Sutter Health

Sutter Health Mills-Peninsula Medical Center

2022–2024 Community Benefit Plan

Responding to the 2022 Community Health Needs Assessment

Submitted to the Department of Health Care Access and Information May 2023

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Note: This community benefit plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

The Implementation Strategy Plan describes how Sutter Health Mills-Peninsula Medical Center (MPMC), a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022 – 2024 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.

MPMC welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022 – 2024 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, ATTN TO: Community Benefit; and
- In-person at the hospital's Information Desk.

About Sutter Health

Mills-Peninsula Medical Center is affiliated with Sutter Health, a not-for-profit, integrated healthcare system that is committed to delivering innovative, high-quality, equitable patient care and helping to improve the overall health of the communities it serves. Our 65,000 employees and associated clinicians serve more than 3 million patients in California through our hospitals, primary and specialty care centers, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org.

Sutter Health's total investment in community benefit in 2022 was $899 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health system has implemented charity care policies to help provide access to medically necessary care for eligible patients, regardless of their ability to pay. In 2022, Sutter Health invested $82 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").

2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal do not cover the full costs of providing care. In 2022, Sutter Health invested $615 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helps local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community and works to achieve health equity by visiting sutterhealth.org/community-benefit.

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 2022 Community Health Needs Assessment process, the following significant community health needs were identified:

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

The 2022 Community Health Needs Assessment conducted by MPMC is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

In 2021, a number of nonprofit hospitals/healthcare systems across San Mateo and Santa Clara counties, El Camino Health, Lucile Packard Children's Health-Stanford, Stanford Health Care, and Sutter Health's Menlo Park Surgical Hospital and Mills-Peninsula Medical Center, with additional support from the Palo Alto Medical Foundation (a nonprofit multi-specialty group), formed an informal collaborative to conduct a dual-county, triennial CHNA in compliance with current federal requirements. The 2022 CHNA, which took place over 10 months in 2021, builds upon earlier assessments in San Mateo and Santa Clara counties.

For the purposes of the assessment, "community health" was not limited to traditional health measures. The hospitals also considered indicators relating to the quality of life (e.g., access to healthcare, affordable housing, food security, education, and employment) and to the physical, environmental, and social factors that influence the health of the county's residents. This broader definition reflects the collaborating hospitals' philosophy that many factors affect community health and that community health cannot be adequately understood without consideration of trends outside the realm of healthcare.

To assess community health trends, the hospitals directed their consultant, Actionable Insights (AI), to obtain secondary data from a variety of sources. Primary data were obtained through direct community input: (a) interviews with local experts and (b) focus groups with community residents and people who serve residents.

A total of eleven health needs were identified in the 2022 CHNA, described later in this report. The full 2022 Community Health Needs Assessment conducted by MPMC is available at https://www.sutterhealth.org/.

Definition of the Community Served by the Hospital

The collaborating hospitals relied on the Internal Revenue Service's definition of the community served by a hospital as "those people living within its hospital service area." A hospital service area comprises all residents in a defined geographic area and does not exclude low-income or underserved populations. MPMC and its Menlo Park Surgical Hospital (MPSH) campus are located in San Mateo County and serve the entire county.

San Mateo County comprises 19 cities and more than two dozen unincorporated towns and areas. The county had approximately 746,752 residents in 2019. 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.[1] Redwood City is the largest city in the county by area, and Daly City is San Mateo County's largest city by population, with just over 106,000 people (14% of the county's total). The population of the county is substantially more dense than the state, with 9,206 people per square mile compared to 8,486 per square mile in California. The median age in San Mateo County is 40.3 years old. Over 20% of the county's residents are under the age of 18, and nearly 16% are 65 years or older.[2]

San Mateo County also includes the following unincorporated towns and areas, many of which are located in the Coastside area: Broadmoor, Burlingame Hills, Devonshire, El Granada, Emerald Lake Hills, Fair Oaks, Highlands/Baywood Park, Ladera, La Honda, Loma Mar, Los Trancos Woods/Vista Verde, Menlo Oaks, Montara, Moss Beach, North Fair Oaks, Palomar Park, Pescadero, Princeton, San

[1] County of San Mateo. 2015–2017 County Profile.

[2] Census data in prior paragraph from https://www.census.gov/quickfacts.

Francisco International Airport, San Gregorio, South Coast/Skyline, Sequoia Tract, Skylonda, Stanford Lands, and West Menlo Park.[3]

The ethnic makeup of San Mateo County is extremely diverse, with the non-white population representing about 62% of its total population. More than 34% of residents in San Mateo County are foreign-born. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).[4]

Our community earns some of the highest annual median incomes in the U.S., but also bears some of the highest costs of living. Median household income is $130,820 in San Mateo County, far higher than California's median of $82,053.[5] Yet the California Self-Sufficiency Standard,[6] set by the Insight Center for Community Economic Development, suggests that many households in San Mateo County are unable to meet their basic needs.[7] (The Standard in 2021 for a family with two children was $166,257 in San Mateo County.) The minimum wage in San Mateo County[8] was $14–$15.90 per hour in 2021, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 26% increase in the cost of living in San Mateo County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 3.3% per year average increase in wages in the San Jose-San Francisco-Oakland combined statistical area (which includes San Mateo County) between 2019 and 2021.

Housing costs are high: In 2021, the median home price was $1.6 million[9] and the median rent was $2,451 in San Mateo County. In San Mateo County, 26% of the children are eligible for free or reduced-price lunch and close to one quarter (22%) of children live in single-parent households. About 4% of people in our community are uninsured.

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the county's population overall is healthier than the national average.[10] Although San Mateo County is quite diverse and has substantial resources, there is significant inequality in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality[11], is higher in certain Zip Codes compared to others.

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[3] San Mateo County Assessor-County Clerk-Recorder and Chief Elections Officer. (2015). *Roster of Towns and Cities Located in San Mateo County.*

[4] Data from https://www.census.gov/quickfacts

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

[6] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic security in San Mateo County.

[7] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org/node/44

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

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

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

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

Certain areas also have poorer access to high speed internet (e.g., Zip Codes 94305, 94074), or to walkable neighborhoods (e.g., Zip Codes 94021, 94060, 94074), or jobs (e.g., Zip Codes 94014, 94015, 94044). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

Significant Health Needs Identified in the 2022 CHNA

The following significant health needs were identified in the 2022 CHNA (listed in priority order):

1. **Behavioral Health:** The community prioritized behavioral health, including mental health and substance use, in most focus groups and nearly all key informant interviews. The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Statistics suggest that youth mental health is an issue: for example, the self-harm injury hospitalization rate for youth ages 0-17 is significantly higher than the state's rate. In addition, drug overdose mortality has been rising overall in San Mateo County. There are disparities associated with behavioral health, including suicidal ideation and drug overdose deaths. Racism and discrimination as well as fear and mistrust of treatment pose barriers to BIPOC community members seeking help for behavioral health issues.

2. **Economic Security:** The community placed a high priority on economic security, including income, education, and food security. Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work. Education generally correlates with income; thus, educational statistics that differ by race/ ethnicity are particularly concerning, such as the county's lower proportions of BIPOC students who met or exceeded English-language arts and math standards, and who completed college-preparatory courses.

3. **Healthcare Access & Delivery:** Most key informants and focus group participants identified access and delivery as a priority health need. They felt there was a lack of access to primary and specialty care, especially for middle- and low-income community members and for youth. San Mateo County residents who are BIPOC experience significantly worse health than residents of other races, such as preventable hospital stays, which may be a sign of inequitable access to high-quality care. Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. The need for healthcare workforce training to deliver care in a sensitive manner was another common theme among key informants and focus group participants.

4. **Housing & Homelessness:** More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo County are extremely high. Most feedback about housing from key informants and focus group participants concerned housing affordability, which is worse in the county than the state. CHNA participants said high housing costs are driving out-migration as well as overcrowding, the latter

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

of which they noted can contribute to the spread of infectious diseases, including COVID. The county's homelessness numbers also rose in 2019 (the most recent homeless count).

5. **Cancer:** Mortality rates for cancer in San Mateo County are better than state benchmarks. However, indicators of concern include rates of breast cancer incidence, prostate cancer incidence, childhood cancer incidence, and rising prostate cancer mortality. There are socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes, which the National Cancer Institute attributes to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation.

6. **Climate/Natural Environment:** Climate issues have risen to the fore over the past three years, including climbing temperatures, more extreme weather, flooding, and wildfires. San Mateo County is at significantly greater risk of heat waves, as well as coastal and river flooding, than the state as a whole. Poor air quality may also be increasing asthma prevalence in the county. Both focus group participants and key informants mentioned the adverse effects of environmental issues, particularly on low-income and BIPOC individuals, not only related to physical health but also with regard to the mental and financial stress of evacuation due to floods or wildfires.

7. **Community Safety:** Community safety includes violent crime, domestic violence, and other forms of intentional injury. While many community safety statistics are better in San Mateo County than the state, the rate of rape in Silicon Valley is higher than the state. The homicide rate among the county's Black population is also higher than the state rate, which may, in part, be attributed to residential segregation. Among the county's youth, bullying and harassment, including cyberbullying, are worse than state rates, especially for BIPOC youth. Some experts expressed concern about COVID-related stress contributing to domestic violence and/or sexual abuse; one mentioned that virtual visits made it harder for patients experiencing domestic violence to obtain both confidentiality and safety.

8. **Diabetes & Obesity:** Although diabetes deaths appear to be trending down in San Mateo County, the trend for adult obesity has been worsening. The lack of physical activity was cited as a driver of obesity by multiple key informants, primarily in the context of the pandemic's interference with regular activities; related to this issue, the walkability index is worse for the county than the state overall. The county's BIPOC middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide. The American Diabetes Association has suggested that racism is a root cause for disparities in diabetes outcomes in minority populations.

9. **Maternal & Infant Health:** Most maternal and infant health statistics in both counties are better than state benchmarks. However, inequities in maternal and infant health exist: For example, teen births are significantly higher among young Latinas in the county compared to their peers statewide. CHNA participants felt that BIPOC people who are pregnant or have recently given birth need improved access to care. A maternal and child health expert indicated that these inequities may also be traced back not only to healthcare access and delivery barriers but also to social determinants of health such as racism.

10. **Sexually Transmitted Infections:** Although statistics on sexually transmitted infections are better than the state for San Mateo County, there are concerning trends, including the rate of syphilis and the rate of chlamydia incidence among youth. The Centers for Disease Control and

Prevention suggest that income inequality, poverty, lack of employment, relative lack of education, and distrust of the healthcare system (whether due to shame or stigma, experience or fear of discrimination, or other reasons) affect the ability of individuals to remain sexually healthy.

11. **Unintended Injuries/Accidents:** One expert noted an increase in falls among older adults, although San Mateo County's statistics are not worse than the state's. Road network density and traffic volume were both significantly higher in the county than state averages. One consequence of high traffic volume can be motor vehicle, bicycle, and pedestrian accidents. Racial inequities in accident rates have been found nationwide, and are attributed in part to unequal access to safe transportation.

Process and Criteria to Identify and Prioritize Significant Health Needs

To determine participants' health priorities, key informants and focus group members voted on their community's needs from a list derived from the previous CHNA. AI then tabulated how many focus groups and key informants chose each health need as a priority.

In the fall of 2021, AI synthesized primary qualitative research and secondary and longitudinal data to create a list of health needs for the collaborating hospitals. AI then filtered that list against a set of criteria to identify the significant needs of the community.

These criteria included:

1. Indicator meets the definition of a "health need."
2. At least two data sources were consulted.
3. Must be prioritized by multiple focus groups or key informants, or two or more direct indicators must:
    a. Exhibit documented inequities by race; or
    b. Show worsening trends; or
    c. Fail the benchmark by 5 percent or more.

Senior leadership of Mills-Peninsula Medical Center (MPMC) reviewed the list of identified community health needs and, based on their knowledge and experience working with the community, separated the needs into two priority categories based on their importance. Their review and consensus prioritization produced MPMC's final list of 2022 Prioritized Health Needs.

2022 – 2024 Implementation Strategy Plan

The Implementation Strategy (IS) describes how MPMC plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA) and is aligned with the hospital's charitable mission. The IS 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 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address:

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other MPMC 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 or discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue to focus on the health needs listed below.

Process and Criteria Used to Select Needs

Sutter Health's senior community benefit staff and MPMC leadership reviewed the 2022 CHNA report and, based upon the data and findings, selected the needs that the hospital could most appropriately address. The following health needs were selected:[12]

1. Access to Care
2. Behavioral Health
3. Economic and Housing Stability

Actionable Insights, LLC (AI) provided guidance and expertise for the IS process and conducted research on evidence-based and promising practices for each selected health strategy. AI is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

Description of Health Needs That the Hospital Plans to Address

Access to Care

Healthcare access and delivery, which affects various other community health needs, was identified as a top health need by five of seven focus groups and half the key informants in San Mateo County. Experts and county residents felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Healthcare access may be especially problematic for youth in the community: In San Mateo County schools, the ratio of students to each school nurse (4,464 to one) substantially exceeds the state ratio (2,410 to one). The county's ratio of other primary care providers (i.e., not primary care physicians) is also worse (2,130 to one) than the state's ratio (1,480 to one). In addition, San Mateo County community members who are Black, Indigenous, or other people of color (BIPOC) experience significantly worse health than residents of other races; for example, a higher rate of preventable hospital stays among Native American (27,270 per 100,000 Medicare enrollees) and Black (3,686 per 100,000 Medicare enrollees) community members versus the state rate (3,358 per 100,000 Medicare enrollees) may be a sign of inequitable access to high-quality care.

Many key informants and focus group participants connected healthcare access with economic insecurity. For example, some mentioned that low-income residents might be required to prioritize rent and food over healthcare. Some reported that low-income and undocumented community members especially have difficulty accessing insurance. Affordability, both of insurance premiums and of healthcare itself,

[12] For the purposes of simplicity and clarity in the Implementation Strategy Plan, the following changes were made to the names of the needs: (1) The need "Healthcare Access and Delivery" was renamed "Access to Care." (2) The needs "Housing and Homelessness" and "Economic Security" were merged into one need and renamed, "Economic and Housing Stability."

especially preventive care, was a particular concern; in our 2019 CHNA report, community members of Latinx and "Other" ancestries[13] in San Mateo County were significantly less likely to have health insurance than others. In 2021, CHNA participants identified the lack of information about healthcare costs for patients as another barrier to accessing care.

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide and patients' lack of privacy. They also expressed concern about the lower reimbursement rate for telephone appointments (i.e., without video). Once in-person appointments were more common again, transportation returned as a barrier to care for those living on the Coastside.

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

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility to retain coverage were specific concerns. Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to healthcare among these groups. Health system navigation was called out as especially difficult for farmworkers and other immigrants who are not familiar with U.S. health systems.

Access issues related to persons with disabilities arose among San Mateo County key informants and focus group participants. In particular, there was discussion about the difficulty people with disabilities have in affording and accessing care.

Access issues related to oral health arose as well. An oral health expert described the lack of preventive dental care for low-income and underserved populations as well as the need to integrate oral healthcare into whole-person care. The oral health expert also noted that low-income pregnant women often do not know they have dental insurance benefits while pregnant, and identified this as an opportunity for better education.

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

Behavioral Health

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need, being prioritized by five out of seven focus groups and nearly all key informants.

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported increased demand for services; however, children and adolescents were of particular concern. Before the pandemic's advent, statistics suggest that youth mental health was an issue: for example, San Mateo County's self-harm injury hospitalization rate for youth ages 0-17 (50.1 per 100,000) is significantly higher than the state's rate (22.4 per 100,000). Experts noted the lack of mental health providers and addiction services overall, especially those providing services in non-English languages.

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data before the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic. Drug overdose deaths have been rising overall in San Mateo County, from less than 8 per 100,000 people in 2016 to about 11 per 100,000 in 2019.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among San Mateo County's Black population (24 per 100,000) occur at nearly twice the rate as all Californians (14 per 100,000). Suicidal ideation occurs at a much higher proportion among the county's Pacific Islander (30%) and multiethnic (22%) 9th and 11th graders than for all California 11th graders (16%). The county's white suicide rate for all ages remains persistently higher (11.0 per 100,000) than the state rate (10.5 per 100,000). Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[14] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to BIPOC community members seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[15] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) are substantially higher for Black (39.8 per 1,000) and somewhat higher for Latinx youth (5.9 per 1,000) in San Mateo County than for California youth overall (4.1 per 1,000).

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due

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

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

to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

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

Economic and Housing Stability

More than half of all focus groups identified housing and homelessness as a top community priority. Housing costs and other costs of living in San Mateo County are extremely high; the median home rental cost of $2,451 is more than 40% higher than the median state home rental cost of $1,689. Moreover, while homeowners statewide are spending approximately 31% of their income on their mortgages, homeowners in San Mateo County are spending more than 39% of their income on their mortgages.

Nearly all focus groups and three quarters of all key informants identified economic security, including income, education, and food security, as a top community priority. Participants identified Daly City, East Palo Alto, North Fair Oaks, and the Coastside as areas of concern related to economic insecurity. Data available on economically precarious households shows that while 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion is much higher among households in San Mateo County (64%). Nearly one-third of Silicon Valley households are not meeting economic self-sufficiency standards. Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty). Experts expressed special concern for older adults in the northern part of the county who are experiencing food insecurity. In our 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic precariousness can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

Income inequality in Silicon Valley is 1.5 times higher than the state level. Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of San Mateo County's BIPOC 11th graders meet or exceed grade-level English-language arts and math standards versus California's 11th graders overall. Related to these statistics, much smaller proportions of San Mateo County's BIPOC high school graduates completed college-preparatory courses compared to high school graduates statewide. In our 2019 CHNA report, we described similar inequities in educational attainment.

Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also "overrepresented in both frontline and hardest-hit sectors" of the economy.[16] Before the pandemic, the cost of childcare may also have been a limiting factor; the annual costs of infant child care (ages 0-2) and pre-K child care (ages 3-5) were

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

substantially higher in San Mateo County ($21,847 and $16,305, respectively) than the state averages ($17,384 and $12,168, respectively).

Most feedback with respect to housing from key informants and focus group participants concerned housing affordability. The housing affordability indices[17] for San Mateo County is lower (i.e., worse) (67.2) than that of the state (88.1). CHNA participants reported the difficulty individuals in poverty—who were described as more likely to be BIPOC—have in affording housing. Focus group participants mentioned out-migration from the area due to the high cost of housing, and some described the difficulty of recruiting employees for the same reason. In San Mateo County, homelessness rose in 2019 (the most recent homeless count). Experts noted that during COVID, landlords may have evicted families with undocumented members because they expected that these families would not seek legal protections.

Other CHNA participants said high housing costs are driving overcrowding, which they noted can contribute to the spread of infectious diseases, including COVID. However, housing quality is also a concern; for example, a greater percentage of children ages 0-5 in San Mateo County (1.7%) have moderately high blood lead levels than the percentage of California children overall (1.2%).

Plan for Addressing Health Needs

Access to Healthcare

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support safety net clinics, including dental clinics[18]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members.
Anticipated Outcomes	Increased access to healthcare.
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available)

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

[18] Knudsen, J., & Chokshi, D. A. (2021). Covid-19 and the Safety Net—Moving from Straining to Sustaining. *New England Journal of Medicine*, 385(24), 2209-2211. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp2114010

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to healthcare, including oral healthcare, among vulnerable populations (e.g., supporting promotorx, community health navigators, *pro bono* surgery)[19, 20, 21, 22, 23]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Reduced emergency department admissions for primary care and improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of emergency department admissions (including demographics if available)

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[20] Tomer, A., Fishbane, L, Siefer, A., & Callahan, B. (2020). Digital prosperity: How broadband can deliver health and equity to all communities. *Brookings Institute.* Retrieved from https://www.brookings.edu/research/digital-prosperity-how-broadband-can-deliver-health-and-equity-to-all-communities/ See also: Zuo, G. W. (2021). Wired and Hired: Employment Effects of Subsidized Broadband Internet for Low-Income Americans. *American Economic Journal: Economic Policy.* 13(3): 447-82. Retrieved from https://www.aeaweb.org/articles?id=10.1257/pol.20190648

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[22] Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human Resources for Health*, 16(1), 39. Retrieved from https://link.springer.com/article/10.1186/s12960-018-0304-x

[23] Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, 117(S15): 3541-3550. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/cncr.26264/full. See also: Yates, P. (2004). Cancer care coordinators: Realizing the potential for improving the patient journey. *Cancer Forum*, 28(3):128-132. Retrieved from http://eprints.qut.edu.au/1739/1/1739.pdf.

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to social services that address housing insecurity, which is a driver of poor healthcare access[24, 25, 26, 27]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Improved quality of life among vulnerable/unhoused individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of referrals to social and mental health services

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to improve access to healthcare via better transportation options, mobile clinics, and/or telehealth, including teledentistry[20, 28, 29, 30, 31, 32]

[24] Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A.H., Arya, N., & Hannigan, T. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PloS One*, 15(4), p.e0230896. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230896

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[32] Estai, M., Kanagasingam, Y., Tennant, M., & Bunt, S. (2018). A systematic review of the research evidence for the benefits of teledentistry. *Journal of Telemedicine and Telecare*, 24(3), 147-156. Retrieved from https://www.researchgate.net/profile/Mohamed-

Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Fewer missed appointments/reduced no-show rate
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of telehealth visits (including demographics if available) Number of visits to mobile clinics (including demographics if available)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support collaboration with other providers in the county to reduce silos around access to care (e.g., streamlining intake and referral process, universal walk-in policy)[33, 34, 35, 36, 37, 38]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Improve access to affordable, high-quality healthcare services for vulnerable community members
Anticipated Outcomes	Improved collaboration and efficiency in healthcare access, reduced wait times for appointments, and improved health equity

Estai/publication/312836443_A_systematic_review_of_the_research_evidence_for_the_benefits_of_teledentistry/links/59e06af8a6fdcca9842ec1a0/A-systematic-review-of-the-research-evidence-for-the-benefits-of-teledentistry.pdf

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[35] Unützer, J., Harbin, H, Schoenbaum, M., & Druss, B. (2013). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes.* Health Home Information Resources Center. Retrieved from https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. See also: Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 347: f4913.

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[38] Mohler, J. M. (2013). Collaboration across clinical silos. *Frontiers of Health Services Management,* 29(4): 36-44.

Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of services provided (surgeries, procedures, etc.) Number of MPMC medical volunteers Average wait times for appointments

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support workforce development efforts to increase the number of bilingual and LGBTQ healthcare workers from the local community[39, 40, 41, 42, 43, 44]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Increase levels of culturally competent, compassionate, and respectful healthcare delivery
Anticipated Outcomes	Increased access to care among underserved community members, especially individuals with limited English proficiency
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of family medicine residents trained Number of patient visits per year at MPMC (including demographics if available) Number of patient visits per year at local FQHC (including demographics if available)

[39] Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.

[40] Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.

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Behavioral Health

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to increase mental/behavioral health services for youth and other vulnerable populations[45, 46, 47, 48, 49, 50, 51, 52, 53, 54]

[45] Chiesa, A. & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research*, 187(3), 441-453. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20846726 ; also, Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. *Journal of Psychiatric Practice*, 18(4), 233-252. Retrieved from www.ncbi.nlm.nih.gov/pubmed/22805898 ; see also Zenner, C., Herrnleben-Kurz, S., & Walach, H. (2014). Mindfulness-based interventions in schools—a systematic review and meta-analysis. *Frontiers in Psychology*, 5, 603. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC4075476/

[46] Lopez-Maya, E., Olmstead, R., & Irwin, M. R. (2019). Mindfulness meditation and improvement in depressive symptoms among Spanish-and English speaking adults: A randomized, controlled, comparative efficacy trial. *PloS One*, 14(7), e0219425. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0219425

[47] Firth, J., Torous, J., Nicholas, J., Carney, R., Pratap, A., Rosenbaum, S., & Sarris, J. (2017). The efficacy of smartphone-based mental health interventions for depressive symptoms: A meta-analysis of randomized controlled trials. *World Psychiatry*, 16: 287-298. Retrieved from doi.org/10.1002/wps.20472

[48] Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *International Review of Psychiatry*, 26(4), 467-475. Retrieved from https://www.researchgate.net/profile/Gergoe-Hadlaczky/publication/264867737_Mental_Health_First_Aid_is_an_effective_public_health_intervention_for_improving_knowledge_attitudes_and_behavior_A_meta-analysis/links/55e99d7308ae21d099c2fcc8/Mental-Health-First-Aid-is-an-effective-public-health-intervention-for-improving-knowledge-attitudes-and-behavior-A-meta-analysis.pdf

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[52] Brister, T., Cavaleri, M. A., Olin, S. S., Shen, S., Burns, B. J., & Hoagwood, K. E. (2012). An evaluation of the NAMI basics program. *Journal of Child and Family Studies*, 21(3), 439-442. Retrieved from https://www.researchgate.net/profile/Kimberly-Hoagwood/publication/251197055_An_evaluation_of_the_NAMI_basics_program/links/0deec52cdb946573b1000000/An-evaluation-of-the-NAMI-basics-program.pdf

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Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Promote mental/behavioral health among youth and other vulnerable populations
Anticipated Outcomes	Improved mental/behavioral health among youth and members of other vulnerable populations
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of encounters

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support integrated mental health and substance use services/treatment for co-occurring mental illness and addiction[55]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Promote mental/behavioral health among youth and other vulnerable populations
Anticipated Outcomes	Improved access to mental healthcare and substance use services for vulnerable populations, improved coordination of mental/behavioral health services, and improved mental and behavioral health among homeless and vulnerable individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available) Number of encounters

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support efforts to increase integration of behavioral health services into existing primary care settings for vulnerable county residents[26, 34, 35]

Retrieved from https://www.researchgate.net/profile/Robert-Glueckauf/publication/8392677_Online_Support_and_Education_for_Dementia_Caregivers_Overview_Utilization_and_Initial_Program_Evaluation/links/599e0f360f7e9b892bb40c7f/Online-Support-and-Education-for-Dementia-Caregivers-Overview-Utilization-and-Initial-Program-Evaluation.pdf

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Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Promote mental health among youth and other vulnerable populations
Anticipated Outcomes	Improved access to mental healthcare and substance use services for vulnerable populations and improved mental and behavioral health among homeless and vulnerable individuals
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served (including demographics if available)

Economic and Housing Stability

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that expand affordable housing opportunities (rental and ownership), including those on existing residential properties[56, 57]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Increased amount of and access to affordable housing
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of affordable housing units in community

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support local homeless prevention and intervention organizations that provide temporary housing, financial assistance, career guidance/support, case management, and/or other needed services to homeless and otherwise vulnerable community

[56] Hope, H. (2022). *Accessory dwelling units promoted as a strategy to increase affordable housing stock at White House event.* Smart Growth America. Retrieved from https://smartgrowthamerica.org/white-house-adus-event/ See also: California Department of Housing and Community Development. (2021). *Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs).* Retrieved from https://www.hcd.ca.gov/policy-research/accessorydwellingunits.shtml

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	members[58, 59, 60, 61, 62]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Increased social services to prevent homelessness, and more community members remain independent longer
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants linked to social services (e.g., cash aid, legal support, counseling)

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs and initiatives for the retention of providers in community/safety net clinics[40, 41, 42]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community

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[59] Holl, M., Van Den Dries, L., & Wolf, J. R. (2016). Interventions to prevent tenant evictions: a systematic review. *Health & Social Care in the Community*, 24(5), 532-546. Retrieved from https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12257 . See also Cassidy, M. T., & Currie, J. (2022). *The Effects of Legal Representation on Tenant Outcomes in Housing Court: Evidence from New York City's Universal Access Program (No. w29836).* National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w29836/w29836.pdf

[60] Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27(4), 334. See also Santa Clara County. (Undated). *Evidence That Supportive Housing Works*. Retrieved from https://housingtoolkit.sccgov.org/sites/g/files/exjcpb501/files/Evidence%20That%20Supportive%20Housing%20Works.pdf

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[62] Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, 96(10), 1727-1729. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2005.070839 . See also: Jason, L. A., Davis, M. I., & Ferrari, J. R. (2007). The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive Behaviors*, 32(4), 803-818.

	members with a living wage
Anticipated Outcomes	Reduced economic insecurity, more people employed in healthcare settings, and greater diversity among healthcare workers
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of providers by tenure in each clinic Number of loans repaid

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that improve substandard living conditions, including overcrowding[63, 64]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Reduced proportion of overcrowded, sub-standard dwellings and related improved health outcomes
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support initiatives to routinize the use of social determinants of health screenings during primary care visits[65, 66]

[63] ChangeLab Solutions. (2015). *Up to Code: Code Enforcement Strategies for Healthy Housing.* Retrieved from https://changelabsolutions.org/sites/default/files/Up-tp-Code_Enforcement_Guide_FINAL-20150527.pdf

[64] See, for example, Kercsmar, C. M., Dearborn, D. G., Schluchter, M., Xue, L., Kirchner, H. L., Sobolewski, J., Greenberg, S. J., Vesper, S. J. & Allan, T. (2006). Reduction in asthma morbidity in children as a result of home remediation aimed at moisture sources. *Environmental Health Perspectives*, 114(10): 1574-1580. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626393/ . See also: Sauni, R., Uitti, J., Jauhiainen, M., Kreiss, K., Sigsgaard, T., & Verbeek, J. H. (2013). Remediating buildings damaged by dampness and mould for preventing or reducing respiratory tract symptoms, infections and asthma. *Evidence-Based Child Health: A Cochrane Review Journal*, 8(3), 944-1000.

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[66] O'Gurek, D. T., & Henke, C. (2018). A practical approach to screening for social determinants of health. F*amily Practice Management*, 25(3), 7-12. Retrieved from https://www.aafp.org/pubs/fpm/issues/2018/0500/p7.html?cmpid=em_FPM_20180516 and see American Academy

Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce housing instability among community members in order to support improved health
Anticipated Outcomes	Improved health outcomes for those at-risk of and/or experiencing homelessness
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of people served Number of referrals to social services

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs that combine housing and employment for currently or recently unhoused individuals[67, 68, 69, 70]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	More people earning a living wage
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants Number of participants employed before and after program participation

of Family Physicians. (Undated). *Social Needs Screening Tool.* Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

[67] Tsemberis, S., Joseph, H., et al. (2012). Housing First for Severely Mentally Ill Homeless Methadone Patients. *Journal of Addictive Diseases*, (31)3, 270-7. See also Davidson, C., et al. (2014). Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use. *Psychiatric Services*, 65(11), 1318-24.

[68] Poremski, D., Rabouin, D., & Latimer, E. (2017). A randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(2), 217-224.

[69] Bretherton, J., & Pleace, N. (2019). Is work an answer to homelessness?: Evaluating an employment programme for homeless adults. *European Journal of Homelessness*, 59-83. Retrieved from https://eprints.whiterose.ac.uk/145311/1/13_1_A3_Bretherton_v02.pdf

[70] Johnsen, S., & Watts, B. (2014). Homelessness and Poverty: reviewing the links. In Paper presented at the *European Network for Housing Research (ENHR)* conference (Vol. 1, p. 4). Retrieved from https://pure.hw.ac.uk/ws/portalfiles/portal/6831437/ENHRfullpaper_H_P.pdf

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support programs shown to increase the pipeline of diverse education and healthcare providers[39, 71, 72]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	More people employed in healthcare settings and greater diversity among healthcare workers
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of family medicine residents and allied health program interns and fellows trained (including demographics if available) Number of students participating in pipeline programs (including demographics if available) Number of staff supervising and training students

Name of Program/ Activity/Initiative	Grants, sponsorships, and/or collaborative partnerships to support employment-support or job-training programs that include financial literacy education[73]
Description	Grants, sponsorships, and partnerships are decided annually based on community need. Selected executed grants, sponsorships, and partnerships will be reported at year end.
Goal	Reduce barriers to employment/careers that provide community members with a living wage
Anticipated Outcomes	More people earning a living wage, reduced economic insecurity
Metrics Used to Evaluate the Program/Activity/ Initiative	Possible metrics include: Number of program participants (including demographics if available)

[71] Mannion, R. (2014). Enabling compassionate healthcare: perils, prospects and perspectives. *International Journal of Health Policy and Management*, 2(3), 115-7. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992785/

[72] Lown, B. A., Muncer, S. J., & Chadwick, R. (2015). Can compassionate healthcare be measured? The Schwartz center compassionate care scale™. *Patient Education and Counseling*, 98(8), 1005-1010. Retrieved from https://research.tees.ac.uk/ws/files/6461528/581617.pdf

[73] Cedeño, D., Lannin, D. G., Russell, L., Yazedjian, A., Kanter, J. B., & Mimnaugh, S. (2021). The effectiveness of a financial literacy and job-readiness curriculum for youth from low-income households. Citizenship, *Social and Economics Education*, 20(3), 197-215. See also Lopus, J. S., Amidjono, D. S., & Grimes, P. W. (2019). Improving financial literacy of the poor and vulnerable in Indonesia: An empirical analysis. *International Review of Economics Education*, 32, 100168. Retrieved from https://www.sciencedirect.com/science/article/pii/S1477388019300143

Evaluation Plans

As part of MPMC's ongoing community health improvement efforts, it partners with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through its triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

MPMC will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, MPMC will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report year-end performance on annual metrics, which are synthesized and shared with the public as well as state and federal regulatory bodies.

Needs Sutter Health Mills-Peninsula Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Health Mills-Peninsula Medical Center (MPMC) 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 2022 Community Health Needs Assessment for the following reasons:

1. **Cancer:** This need was of lower priority to the community than other needs. MPMC addresses this need indirectly through Access to Healthcare strategies.

2. **Climate/Natural Environment:** This need was of lower priority to the community than other needs. This is outside of MPMC's core competencies and is being addressed by other organizations.

3. **Community Safety:** This need was of lower priority to the community than other needs. This topic is outside of MPMC's core competencies. Other organizations are better equipped to address this need.

4. **Diabetes and Obesity:** This need was of lower priority to the community than other needs. MPMC addresses this need indirectly through other strategies and through work with other organizations.

5. **Maternal and Infant Health:** This need was of lower priority to the community than other needs. MPMC addresses this need indirectly through Access to Healthcare strategies.

6. **Sexually Transmitted Infections:** This need was of lower priority to the community than other needs. MPMC addresses this need indirectly through Access to Healthcare strategies and through work with other organizations.

7. **Unintended Injuries/Accidents:** This need was of lower priority to the community than other needs. Prevention of this need is outside of MPMC's core competencies; other organizations in the community are better equipped to address prevention.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan were approved by the Sutter Health Bay Hospitals Board of Directors on October 19, 2022.

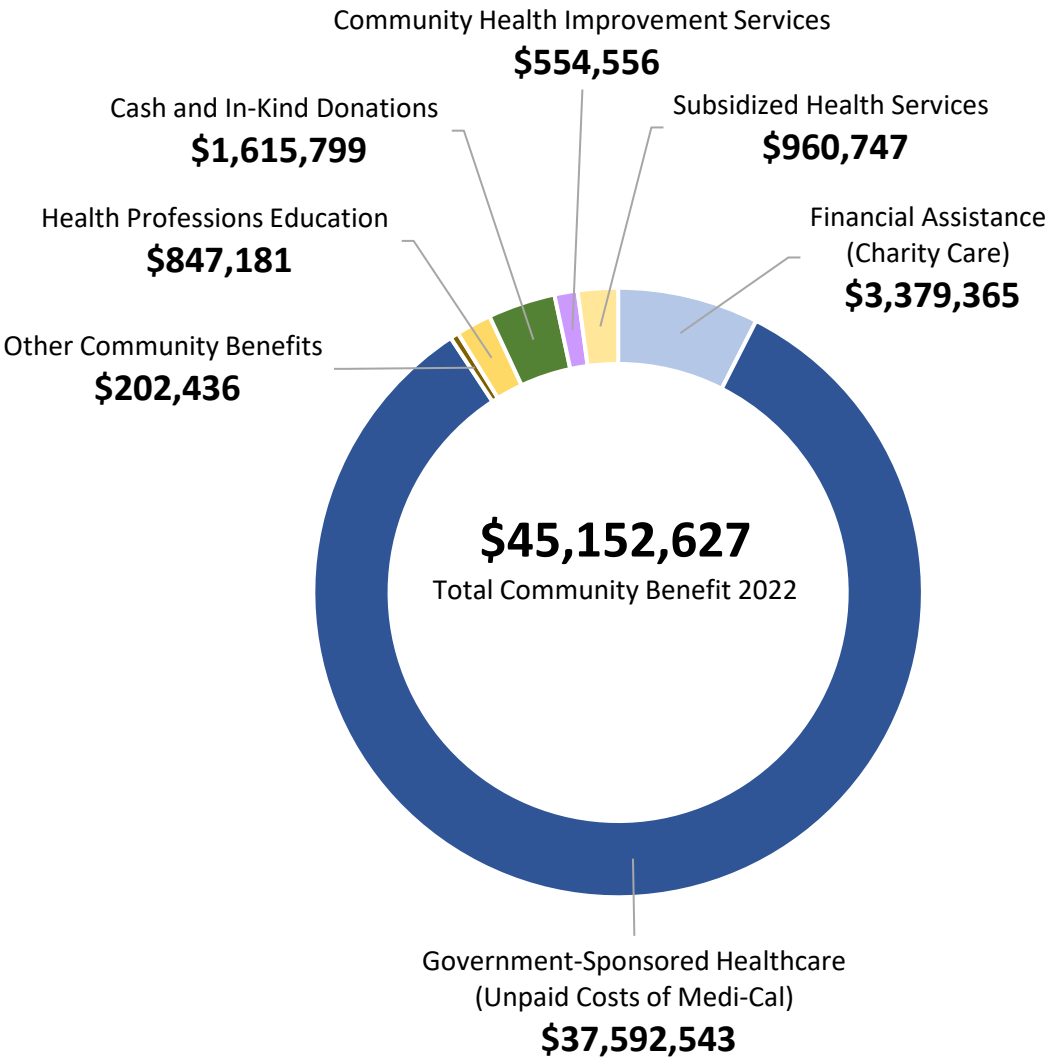
Appendix: 2022 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

The graph of Mills-Peninsula Medical Center community benefit investments on the following page includes Mills Health Center.

Mills-Peninsula Medical Center & Mills Health Center 2022 Total Community Benefit & Unpaid Costs of Medicare



2022 unpaid costs of Medicare were $117,056,973