

Hospital Equity Measures Report

General Information

Report Type:	Hospital Equity Measures Report
Year:	2024
Hospital Name:	LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD
Facility Type:	Children Hospital
Hospital HCAI ID:	106434040
Report Period:	1/1/2024 - 12/31/2024
Status:	Complete
Due Date:	09/30/2025
Last Updated:	02/05/2026
Hospital Location with Clean Water and Air:	Y
Hospital Web Address for Equity Report:	https://www.stanfordchildrens.org/en/about/quality.html

Overview

Assembly Bill No. 1204 requires the Department of Health Care Access and Information (HCAI) to develop and administer a Hospital Equity Measures Reporting Program to collect and post summaries of key hospital performance and patient outcome data regarding sociodemographic information, including but not limited to age, sex, race/ethnicity, payor type, language, disability status, and sexual orientation and gender identity.

Hospitals (general acute, children's, and acute psychiatric) and hospital systems are required to annually submit their reports to HCAI. These reports contain summaries of each measure, the top 10 disparities, and the equity plans to address the identified disparities. HCAI is required to maintain a link on the HCAI website that provides access to the content of hospital equity measures reports and equity plans to the public. All submitted hospitals are required to post their reports on their websites, as well.

Laws and Regulations

For more information on Assembly Bill No. 1204, please visit the following link by copying and pasting the URL into your web browser:

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1204

Hospital Equity Measures

Joint Commission Accreditation

Children's hospitals are required to report three structural measures based on the Commission Accreditation's Health Care Disparities Reduction and Patient-Centered Communication Accreditation Standards. For more information on these measures, please visit the following link by copying and pasting the URL into your web browser:

<https://www.jointcommission.org/standards/r3-report/r3-report-issue-36-new-requirements-to-reduce>

-health-care-disparities/

The first two structural measures are scored as "yes" or "no"; the third structural measure comprises the percentages of patients by five categories of preferred languages spoken, in addition to one other/unknown language category.

Designate an individual to lead hospital health equity activities (Y = Yes, N = No).

Y

Provide documentation of policy prohibiting discrimination (Y = Yes, N = No).

Y

Number of patients that were asked their preferred language, five defined categories and one other/unknown languages category.

31359

Table 1. Summary of preferred languages reported by patients.

Languages	Number of patients who report preferring language	Total number of patients	Percentage of total patients who report preferring language (%)
English Language	24294	31359	77.5
Spanish Language	5780	31359	18.4
Asian Pacific Islander Languages	567	31359	1.8
Middle Eastern Languages	116	31359	0.4
American Sign Language	30	31359	0.1
Other Languages	445	31359	1.4

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure

There are five domains that make up the CMS Hospital Commitment to HCHE measures. Each domain is scored as "yes" or "no." In order to score "yes," a children's hospital is required to confirm all the domain's attestations. Lack of one or more of the attestations results in a score of "no." For more information on the CMS Hospital Commitment to HCHE measures, please visit the following link by copying and pasting the URL into your web browser:

<https://data.cms.gov/provider-data/topics/hospitals/health-equity>

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure Domain 1: Strategic Planning (Yes/No)

- Our hospital strategic plan identifies priority populations who currently experience health disparities.
- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital strategic plan outlines specific resources that have been dedicated to achieving our equity goals.
- Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Y

CMS HCHE Measure Domain 2: Data Collection (Yes/No)

- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health

information.

- Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology.

Y

CMS HCHE Measure Domain 3: Data Analysis (Yes/No)

- Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information in hospital performance dashboards.

Y

CMS HCHE Measure Domain 4: Quality Improvement (Yes/No)

- Our hospital participates in local, regional or national quality improvement activities focused on reducing health disparities.

Y

CMS HCHE Measure Domain 5: Leadership Engagement (Yes/No)

- Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
- Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually review key performance indicators stratified by demographic and/or social factors.

Y

Centers for Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH)

Children's hospitals are required to report on rates of screenings and intervention rates among patients above 18 years old for five health related social needs (HRSN), which are food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. These rates are reported separately as being screened as positive for any of the five HRSNs, positive for each individual HRSN, and the intervention rate for each positively screened HRSN. For more information on the CMS SDOH, please visit the following link by copying and pasting the URL into your web browser:

<https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs>

Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the five HRSN

0

Total number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission

13330

Rate of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who screened positive for one or more of the HRSNs

00.0

Table 2. Positive screening rates and intervention rates for the five Health Related Social Needs of the Centers of Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH).

Social Driver of Health	Number of positive screenings	Rate of positive screenings (%)	Number of positive screenings who received intervention	Rate of positive screenings who received intervention (%)
Food Insecurity				
Housing Instability				
Transportation Problems				
Utility Difficulties				
Interpersonal Safety				

Core Quality Measures for Children's Hospitals

There are two quality measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. For more information on the HCAHPS survey, please visit the following link by copying and pasting the URL into your web browser:

<https://hcahpsonline.org/en/survey-instruments/>

Patient or Guardian Willingness to Recommend Hospital

The first quality measure is the percentage of patients or guardians who respond that they would be willing to recommend the hospital in a pediatric experience survey. For this measure, hospitals provide the percentage of patient respondents who responded “probably yes” or “definitely yes” to whether they would recommend the hospital, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for the percentages. The percentages and inputs are stratified by race and/or ethnicity, age categories for children's hospitals, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Number of respondents who reported willingness to recommend the hospital in the pediatric experience survey

524

Total number of respondents to the pediatric experience survey

608

Percentage of respondents who reported willingness to recommend the hospital

86.2

Total number of respondents of the pediatric experience survey

6525

Response rate, or the percentage of people who responded to the pediatric experience survey

9.3

Table 3. Patient or guardian recommends hospital or hospital system by race and/or ethnicity, age categories for children's hospitals, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed	suppressed	suppressed
Asian	88	103	85.4	1109	9.3
Black or African American	11	13	84.6	185	7
Hispanic or Latino	187	211	88.6	2790	7.6
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)	25	33	75.8	272	12.1
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed	suppressed	suppressed
White	167	193	86.5	1615	12

Age	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age 0 to 4	157	179	87.7	2472	7.2
Age 5 to 9	suppressed	suppressed	suppressed	suppressed	suppressed
Age 10 to 14	suppressed	suppressed	suppressed	suppressed	suppressed
Age 15 Years and Older	153	171	89.5	1628	10.5

Sex assigned at birth	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female	235	277	84.8	3014	9.2
Male	289	331	87.3	3510	9.4
Unknown				1	

Payer Type	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare	suppressed	suppressed	suppressed	suppressed	suppressed
Medicaid	216	247	87.4	3143	7.9
Private	283	332	85.2	3094	10.7
Self-Pay				6	
Other	suppressed	suppressed	suppressed	suppressed	suppressed

Preferred Language	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language	412	483	85.3	5038	9.6
Spanish Language	suppressed	suppressed	suppressed	suppressed	suppressed
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign Language				5	
Other/Unknown Languages	suppressed	suppressed	suppressed	suppressed	suppressed

Disability Status	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition disability					
Has a hearing disability					
Has a vision disability					
Has a self-care disability					
Has an independent living disability					

Sexual Orientation	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of respondents willing to recommend hospital	Total number of responses	Percentage of willing to recommend hospital responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans					
Male					
Male-to-female (MTF)/ transgender female/trans woman					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

The second core quality measure for children's hospitals is the HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, which is defined as the percentage of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients. These rates are reported by race and/or ethnicity, age categories for children's hospitals, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on calculating the HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, please visit the following link by copying and pasting the URL into your web browser:
https://hcai.ca.gov/wp-content/uploads/2024/10/HCAI-All-Cause-Readmission-Rate-Exclusions_ADA.pdf

Number of inpatient hospital admissions which occurs within 30 days of the discharge date of an eligible index admission

83

Total number of patients who were admitted to the children's hospital

338

Rate of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge

24.6

Table 4. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for any eligible condition by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	12	48	25
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	37	155	23.9
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	27	99	27.3

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 0 to 4	suppressed	suppressed	suppressed
Age 5 to 9	suppressed	suppressed	suppressed
Age 10 to 14	suppressed	suppressed	suppressed
Age 15 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	49	176	27.8
Male	34	162	21
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare			
Medicaid	15	40	37.5
Private	24	119	20.2
Self-Pay			
Other	44	178	24.7

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Health Equity Plan

All children's hospitals report a health equity plan that identifies the top 10 disparities and a written plan to address them.

Top 10 Disparities

Disparities for each hospital equity measure are identified by comparing the rate ratios by stratification groups. Rate ratios are calculated differently for measures with preferred low rates and those with preferred high rates. Rate ratios are calculated after applying the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

Table 5. Top 10 disparities and their rate ratio values.

Measures	Stratifications	Stratification Group	Stratification Rate	Reference Group	Reference Rate	Rate Ratio
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicaid	37.5	Private	20.2	1.9
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Sex Assigned at Birth	Female	27.8	Male	21	1.3
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Other	24.7	Private	20.2	1.2
Pediatric experience survey with scores of willingness to recommend the hospital	Race/Ethnicity	Multiracial and/or Multiethnic (two or more races)	75.8	Hispanic or Latino	88.6	1.2
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race/Ethnicity	White	27.3	Hispanic or Latino	23.9	1.1
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race/Ethnicity	Asian	25	Hispanic or Latino	23.9	1
Pediatric experience survey with scores of willingness to recommend the hospital	Race/Ethnicity	Black or African American	84.6	Hispanic or Latino	88.6	1
Pediatric experience survey with scores of willingness to recommend the hospital	Race/Ethnicity	Asian	85.4	Hispanic or Latino	88.6	1
Pediatric experience survey with scores of willingness to recommend the hospital	Sex Assigned at Birth	Male	87.3	Male	87.3	1
Pediatric experience survey with scores of willingness to recommend the hospital	Expected Payor	Medicaid	87.4	Medicaid	87.4	1

Plan to address disparities identified in the data

The rate ratio for most of the metrics identified is very close to or equal to 1, which means that there is very little difference between the disparity group and reference group. The most notable disparity based on our data is the difference in the readmission rate between patients insured by Medicaid and those with private insurance. Previously published studies highlight that publicly insured patients have higher admission and readmission rates due to a myriad of factors including 1) the influence of social risk factors and health related social needs which can make the hospital-to-home transition challenging, 2) inequitable access to follow up services, 3) the disproportionate number of children with medical complexity insured by Medicaid, and 4) the lack of access to care coordination support. We also serve a large proportion of families who use a language other than English (LOE) to communicate with their healthcare team. Communication failures can contribute to higher

readmission rates, especially if families are not given information that adheres to health literacy principles and in their preferred language. We hope to address the disparity in readmissions by addressing upstream factors that impact health. We will continue to place significant emphasis on health-related social needs screening and response efforts. We are working closely with our Social Work and Care Management teams to reliably identify patients who would benefit from additional support through programs like CalAIM. We will continue to prioritize our enterprise-wide efforts to consistently provide language concordant care. Our ambulatory missed appointment pilot will help us identify patients and families with specific barriers to attending ambulatory appointments. Additionally, we work hand in hand with our Family Centered Care and Patient and Family Experience teams to ensure every patient and family who receives care at Stanford Medicine Children's Health feels seen, heard, respected, and valued. Our specific aims to address the identified gaps are as follows:

Language Concordant Care: Increase the delivery of spoken language concordant care to patients and families with a preferred language other than English seen in the ambulatory and inpatient setting from a baseline of 87.5% to 90% by the end of FY26.

Health Related Social Needs Screening and Response: Implement a reliable and empathic health related social needs (HRSN) screening and response processes that 1) promotes self-disclosure of HRSN by patients and families; 2) effectively connects families with support and resources based on their needs. We are specifically focusing on developing a core HRSN screener that includes questions about food insecurity, housing insecurity, financial strain, and transportation barriers. We have integrated FindHelp into the electronic health record and will pilot closed loop referrals with specific community-based organizations. Finally, we are currently screening for food insecurity in the inpatient setting and 3 ambulatory clinics. We will be working in partnership with Ronald McDonald House to provide caregivers of hospitalized children access to food via storage of non-perishable items on specific acute care units.

Performance in the priority area

Children's hospitals are required to provide hospital equity plans that address the top 10 disparities by identifying population impact and providing measurable objectives and specific timeframes. For each disparity, hospital equity plans will address performance across priority areas: person-centered care, patient safety, addressing patient social drivers of health, effective treatment, care coordination, and access to care.

Person-centered care

Stanford Medicine Children's Health (SMCH) is committed to advancing person-centered care by ensuring that all patients and families feel seen, heard, respected, and valued in every aspect of their healthcare journey. As a result, the principles of person-centered care inform many of SMCH's health equity related initiatives.

Language access plays a critical role in ensuring equitable, safe, and effective healthcare delivery. Patients and families with a preferred spoken or written language other than English (LOE) often experience significant barriers to care when appropriate language support is not provided.

Language concordant care refers to healthcare delivery in the patients and family preferred language. SMCH aspires to provide language concordant care for patients and families with LOE; this commitment is reflected in an enterprise-wide quality improvement initiative and the inclusion of language concordant care provision as a hospital-wide quality goal for fiscal years 25 and 26.

Interventions include revising current language access policies, development and dissemination of language concordant care guidelines, promotion of the Qualified Bilingual Staff Program, optimizing

workflows for requesting interpreters, implementing unit-based interpreters across inpatient units, and exploring ways to incorporate data from the organizations video interpretation vendor to more accurately capture our language concordant care efforts. This initiative consists of a portfolio of work inclusive of not only interpreter and translation-related efforts but also digital access via modalities such as MyChart.

Additionally, the organization works collaboratively with patients, caregivers, and community partners to design and improve care systems. This includes incorporating direct input from families and community partners into health equity strategic planning, quality improvement initiatives and program implementation. More specifically, the Department of Family Centered Care at Stanford Medicine Children's Health consists of 50 parents whose children are a variety of ages and are seen in a variety of service lines. Most of the parents serve on Family Advisory Councils (FACs); a forum where caregivers, staff, and clinicians collaborate to enhance patient and family perspectives in operations. In addition to our service line FACs, we have a Latinx FAC and an FAC for parents who have children with developmental disabilities. This year we have also had the opportunity to be a part of the Institute for Patient and Family Centered Care's Diversity, Equity, and Inclusion learning collaborative of nearly 30 US and Canadian children hospitals. Our Chief Health Equity Officer, Dr. Ndidi Unaka, helped develop the national collaborative and is on the leadership team. As a part of that work, we aim to have a Spanish speaking parent and a parent of a child with disabilities on each of our FACs. We are almost there! Having these parents on each FAC ensures that we are co-producing initiatives and solutions with a diverse group of parents that reflect the population we serve.

Moreover, the parent mentor program is a group of FCC parents who are trained to give peer support and help families navigate the healthcare system in partnership with their child's healthcare providers. This group of parents includes native Spanish speakers and parents of children with disabilities who come to our healthcare system with a different lens. Our parent mentors also bring back the voices of the families with whom they work so that their perspectives are shared with our organization.

Patient safety

Our Patient Safety Program (PSP) supports organization-wide engagement in safety activities and is aligned with national best practices, including high reliability principles. SMCH's deployment of the Mission Zero initiative, through membership in the Solutions for Patient Safety (SPS) collaborative, reflects our commitment to eliminating preventable harm. This framework emphasizes evidence-based practices that reduce harm and strengthen safety culture. These practices are fully embedded in the Daily Management System (DMS), resulting in measurable improvements in harm prevention and long-term safety culture. Notably, SMCH achieved a 79% decrease in Serious Safety Events (SSEs) per fiscal year between 2017 and 2024 (24 to 5). As of FY25, only four SSEs have occurred to date, which would equate to an 83% reduction if sustained through August 2025.

We also recognize that inequities exist in patient safety, with racial/ethnic minorities and those on public insurance experiencing higher rates of adverse events. To address this, SMCH:

1. Disaggregates safety metrics by race, ethnicity, language, and payer, including serious safety events and hospital-acquired infections.
2. Operates a patient safety reporting system that allows teams to document when barriers such as language contributed to incidents.
3. Leverages a large language model (LLM) to categorize incident reports with a dedicated equity category, improving detection of inequities within safety events.

In 2022, SMCH implemented the RCA2 methodology as the standard for conducting Root Cause Analyses (RCAs), enabling more efficient reviews, stronger corrective actions, and improved resource stewardship. In 2024, in collaboration with SPS, we launched Proactive Safety

methodologies. These approaches identify risks earlier and support low-resource interventions before escalating to SSEs. Together, these methods represent a cultural shift toward prevention and resilience in patient safety. Activities supporting these efforts include national presentations, SPS learning sessions, and local integration of SPS tools into daily operations. Weekly Event Review meetings ensure cross-disciplinary accountability and determine when further analysis is required. All SSEs are evaluated for Root Cause Analysis (RCA), Common Cause Analysis (CCA), or proactive risk assessments, with each case assigned an executive sponsor for oversight. The Chief Health Equity Officer is invited to all event reviews. Oversight of patient safety is embedded across leadership. The Chief Quality Officer, reporting to the Chief Medical Officer, is responsible for enterprise-wide patient safety, quality improvement, and performance improvement. The Vice President of CPMV provides operational oversight, while the Director of Patient Safety coordinates RCA/CCA reviews and frontline engagement. Patient Safety Advisors manage the electronic reporting system, ensuring confidentiality under California Evidence Code 1157, and conduct data analyses for trend identification and strategic planning.

To further advance equity and transparency, SMCH utilizes a sophisticated safety dashboard that integrates visual analytics with a critical equity lens. This system disaggregates patient safety data by race, ethnicity, language, and insurance type, empowering multidisciplinary teams to uncover disparities and direct resources toward targeted interventions. The dashboard supports proactive risk identification, enhances accountability, and drives continuous quality improvement. Recent milestones illustrate our progress:

- Implementation of RCA2 methodology (2022) as the hospital standard for RCAs.
- A 79% reduction in SSEs (2017 - 2024), with early FY25 data indicating an even greater decline if sustained.
- Launch of Proactive Safety methodologies (2024), helping frontline teams identify and mitigate safety risks earlier.
- Development of the LLM to analyze near-miss and precursor safety events, enhancing early detection and enabling equity-focused insights from the 99% of safety data not captured in SSEs.

Together, these initiatives highlight SMCH's commitment to preventing harm, fostering transparency, and ensuring equitable patient safety for all the populations served.

Addressing patient social drivers of health

SMCH continues to prioritize the identification of and response to health-related social needs (HRSN) as part of its broader commitment to advancing health equity. The organization distinguishes between social risk factors, such as food insecurity and housing instability, and health-related social needs that require an immediate response to support individual and family well-being. To address these needs, SMCH has implemented enterprise-wide screening workflows. Screening is currently conducted in both the inpatient setting and across three ambulatory clinics, with a focus on food insecurity. Future implementation phases will expand to other key domains such as housing instability, transportation needs, and financial strain, via use of a core HRSN questionnaire. Bundle food insecurity questions with other relevant screenings will help normalize the inquiry. Currently, screening for food insecurity is initiated by frontline staff (e.g. nurses). Patient/caregiver responses are then entered into the EHR. Evidence suggests that patients and families are more likely to disclose HRSNs if the screening questions are self-administered. We aim to pilot the deployment of a core HRSN screener via EPIC MyChart in FY 26. Efforts to streamline processes across the care delivery system are central to this work. SMCH is actively coordinating internally to reduce duplicative screening efforts and optimize workflows that ensure timely follow up and support. This includes building infrastructure that supports both screening and referral at scale and establishing mechanisms to monitor impact. D

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The organization is also working to build out coordinated response pathways. In December 2024, SMCH integrated the FindHelp closed-loop referral platform into EPIC. This system enables staff to connect families with community-based resources based on their specific needs and supports closed-loop referrals to track whether services were accessed. Additional planning is underway to enhance workflows that allow for broader, more seamless use of FindHelp across clinical teams. Since its December 2024 integration, SMCH has focused on stabilizing and operationalizing the use of FindHelp as the enterprise-wide closed-loop referral platform. Efforts in FY25 have included building internal workflows, aligning social work and community engagement teams, and establishing governance to ensure consistent use across service lines. A key component of this work has been prioritizing community-based organizations for early onboarding, with an emphasis on high-volume partners such as Ronald McDonald House and other agencies providing wraparound support. SMCH has also worked to refine referral processes to allow both listable and non-listable programs to be captured on the platform. Efforts have begun piloting direct referral workflows to reduce reliance on self-referrals alone. Early implementation has highlighted the importance of clear training, internal communication, and technical vendor support, which will continue to be phased in across FY26. Looking forward, SMCH will focus on expanding the number of active CBO partners, improving closed-loop referral tracking, and leveraging platform analytics to identify gaps in community resource availability and strengthen equitable access for patients and families.

Performance in the priority area continued

Performance across all of the following priority areas.

Effective treatment

Stanford Medicine Children's Health recognizes the importance of ensuring patients receive equitable, evidence-based, and appropriate clinical care. Several initiatives are in place to support this effort. The successful implementation of clinical practice guidelines and pathways is a strategy to promote evidence-based healthcare delivery and practice and helps minimize the intrusion of bias in clinical practice. The Packard Clinical Pathway Program is focused on the development and implementation of high-quality clinical pathways to generate meaningful improvements in the 6 domains of healthcare quality. Currently 65 pathways have been created of which 35 have clinical decision support, and 17 have associated analytic reports. Over the past 12 months, 2 pathways have been developed and implemented to support the evaluation and management of 1) patients with Kawasaki Disease (which a specific section focused on patients of Asian ancestry) and 2) Sickle Cell Disease patients who have vaso-occlusive episodes.

Additionally, access to equitable, evidenced-based and appropriate mental and behavioral healthcare is of critical importance to our patient population. The mental and behavioral health crisis among youth, disproportionately impacts racial and ethnic minorities, LGBTQ+ youth, and those who are publicly insured. Mental health is a fundamental component of our Stanford Medicine Children's Health long-range plan and remains a recurring community health need. We are committed to addressing this need with urgency, dedication, and partnership. To advance our mission and approach to youth mental health services, the CEO of Stanford Medicine Children's Health is sponsoring a one-day mental health summit in October 2025. The summit is being co-led by the Chief Health Equity Officer, and the Senior Vice President, Chief Government Relations Officer. This summit will be crucial for us to gain a common understanding of the current landscape of youth mental health services at Stanford Medicine Children's Health. We will identify potential initiatives to improve access and prioritize key questions for future exploration. Our primary focus

during the summit will be on existing pediatric/adolescent populations cared for at Packard, but we will also welcome colleagues from Stanford Medicine more broadly and local community partners to provide a more comprehensive understanding of current state. This summit will provide a foundation from which we will be able to build a more informed strategic plan for mental health services in future sessions.

Finally, several of our clinical teams are focused on delivering equitable care to their specific patient populations. The Division of Endocrinology Teamwork, Targets, Technology, and Tight Control (4T) program is a prime example of the power of centering equity to improve patient outcomes. The 4T program uses evidence-based guidelines to redesign management of type 1 diabetes in the first year of diagnosis. The specific components of the program include 1) Team-based approach to uniform technology access and unified glycemic target setting to facilitate the development of self-management skills by patients and caregivers; 2) Incorporation of remote patient monitoring (RPM) to tighten glucose control through more frequent engagement in education and for insulin dose adjustments; and 3) Systems development to track CGM data and dashboard built to provide clinical decision support to help identify patients who would benefit from electronic health record messaging. This program was implemented via grant funding and focused on the following:

- Approached all patients with new-onset T1D who intended to follow in clinic for enrollment
- Eliminated exclusion criteria such as language and social stressors, which are normally barriers to enrollment
- Multilingual, multicultural study staff to meet the study cohort needs, including recruitment, retention and logistical support for families (e.g., tech support for video visits, patient portal messaging and sensor issues)
- For patients without CGM coverage, obtained funding to support the first year of CGM access
- Used funding to provide iPod Touch devices to patients who did not have compatible smartphones
- Helped bridge connectivity issues by helping families advocate for access to the school Wi-Fi

The 4T program has had very successful results. At 12 months after diabetes diagnosis, young people in this study had a mean HbA1c of 6.58% and mean GMI of 7.11%. An HbA1c < 7%, the American Diabetes Association and International Society for Pediatric and Adolescent Diabetes target, was reached by 64% of participants by A1c and 57% by GMI. Participants had a mean time in range of 68% with minimal hypoglycemia. Young people in 4T Study 1 had a lower HbA1c at 6 months after diagnosis. The team achieved these outcomes while providing equitable access to CGM and RPM.

Care coordination

Stanford Medicine Children's Health continues to advance integrated and patient-centered care through intentional efforts that strengthen care coordination across inpatient, ambulatory, and community-based settings. A key emphasis has been placed on improving communication and support throughout the patient's journey, especially for medically complex patients and those impacted by health-related social needs. These efforts are supported by the work of care managers who help patients and families navigate complex health systems.

The organization's Patient and Family-Centered Care Model reinforces a culture where interdisciplinary teams, families, and caregivers work collaboratively to develop and implement care plans tailored to individual patient needs. This model is supported by embedded care coordination practices that prioritize shared decision making and responsiveness to family goals and preferences. Care coordination is also being operationalized through initiatives such as our Social Determinants of Health strategy, which leverages screening tools and closed-loop referral pathways to connect families to community resources. This work is supported by collaboration among clinical, social

work, and community engagement teams, ensuring that families receive holistic support that extends beyond the hospital walls.

Specialized care management teams exist to support the needs of patient families who demonstrate the greatest risk factors. For families of patients who have concurrent medical and psychosocial complexities, the Novel Interventions in Children's Healthcare (NICH) program is available. Through this, NICH navigators who carry very limited caseloads of up to 8 families spend 12 months working with those families to optimize their utilization of the healthcare system. Each navigator is empowered to support families creatively as they address factors that destabilize, helping them move to self-management over the course of the year of intensive services. Another program, Coordinating and Optimizing Resources Effectively (CORE) focuses on supporting families of patients who are seen in three or more specialty clinics, for whom the coordination of care becomes complex and often burdensome. In this program, a transdisciplinary team including a nurse coordinator, case manager, care coordinator, social worker, and medical director collaboratively assess and triage the needs of families, helping by stacking appointments on the same day, facilitating transportation coordination, and otherwise removing barriers to care. The aim here, too, is to educate and empower families to move toward self-management and graduate from the program.

Our Stanford Children's International Patient Services (SCIPS) further exemplifies patient-centered care coordination. At SCIPS we are committed to providing world-class healthcare tailored for our international patient community. We welcome young patients from diverse countries. Recent countries of origin represented in our patient population include Poland, Argentina, Brazil, Peru, the UK, UAE, Saudi Arabia, China, Taiwan, Japan, and Singapore, establishing ourselves as leaders in pediatric care. With expertise in additional critical specialties such as obstetrics as well as reproductive endocrinology and infertility services, we manage around 30 inpatient discharges each year, ensuring both outstanding care and strong financial performance. Our renowned Centers of Emphasis (COEs), the Heart Center, the Johnson Center for Mothers and Babies, and Medical Specialties, are designed to meet the unique needs of our international families. We streamline appointment scheduling, facilitate financial clearance, and assist with accommodation. All aimed at creating a supportive and seamless experience. We strive to provide language concordant care, utilizing translators either in-person or via iPad or telephone if needed. The Language Concordant Care initiative further strengthens care coordination by addressing language barriers that can compromise understanding of treatment plans. Together, these initiatives reflect a system-wide commitment to advancing care coordination as a central driver of quality, safety, and equity across the continuum of care.

Access to care

Stanford Medicine Children's Health (SMCH) has prioritized equitable access to care through multiple quality, safety, and health equity initiatives. Recognizing that access is multifaceted, impacted by language, physical ability, social needs, and system navigation, SMCH has aligned its strategy to address barriers at multiple levels.

Language Concordant Care remains a central component of SMCH's access improvement efforts. The organization continues to expand and strengthen language access services for patients and families who speak a primary language other than English. Initiatives include advancing provider-patient language concordance and, improving access to professional medical interpreters. These enhancements are designed to reduce communication barriers and ensure that LOE families can fully participate in care decision-making, treatment planning, and follow-up.

SMCH has also made significant strides in addressing health-related social needs that often impact a patient's ability to access timely and appropriate care. Through a system-wide effort to integrate social needs screening and response processes, the organization is implementing a closed-loop referral platform that links families to community-based resources addressing food insecurity, housing instability, transportation challenges, and other non-clinical barriers to care.

Additionally, SMCH has committed to improving physical and digital accessibility for patients with disabilities. As part of the Phase 3 expansion of the We Ask Because We Care initiative, the organization is implementing enhanced disability data collection protocols and building workflows to ensure accommodation needs are proactively addressed. SMCH has engaged an accessibility vendor to conduct an environmental assessment of facilities and digital assets and is refining Epic-based solutions to document and track patient-specific accommodation requests. These efforts are expected to reduce barriers and enhance care access for patients and families requiring ADA-compliant services.

SMCH is also strengthening care coordination and navigation support to promote seamless transitions for complex pediatric patients, particularly during discharge and referrals to community-based care. By aligning efforts across clinical teams and social services, the organization is enhancing its ability to provide families with the information and assistance needed to engage with care services beyond the hospital walls.

In addition to internal care coordination strategies, SMCH also leverages an expansive network of external partnerships to advance access to care. With 59 strategic alliances across healthcare systems, school districts, counties, and community organizations, SMCH is able to extend high-quality care into patients' home communities. These collaborations are anchored in guiding principles of equitable access, seamless transitions to advanced care at LPCH, and the strengthening of existing community relationships to support continuity of care. Notable examples include enduring partnerships with Gardner Family Health Network and Ravenswood Family Health Network. Allowing Stanford physicians to deliver pediatric care in community settings; as well as joint ventures with regional hospitals such as Dominican Hospital and Salinas Valley Health. These strategic partnerships ensure that patients and families have geographically and culturally relevant access to services.

Furthermore, SMCH is piloting a dynamic dashboard that disaggregates missed clinic appointment data by sociodemographic factors such as clinic site, race, ethnicity, language, and payor type. This tool furnishes invaluable insights that can substantially improve patient access in numerous ways, including the identification and resolution of access barriers, optimization of resource allocation, and augmentation of clinic efficiency and patient experience. Through this data-driven approach, clinics will gain a deeper understanding of the specific factors influencing patient access to care. It facilitates the development of targeted interventions, optimizes resource use, and improves the patient experience, ultimately enhancing patient access and fostering more equitable health outcomes.

A recent pilot project leveraged this data-driven approach by implementing a machine learning model to predict and address missed appointments in a pediatric allergy and immunization clinic. The model identified high-risk patients and facilitated proactive outreach to address barriers to attendance. Results from Phase I demonstrated a reduction in missed appointments from 15.6% to 11.8%, with continued promising outcomes in Phase II. This success not only improves clinic efficiency and patient outcomes but also highlights the potential for scalable equity-driven interventions across other specialties.

Methodology Guidelines

Did the hospital follow the methodology in the Measures Submission Guide? (Y/N)

Y