

## Sutter Health

### Mills-Peninsula Medical Center

2019 – 2021 Implementation strategy Plan  
Responding to the 2019 Community Health Needs Assessment

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## Introduction

The Implementation Strategy Plan describes how Mills-Peninsula Medical Center, a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

Mills-Peninsula Medical Center welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at 1501 Trousdale Drive, Burlingame, CA 94010, Attention: Community Benefit Department; and
- In-person at the hospital's Information Desk.

## Executive Summary

Mills-Peninsula Medical Center is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating health care facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities it serves through a not-for-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health and its affiliates have committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of \$734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2018, Sutter invested \$435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2019 Community Health Needs Assessment process the following significant community health needs were identified:

- Mental Health and Well-Being
- Housing and Homelessness
- Healthy Lifestyles
- Health Care Access and Delivery
- Cancer
- Communicable Diseases
- Oral/Dental Health
- Food Insecurity
- Asthma/Respiratory Conditions
- Neighborhood and Built Environment

The 2019 Community Health Needs Assessment conducted by Mills-Peninsula Medical Center is publicly available at [www.sutterhealth.org](http://www.sutterhealth.org).

### **2019 Community Health Needs Assessment Summary**

Mills-Peninsula Medical Center (MPMC) participates in a collective needs assessment process as a member of the Healthy Community Collaborative (HCC) of San Mateo County, a collaborative body of representatives from nonprofit hospitals, the county's health department and human services agency, and other public entities. The HCC contracted Actionable Insights (AI), LLC, an independent, local research firm, to complete the Community Health Needs Assessment (CHNA).

The HCC completes a CHNA once every three years, which provides data enabling identification of priority issues affecting health and is the foundation for various health planning processes, as well as each participating nonprofit hospital's CHNA and Implementation Strategy. For the 2019 CHNA, the HCC built upon existing work by starting with a list of health needs identified during the 2016 CHNA. Updated secondary data were collected for these health needs. Community input added health needs to the list and prompted the HCC to delve deeper into questions about health care access, delivery, barriers to care, and solutions. The CHNA team also specifically sought to understand mental health needs in the community due to the strong interest in this topic expressed by community leaders.

To assess community health trends, the MPMC directed its consultant AI to obtain secondary data from a variety of sources. Primary data were obtained through direct community input: (a) key informant interviews with local health experts, (b) focus groups with community leaders and representatives, and (c) focus groups with residents.

The full 2019 Community Health Needs Assessment conducted by Mills-Peninsula Medical Center is available at [www.sutterhealth.org](http://www.sutterhealth.org).

### **Definition of the Community Served by the Hospital**

Mills-Peninsula Medical Center and its Menlo Park Surgical Hospital campus are located in San Mateo County and serves the entire county. In 2017, an estimated 771,410 people resided in San Mateo County, making it the 14th largest in California by population. The county occupies 455 square miles of land on the peninsula south of San Francisco, with the San Francisco Bay to the east and the Pacific Ocean to the west. The county also includes nearly 58 miles of coastline and 292 square miles of water. Redwood City is the largest city in the county by area, and Daly City is the largest city in the county by population (with over 107,000 residents, or 14 percent of the county's total).

Nearly 22 percent of the population in San Mateo County is under the age of 18, and 15 percent is 65 years or older. The median age is 39.5 years old. San Mateo County is also highly diverse. Notably, residents of “some other race” are the third largest racial group, accounting for 11 percent of the population. More than half of the population is White, and nearly one third is Asian. One quarter of residents have Latinx heritage. More than one third of San Mateo County residents are foreign-born.

Approximately 9 percent of the county’s population lives in a linguistically isolated household, marked by wide geographic differences. For example, less than 1 percent of the population in parts of Woodside lives in a linguistically isolated household, compared with more than 50 percent in parts of Daly City, South San Francisco, and Redwood City/North Fair Oaks.

### Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

1. **Mental Health and Well-Being:** The community prioritized mental health and well-being, including substance use, in almost all focus groups and key informant interviews. Depression, poor mental health, binge drinking, deaths from drug overdose, and the adult substance use–related emergency-department visit rate have all recently increased in San Mateo County. Chronic liver disease and cirrhosis was the #9 cause of death in the county, followed by drug-induced death at #10. Suicide ranked #11.
2. **Housing and Homelessness:** Housing is one of the chief concerns of the community and was prioritized by almost all focus groups and key informants. The median rent in San Mateo County is significantly higher than the state average and has been increasing. The proportion of county residents who recently have experienced housing instability has risen. Affordable housing (assisted housing units) is relatively scarce in the county compared with the state overall. The community described experiencing stress related to the high cost of housing.
3. **Healthy Lifestyles:** The community prioritized healthy lifestyles. This health need involves concerns about diabetes, obesity, and fitness, diet, and nutrition. Diabetes ranks among the top 10 causes of death in San Mateo County. The prevalence of diabetes and obesity are both on the rise. County statistics for adult diabetes prevalence and youth fruit/vegetable consumption are significantly worse than state averages. Adults of low socioeconomic status fail state benchmarks for overweight/obesity.
4. **Health Care Access and Delivery:** Community input suggests that health care is often unaffordable in San Mateo County. There are downward trends in the proportion of children who have a usual place for medical check-ups, the proportion of employed county residents whose jobs offer health benefits, and residents’ perceptions of the ease of access to specialty care. Residents of low socioeconomic status are more likely than higher-status groups to have health care access issues.
5. **Cancer:** Cancer is the leading cause of death in San Mateo County. Overall cancer prevalence and the incidence rates for melanoma and breast, uterine, and prostate cancers are significantly higher than state benchmarks. Certain ethnic groups in the county experience disparities, including African Ancestry and Latinx populations.
6. **Communicable Diseases:** The rates of acute hepatitis B and pertussis cases in San Mateo County are significantly higher than state benchmarks, and the rate of tuberculosis cases is greater (worse) than the Healthy People 2020 aspirational goal. Influenza/pneumonia is one of the top 10 causes of death in the county.
7. **Oral/Dental Health:** The community prioritized oral health, citing a lack of access to high-quality dental services and/or dental insurance in San Mateo County. The proportion of county residents without insurance that pays for some or all routine dental care has been rising. Low reimbursement rates and complicated billing procedures may have driven many providers away

from accepting Denti-Cal, which seems to have contributed to significant income disparities in oral health.

8. **Food Insecurity:** The county's population has been experiencing food insecurity at an increasing rate, which is already significantly higher than the state benchmark. The proportion of individuals receiving SNAP benefits, as well as the percentage receiving free meals and/or supplies from food banks, has also been rising.
9. **Asthma/Respiratory Conditions:** Asthma prevalence in San Mateo County is significantly worse than benchmarks and increasing. Conditions correlated with higher rates of asthma (e.g., overweight/obesity and smoking) are significantly higher among people of low socioeconomic status. COPD, bronchitis, and emphysema rates are twice as high as the state average and rising. Chronic lower respiratory disease and influenza/ pneumonia are both among the top 10 causes of death in the county.
10. **Neighborhood and Built Environment:** This need includes access to food and recreation, community and family safety, community infrastructure and housing quality, natural environment/climate, and transportation and traffic. Proportions of healthy food stores and WIC-authorized food stores, drinking water violations, as well as statistics for public transit access, road network density, and flood vulnerability in San Mateo County are all significantly worse than state averages. Ethnic and income disparities are evident in almost all aspects of this health need.

Health needs identification and prioritization was a multi-step process. To determine participants' health priorities, focus group members voted on their community's needs from a list derived from the previous CHNA, and key informants stated what they believed were their community's top needs. The consultant working on this project, Actionable Insights (AI), then tabulated how many focus groups and key informants cited each health need as a priority. In the fall of 2018, AI synthesized primary qualitative research and secondary and longitudinal data to create a list of health needs for the HCC.

The CEO of Mills-Peninsula Medical Center (MPMC) invited senior leadership to review the list of identified community health needs and, based on their knowledge and experience working with the community, rank each need in order of importance. The rankings from each senior leader were averaged together to produce MPMC's final list of 2019 Prioritized Health Needs.

### 2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Mills-Peninsula Medical Center plans to address significant health needs identified in the 2019 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2019 CHNA.

### Prioritized Significant Health Needs the Hospital will Address:

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Mills-Peninsula Medical Center initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Healthcare Access and Delivery
2. Mental Health and Well-Being

- 3. Oral/Dental Health
- 4. Housing and Homelessness

## Healthcare Access and Delivery

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| <b>Name of program/activity/initiative</b>                      | Samaritan House   |
| <b>Description</b>  | <p>MPMC and Samaritan House (SH), a comprehensive safety-net health and social services organization, have partnered for more than two decades to create access to primary medical care and dental care for more than 2,500 uninsured residents living in poverty in San Mateo County.</p> <p>MPMC provides SH with grant funding and uncompensated services such as screenings and mammograms. The support allows SH to extend, free of charge, comprehensive multi-specialty outpatient medical care in: cardiology, dermatology, endocrinology, gynecology, neurology, nephrology, nutrition, orthopedics, psychiatry, rheumatology, and diagnostic testing. For advanced specialty care, the partnership allows MPMC specialists to see SH patients in their offices, and its medical personnel serve as volunteers at SH Free Clinics throughout the year.</p> |
| <b>Goals</b>  | <p>Ensure primary health care access for patients who have not established primary care relationships.</p> <p>Provide SH Free Clinic with supportive services to enable the delivery of primary healthcare and health screenings.</p> <p>Provide vulnerable patients assistance with core services.</p>   |
| <b>Anticipated Outcomes</b>                                     | Sustain ongoing access to primary health care at SH health clinic and provide vulnerable patients with core services.   |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | <p>Number of persons served (including demographics if available)</p> <p>Number of people connected to a PCP</p> <p>Number of health screenings</p> <p>Number of people connected to social services</p>  |

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| <b>Name of program/activity/initiative</b>                      | Operation Access  |
| <b>Description</b>  | MPMC partners with Operation Access to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. MPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. MPMC also provides a grant to support Operation Access's operating costs. |
| <b>Goals</b>  | Increase health care equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by providing the resources and promoting the medical volunteerism needed for the donation of these services.   |
| <b>Anticipated Outcomes</b>                                     | Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients.   |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | <p>Number of persons served</p> <p>Number of services provided (surgeries, procedures, etc.)</p>  |

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| <b>Name of program/activity/initiative</b>                      | Senior Focus  |
| <b>Description</b>  | <p>Mills-Peninsula Medical Center's Senior Focus offers a variety of programs and services to help older adults and their caregivers lead more active and well-balanced lives. These programs include the following:</p> <ul style="list-style-type: none"> <li>• Adult Day Health Center: Comprised of both the Adult Day Health Program and Alzheimer's and Dementia Day Health Program; these programs provide individualized health care services under the direction of the participant's Primary Care Provider.</li> <li>• Family Caregiver Support Program: Offers classes, counseling, support groups and resources specifically for caregivers; this program can also help locate resources for participants.</li> <li>• Health Promotion and Education: Comprised of both the Diabetes Empowerment Education Program (DEEP) and the Wise &amp; Well Program; these programs offer health education, health screenings, and counseling with a nurse for participants.</li> <li>• Senior Volunteer Programs: Comprised of the Foster Grandparent Program and RSVP; these programs connect adults 55 years and older with non-profit volunteer opportunities.</li> </ul> |
| <b>Goals</b>  | Encourage and support a healthy lifestyle, quality of life and independence for older adults and their caregivers.  |
| <b>Anticipated Outcomes</b>                                     | Maintain the number older adults living in community settings rather than skilled nursing facilities and increase the well-being of caregivers.   |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | <p>Number of persons enrolled in the program (including demographics if available)</p> <p>Number of encounters</p> <p>Number connected to mental health services</p> <p>Number connected to social services</p> <p>Number of rides/transportation provided</p> <p>Number of workshops/classes offered</p> <p>Number of health screenings</p> <p>Number of outreach events</p>   |

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| <b>Name of program/activity/initiative</b> | Advanced Illness Management (AIM) Program  |
| <b>Description</b>                         | <p>Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to improve care transitions and reduce future hospitalization. It helps them to manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want.</p> <p>MPMC supports the program, providing funding towards the care of the people who enroll in the program in the San Mateo County service area.</p> <p>Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's</p> |



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|   | office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know. |
| <b>Goals</b>  | Help chronically ill patients better manager their health/illness through skilled, respectful coaching and care tailored to their needs.  |
| <b>Anticipated Outcomes</b>                                     | Increase coaching services and support for patients who need help in self-managing advanced chronic illness.  |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | Number of persons enrolled in the program (including demographics if available)<br>Number of persons transitioned to home from hospital<br>Number of persons assisted with self-managing their medications  |

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| <b>Name of program/activity/initiative</b>                      | Grants and Sponsorships Addressing Healthcare Access and Delivery  |
| <b>Description</b>  | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.<br>Examples of organizations that may receive grants or sponsorships to address Access to Care are RotaCare Coastside Clinic and Daly City Youth Center. |
| <b>Goals</b>  | Expand the county's safety net by making health care services more readily available to publicly insured and uninsured populations.  |
| <b>Anticipated Outcomes</b>                                     | Increase affordable, accessible health care services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of the underserved populations are met.     |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | MPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations. Possible metrics include:<br>Number of persons served (including demographics if available)<br>Number of classes/workshops offered<br>Number of screenings provided                     |

## Mental Health and Well-Being

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| <b>Name of program/activity/initiative</b> | Grants and Sponsorships Addressing Mental Health and Well-Being   |
| <b>Description</b>                         | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.<br>Examples of organizations that may receive grants or sponsorships to address Mental Health and Well-Being are Gatepath and Caminar.                        |
| <b>Goals</b>                               | Promote mental health and well-being in the broader community and at-risk communities   |
| <b>Anticipated Outcomes</b>                | Examples: <ul style="list-style-type: none"> <li>• Increase substance use disorder treatment services</li> <li>• Increase age appropriate art therapy services</li> <li>• Increase integrated treatment services for clients with co-occurring substance use disorder and mental health problems</li> </ul> |

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| <b>Metrics Used to Evaluate the program/activity/initiative</b> | MPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations. Possible metrics include:<br>Number of persons served (including demographics if available/applicable)<br>Number of encounters<br>Number of persons connected to mental health services or social services |
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## Oral/Dental Health

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| <b>Name of program/activity/initiative</b>                      | Grants and Sponsorships Addressing Oral/Dental Health  |
| <b>Description</b>  | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.<br>Examples of organizations that may receive grants or sponsorships to address Oral and Dental Health are Ravenswood Dental and Sonrisas.                       |
| <b>Goals</b>  | Expand the county's safety net by making dental/oral health care services more readily available to publicly insured and uninsured populations.  |
| <b>Anticipated Outcomes</b>                                     | Increase affordable, accessible oral/dental health care services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of the underserved populations are met. |
| <b>Metrics Used to Evaluate the program/activity/initiative</b> | MPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations. Possible metrics include:<br>Number of persons served (including demographics if available/applicable)<br>Number of classes/workshops offered<br>Number of screenings provided                  |

## Housing and Homelessness

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| <b>Name of program/activity/initiative</b> | Grants and Sponsorships Addressing Housing and Homelessness   |
| <b>Description</b>                         | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.<br>Examples of organizations that may receive grants or sponsorships to address Housing and Homelessness are HIP Housing and Home & Hope. |
| <b>Goals</b>                               | Prevent homelessness and counter displacement by increasing the county's access to healthy, stable and affordable housing.  |
| <b>Anticipated Outcomes</b>                | Increase affordable housing opportunities for unhoused and under housed individuals by supporting community-based organizations that develop/expand housing services to ensure that the needs of the populations are met.   |

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| <b>Metrics Used to Evaluate the program/activity/initiative</b> | MPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations. Possible metrics include:<br>Number of persons served (including demographics if available/applicable)<br>Number of individuals/families sheltered<br>Number of individuals transitioned into permanent housing<br>Number of individuals receiving housing assistance services |
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**Needs Mills-Peninsula Medical Center Plans Not to Address**

No hospital can address all of the health needs present in its community. Mills-Peninsula Medical Center is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy plan does not include specific plans to address the following significant health needs that were identified in the 2019 Community Health Needs Assessment for the following reasons:

1. Healthy Lifestyles – Indirectly through other organizations
2. Cancer – Indirectly through other organizations
3. Communicable Diseases – Indirectly through other organizations
4. Food Insecurity – Indirectly through other organizations
5. Asthma/Respiratory Conditions – Other organizations are better equipped to address this need
6. Neighborhood and Built Environment – Other organizations are better equipped to address this need

**Approval by Governing Board**

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board on November 20, 2019.