children and youth ages 0-25, and pregnant women in Santa Clara (SCC) and San Mateo (SMC) counties.

This health initiative aims to address the "Access to Care" health need identified by the 2012-2013 Community Health Needs Assessment. Interventions will include improved care coordination between health care organizations and systems as well as sustainable adoption and implementation of the medical home model. Please reference the attached Health Profile for the status of this health need in our service area.



Health Initiative Strategies:

- 1.1: Increase supply of providers in community clinics
- 1.2: Support Gardner Family Health Network's new pediatric primary care clinic in Palo Alto
- 1.3 Sustain Packard Children's Mobile Adolescent Health Services
- 1.4: Fund Healthy Kids
- 1.5: Fund Care-A-Van for Kids
- 1.6: Support Mayview Community Health Center's capital expansion project
- 1.7: Support families with health insurance enrollment and/or financial assistance
- 1.8: Provide appropriate financial assistance for uninsured and underinsured patients
- 1.9: Train the next generation of health care providers

Access to Care Health Detailed Outcomes:

1. Through improved care coordination, underserved populations have a seamless transition to/from acute care settings
2. Through the medical home model, underserved populations receive appropriate primary and follow-up medical care as well as supportive services
3. Underserved populations have an ongoing source of primary and preventative health care
4. Inappropriate use of the emergency department is reduced

Strategy 1.1: Enhance capacity of community clinics to provide a medical home for children, teens, and pregnant women.

Community Partners: Ravenswood Family Health Center and San Mateo County Community Health Network for the Underserved
Tactics:
- Assess the needs of community clinic partners
- Provide funding and other resources, such as Packard Children's staff recruitment services, to address identified needs of clinics
- Provide funding and support to establish initiatives aimed at improving care coordination between acute care settings and community health centers

Strategy 1.2: Support Gardner Family Health Network's new pediatric primary care clinic in Palo Alto

Community Partner: Gardner Family Health Network
Tactics:
- Fund Gardner Family Health Network's capital building project for a new community clinic in Redwood City
- Underwrite the under-reimbursement expenses for all pediatric patients insured through government or other means-tested programs
- Fund the training of the next generation of health care providers, including physicians, nurses, and other allied health professionals

Strategy 1.3: Sustain Packard Children's Mobile Adolescent Health Services for homeless and uninsured youth, ages 10-25

Packard Children's Mobile Adolescent Health Services program provides primary treatment and preventative care to homeless and uninsured adolescents ages 10 – 25. Services include acute illness and injury care; complete physical exams; family planning services; testing for, counseling, and treatment of HIV and STDs; pregnancy testing and prenatal care referrals; immunizations; mental health counseling and referrals; nutrition counseling; referrals to community partners; risk behavior reduction counseling; and substance abuse counseling and referrals.

Community Partners: Indochinese Health Development Center in San Francisco, Alta Vista Continuation High School in Mountain View, Peninsula Continuation High School in San Bruno, East Palo Alto Charter

High School in East Menlo Park, Lost Altos High School in Los Altos, LGBTQ Youth Space in San Jose, and Job Corps training site in San Jose

Tactics:

- Provide funding for Teen Van site visits
- Provide operational support for fundraising efforts

Strategy 1.4: Support premium fees for Healthy Kids insurance programs

The Santa Clara and San Mateo County Children's Health Insurance Initiatives (locally called "Healthy Kids" programs) expand health coverage to children who do not qualify for the Medi-Cal or Healthy Families insurance programs.

Community Partners: San Mateo County Children's Health Initiative and Santa Clara Family Health Foundation

Tactics:

- Provide funding for insurance premium subsidies
- Investigate further partnership opportunities aimed at improving care coordination between Healthy Kids primary and preventative health services and other community health care agencies

Strategy 1.5: Sustain the Care-A-Van for Kids program

The Care-A-Van for Kids programs makes life-saving health services accessible to low-income families who lack reliable means of transportation.

Community Partners: Volunteer drivers and corporate funders

Tactic: Provide free transportation services to/from Packard Children's for those without reliable transportation and live outside a 25 mile radius from the hospital

Strategy 1.6: Support for Mayview Community Health Center's capital expansion project

Community Partners: Mayview Community Health Center

Tactic: Provide funding for Mayview Community Health Center's capital building project for site and capacity expansion

Strategy 1.7: Maintain and enhance a system to enroll children in appropriate insurance or financial assistance programs

Tactic: Assist families in identifying what insurance programs they may qualify for and assist them in enrolling.

Strategy 1.8: Provide appropriate financial assistance for uninsured and underinsured patients

Tactic: Maintain and enhance a system for providing free and discounted care for individuals whose family income is below 400 percent of the Federal Poverty Line (FPL)

Strategy 1.9: Train the next generation of health care providers

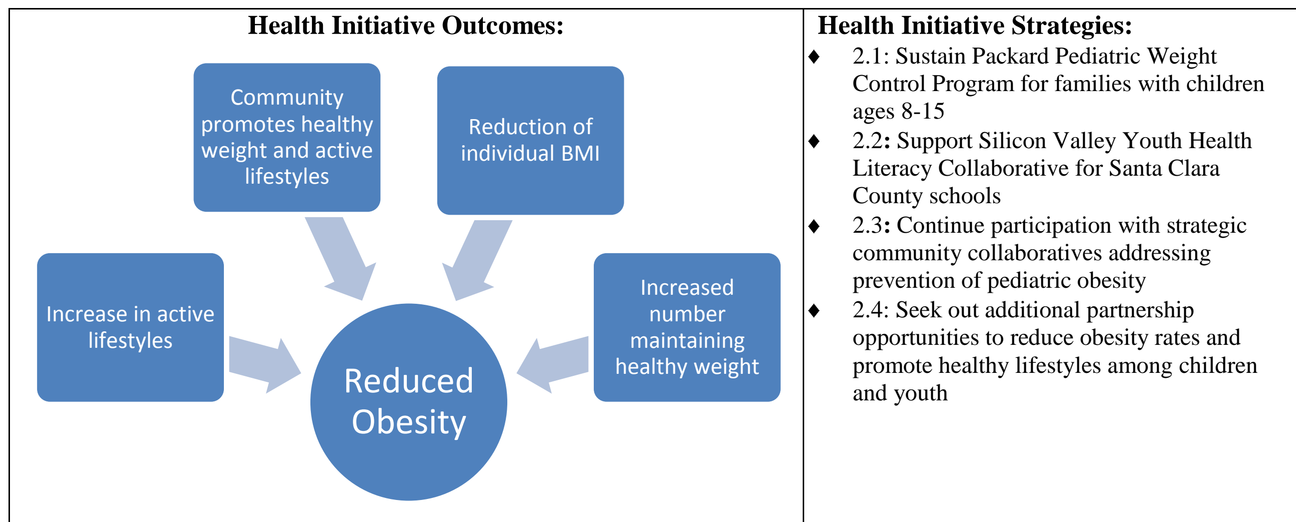
Tactics:

- Provide funding and a setting for training medical students, residents and fellows from Stanford School of Medicine
- Provide funding and a setting for training physician assistant, nursing, clinical laboratory, physical therapy, respiratory therapy, occupational therapy, speech therapy, radiology, nuclear medicine, and psychology students
- Provide funding and a setting for training pharmacy residents

Health Initiative II: Prevention and Treatment of Pediatric Obesity

Goal: Reduce the prevalence and severity of overweight and obese children and youth ages 0-25 in Santa Clara and San Mateo counties, leading to improved health, wellness, and a reduction in chronic, associated health conditions.

This health initiative aims to address the pediatric obesity epidemic and associated health-related issues within San Mateo and Santa Clara counties. A holistic approach will be utilized to address the social determinants of maintaining a healthy weight, including the built environment and legislative policy, as well as the dissemination of evidence-based clinical treatment programs to children and families in the community. Obesity is identified as the top community health need among children and youth by the 2012-2013 Community Health Needs Assessment. Please reference the attached Health Profile for the status of this health need in our service area.



Pediatric Obesity Detailed Outcomes:

1. Children and youth have increased opportunities to live in communities that promote healthy weight maintenance and active lifestyles.
2. Families reduce the Body Mass Index (BMI) of their members
3. An increased number of families maintain a healthy weight

Strategy 2.1: Sustain Packard Pediatric Weight Control Program for families with children ages 8-15

Packard Pediatric Weight Control program is a nationally-recognized, evidence and family-based behavior modification program for overweight children. The 26-week program is offered both at the hospital and at community locations. The program costs $3500 per family and, because insurance plans do not yet reimburse for weight management programs, this cost must be borne by the family. The hospital has set up a mechanism for families to apply for full or partial need-based scholarships through the hospital's charity care program.

Community Partners: YMCA
Tactics:

- Fund the operational needs of the Packard Pediatric Weight Control Program.
- Provide need-based scholarships for participants.

Strategy 2.2: Support Silicon Valley Youth Health Literacy Collaborative for Santa Clara County schools

HealthTeacher is a leading provider of online health promotion, disease prevention, social and emotional wellness, and child safety resources for K-12th graders and is used by nearly 30,000 teachers nationwide.

Community Partners: El Camino Hospital, HealthTeacher, Inc., and participating school districts
Tactics:

- Provide funding to offer the HealthTeacher online health education and physical activity curriculum to all schools in Santa Clara County and select south-county school districts in San Mateo County.
- Provide funding for a full-time Health Education Coordinator responsible for user support, positive participant outcomes, and utilization growth.

Strategy 3: Continue participation with strategic community collaboratives addressing prevention of pediatric obesity

Community Partners: Get Healthy San Mateo County and all of its partners, Bay Area Nutrition and Physical Activity Collaborative (BANPAC) and all of its partners, Coordinated School Health projects within Santa Clara County schools and Palo Alto Unified School District, and the City of San Jose's Street Smarts traffic safety education program
Tactics:

- Maintain connections and partnerships with multiple community efforts and advocate for community change.
- Support these collaboratives through in-kind donations, cooperative programs, and fundraising

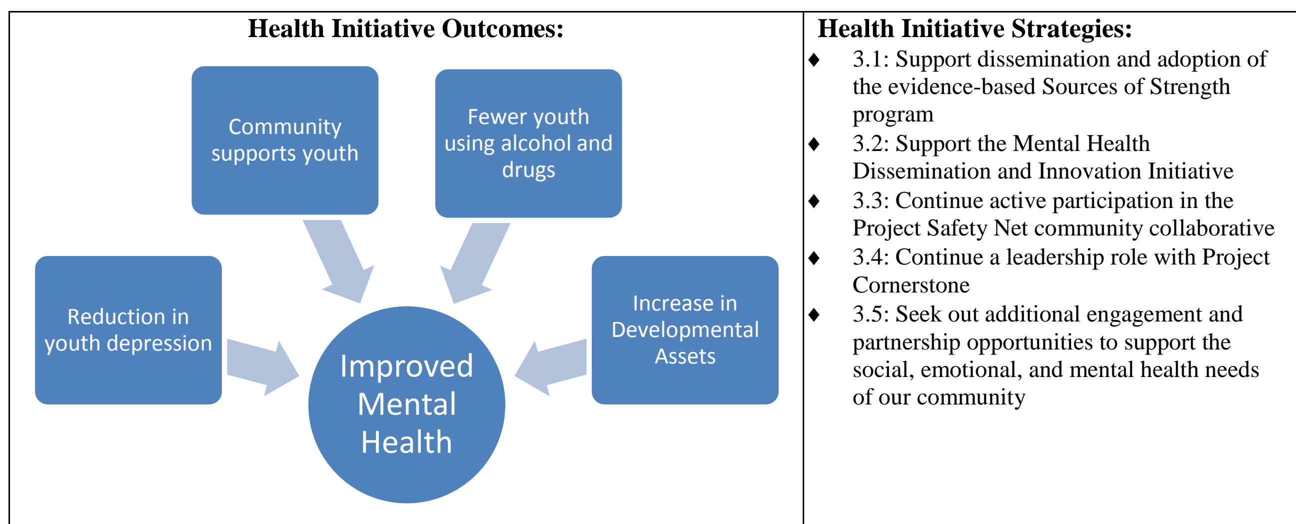
Strategy 2.4: Seek out additional partnership opportunities to reduce obesity rates and promote healthy lifestyles among children and youth

Tactic: To be determined

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

Goal: Partner with and link health care providers, mental health providers, school professionals, and community agencies to increase the emotional and social well-being of children and youth ages 0-25.

This health initiative aims to address the "Mental Health" need identified by the 2012-2013 Community Health Needs Assessment. Interventions will address the proven link between poor social, emotional, and mental health and poor behavioral health, including substance abuse and violence. Please reference the attached Health Profile for the status of this health need in our service area.



Social/Emotional/Mental Health Detailed Outcomes:

1. Fewer youth who report having had feelings of sadness and hopelessness.
2. More youth who report that they have an adult who cares about them and/or are connected to their community.
3. Fewer youth who participate in risk-taking behavior, including drug and alcohol abuse.
4. Fewer children and youth with less than 21 Developmental Assets.

Strategy 1: Support dissemination and adoption of the evidence-based Sources of Strength program

In response to a "contagion" of teen suicides in Palo Alto in 2009, Project Safety Net and the HEARD Alliance, two groups of health care providers, nonprofit agencies, school professionals, and community members, came together to prevent crisis situations and intervene early enough to ensure the crisis stage is never reached. In 2012, Project Safety Net and the HEARD Alliance requested funding to bring the evidence-based Sources of Strength Program to Gunn High School in Palo Alto. The Sources of Strength program trains peer leaders to change norms around codes of silence and increases help-seeking behaviors and connections between peers and caring adults as preventative measures against teen suicide.

Community Partners: Gunn High School, Health Care Alliance for Response to Adolescent Depression (HEARD), and Project Safety Net
Tactic: Provide funding to support the partnership between Packard Children's/Stanford Child Psychiatry Department and Gunn High School to sustain the Sources of Strength program, prevent youth suicide, and boost the social and emotional health of students.

Strategy 2: Support the Mental Health Dissemination and Innovation Initiative

The overarching goal of the Mental Health Dissemination and Innovation Initiative is to prevent the aftermath of traumatic events in young children and adolescents and to ameliorate these effects in youth already demonstrating functional impairment. The program's activities center on a) research on the identification of biological and sociological risk factors for stress vulnerability; b) development, application and dissemination of innovative treatment interventions; and c) community engagement.

Community Partners: Stanford University School of Medicine; Ravenswood Family Health Center; Boys and Girls Club of the Peninsula; Center for Wellness, Bayview; and various state-level committees and task forces on youth mental health
Tactics: Provide funding to support the Mental Health Dissemination and Innovation Initiative through:
- Community education and partnerships
- Partnership between Packard Children's Early Life Stress Research program and Ravenswood City School District
- Treatment protocol dissemination
- Policy and advocacy

Strategy 3: Continue active participation in the Project Safety Net community collaborative

Project Safety Net is a community collaborative born in response to the 2009 teen suicide cluster in Palo Alto, whose mission is to develop and implement an effective, comprehensive, community-based mental health plan for overall youth well-being in Palo Alto. The plan includes collaborative education, prevention and intervention strategies that provide a safety net for youth and teens in Palo Alto.

Community Partners: All organizations and individuals participating in Project Safety Net, including primary and preventative care providers, mental health providers, school professionals, other community agencies, and families
Tactics:
- Seek out additional engagement and partnership opportunities
- Support the collaborative through in-kind donations, cooperative programs, and fundraising

Strategy 4: Continue a leadership role with Project Cornerstone

Under the auspices of the YMCA of Silicon Valley, Project Cornerstone brings the Search Institute's evidence-based Developmental Assets to Santa Clara County. The Developmental Assets are positive values, relationships, skills, and experiences that children and teens need to foster positive identity and self-esteem, make healthy choices instead of engaging in risk-taking behavior, and thrive.

Community Partners: All organizations and individuals supporting the mission, vision, and goals of Project Cornerstone, including primary and preventative care providers, mental health providers, school professionals, other community agencies, and families
Tactic: Participate as a member of the Project Cornerstone Board of Directors

Strategy 5: Seek out additional engagement and partnership opportunities to support the social, emotional, and mental health needs of our community

Tactics:
- Identify organizations supporting the social, emotional, and mental health of children and youth
- Support these efforts through in-kind donations, cooperative programs, and fundraising

9. LIST OF ATTACHMENTS

Attachment 1: Health Need Profile, Access to Health care

Attachment 2: Health Need Profile, Asthma

Attachment 3: Health Need Profile, Birth Outcomes

Attachment 4: Health Need Profile, Mental Health

Attachment 5: Health Need Profile, Pediatric Obesity

See separate attachments.