Sutter Health
Mills-Peninsula Medical Center

2016 – 2018 Implementation Strategy
Responding to the 2016 Community Health Needs Assessment

Mills-Peninsula Medical Center
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www.sutterhealth.org

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Introduction

The implementation strategy describes how Mills-Peninsula Medical Center (MPMC) a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). This document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016 - 2018 determined priorities were reviewed by the hospital to understand and address community health needs in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The implementation strategy 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 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 the patients' ability to pay.

MPMC welcomes comments from the public on the 2016 Community Health Needs Assessment and 2016 – 2018 implementation strategy. 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 1501 Trousdale Dr. Burlingame, CA 94010 and attention to Community Benefit Department; and
- In-person at the hospital's Information Desk.

About Sutter Health

MPMC is operated by Sutter Health as a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, they provide an 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 has committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2015 commitment of $957 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 2015, Sutter Health invested $712 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for 20 percent of Sutter Health's gross patient service revenues in 2015. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2015, Sutter Health's investment in charity care was $52 million.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. We also support 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 hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and address real community needs.

For more facts and information about MPMC visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

In accordance with legislative requirements, MPMC participated in the Healthy Community Collaborative of San Mateo County (HCC) to conduct a CHNA of its service area, San Mateo County (SMC). HCC was formed in 1995 as a subcommittee of the San Mateo County Hospital Consortium. It is a 10 member organization consisting of representatives from nonprofit hospitals, County Health Department and Human Services, public agencies, and community based organizations. In 2015, HCC engaged Applied Survey Research (ASR) to conduct the 2016 CHNA on its behalf. ASR obtained primary and secondary data from a variety of sources, including community input and focus groups to assess community health trends. The mission of the collaborative is to promote the health and well-being of residents living in San Mateo County by identifying and addressing community health needs.

The full 2016 Community Health Needs Assessment conducted by MPMC is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Spreading over 744 sq. miles, San Mateo County is located on the San Francisco Peninsula. It contains 20 cities and towns, and is bordered by the City of San Francisco on the north, San Francisco Bay on the east, Santa Clara County of the south, and the Pacific Ocean on the west. SMC is a mix of urban and suburban industrial, small business, and residential use. The Coastal area is renowned for its significant agricultural, fishing, small business and tourism.

According to the US Census the estimated population in 2014 was 744,581. The County's population is aging and the trend is expected to increase over the next decades. Less than one quarter (24%) of the residents are under the age of 20, while 35% are between the ages of 20 and 44, and the rest (41%) of the residents are over the age of 44. Those aged 60 and older will increase from 20.0% (in 2014) to 30.9%. By 2050, the Asian/Pacific Islander and Hispanic seniors will comprise the largest proportion of seniors.

SMC is also becoming increasingly diverse. The US Census estimates that by 2050, the white population will drop from 43% to 22%, the Latino population will increase from 26% to 38%, the Asian/Pacific Islanders will increase from 26% to 32% and the African-American population will experience a slight increase from 3% to 4%. Currently, the child population is more diverse than the adult population.

One in ten children aged 18 and younger live below the Federal Poverty Level (FPL) and 8% of all SMC individuals live below FPL. According to the 2014 Family Self-Sufficiency Standard (FSSS), a single parent with two children living in SMC must earn approximately $97,200 annually to meet the family's basic needs – the equivalent of five full-time minimum-wage jobs in SMC.

Between 2013 and 2014, there was a 12% drop in the number of uninsured Californians aged 18-64 years old according to data cited by the California Healthcare Foundation. The San Mateo County Health System reported that as of March 2016 (based on 2014 census data) an estimated 62,000 county residents had enrolled in health insurance coverage, made possible by ACA. However, an estimate of 50,000 adults remain uninsured in SMC, approximating an uninsured rate of 7%. SMC no longer insures undocumented immigrants because they are eligible for Covered CA and without SMC's subsidy the care offered through Covered CA is unaffordable for most undocumented immigrants.

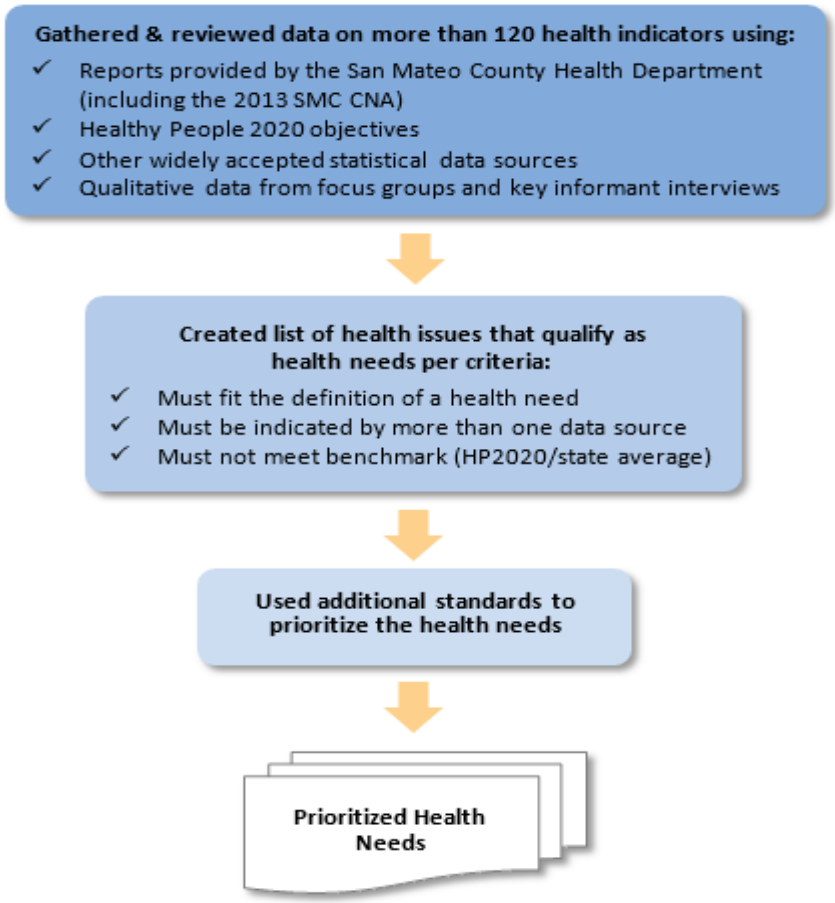
Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. Healthcare Access and Delivery
2. Oral/Dental Health
3. Behavioral Health
4. Well Being
5. Heart Disease & Stroke
6. Diabetes

Criteria used to identify health needs

To identify San Mateo County's Health needs, the 2016 CHNA followed a series of steps show in the graphic below:



Hospital Prioritization Process

Following the HCC review of countywide health needs, MPMC chose a set of criteria to use in a format prioritization of the list of 21 health needs. The criteria were:

- Clear disparities or inequities
- Severity of need: Magnitude /Scale
- Prevention opportunity
- Multiplier effect

2016 – 2018 Implementation Strategy

The implementation strategy describes how MPMC plans to address significant health needs identified in the 2016 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 2016 CHNA.

The Implementation Strategy serves as a foundation for further alignment and connection of other MPMC initiatives that may not be described herein, but which together advance commitment to improving the health of the communities it serves. Each year, MPMC programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change or continue.

The prioritized significant health needs the hospital will address are:

1. Health Care and Delivery
2. Dental/Oral Health
3. Behavioral Health
4. Well Being

Health Care and Delivery

Name of program/activity/initiative	Samaritan House
Description	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. In addition, the partnership provides MPMC's vulnerable patients with access to SH intensive case management and support services, including: shelter, homelessness prevention, nutrition, housing, financial empowerment, and more. 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.
Goals	1) Ensure primary health care access for patients who have not established primary care relationships 2) Provide SH Free Clinics with supportive services to enable the delivery of primary healthcare and health screenings 3) Provide vulnerable patients assistance with core services
Anticipated Outcomes	Goal 1) - SH's operations are meeting patients' needs - Improve patient tracking capacities between MPMC and SH Goal 2) - Sustain ongoing access to primary health care at Samaritan House Health Clinics - SH to employ a full time equivalent nurse practitioner Goal 3) - Provide vulnerable patients assistance with core services
Plan to Evaluate	Goal 1) - Develop a system that connects directly MPMC with SM Free Clinic Staff - SH has an adequate labor capacity to provide access to primary health care - SH to provide patient cards enabling MPMC to identify SH's patients at any point of entry Goal 2) - MPMC to Provide quarterly reports quantifying the utilized Service lines Goal 3) - SH to offer face to face assessments within 1 business day for MPMC referrals - MPMC to send weekly referral reports - SH to submit quarterly reports describing and quantifying the services provided for each referral
Metrics Used to Evaluate the program/activity/initiative	Annual metrics: Goal 1) - Offer MPMC referrals with health care within 5 days of the referrals - Facilitate long term reduction in repetitive visits to MPMC's emergency department Goal 2) - 800 patients will receive services including 500 mammograms, 125 pap smears, 185 HpV tests, 185 Ultrasounds Goal 3) - 80% of clients assessed for homeless prevention services

Name of program/activity/initiative	Senior Focus- Family Caregiver Support Program
Description	Senior Focus has been supporting family caregivers since 1985. It provide services in four areas: education, support groups, individual counseling and information & referral services. Senior Focus sponsors monthly support groups for caregivers including Caring for Elders and Alzheimer's Caregivers. Senior Focus also provides classes on how to manage the care of a loved one as well as how to care for one's own stress while caregiving. One to one counseling is available for those who need or want individualized services. Senior Focus offers an extensive resource library with numerous books and other print materials that are available to support planning and care needs. These services provide family caregivers with the resources allowing them to keep their loved ones living in a community setting rather than in an institution - thereby increasing dignity and quality of life as well as reducing the overall costs of care. San Mateo County Aging and Adult Services has been partially funding these programs since 2000 with annual funding ranging between $20,000 and $45,000. Senior Focus promotes the program using the MPMC's website, advertising in local newspapers, and distribution of flyers to the medical staff, libraries, senior centers and other likely places from which referrals might be made.
Goals	The goal is to provide education and support to family caregivers so that they can continue to care for their loved ones in the least restrictive setting possible. Content areas include physical and emotional aspects of care, knowledge about community resources, home safety, and caring for one's self while caregiving.
Anticipated Outcomes	90% of the caregivers will report that they learned something that will help them in caregiving role.
Plan to Evaluate	Written evaluations completed by those who receive the service will measure their increase in knowledge about the physical aspects of care, community resources, home safety, and caring for one's self while caregiving. We expect to exceed 2015 baseline data.
Metrics Used to Evaluate the program/activity/initiative	Expect to provide annually: - 78 hours of classes and support groups per year - 240 hours of counseling and Information & Referral per year - 300 clients served per year.

Name of program/activity/initiative	Senior Focus: Adult Day Health/Alzheimer's Day Care
Description	Individuals enrolled in the Adult Day Health and Alzheimer's Day Care Resource Center (ADCRC) programs are by definition eligible for institutional placement because of their chronic illnesses and limited ability to care for themselves. The program provides individualized health care services under the direction of the participant's Primary Care Provider (PCP). All services are provided by license health care professionals. These include nursing, social work, physical therapy, occupational therapy, speech therapy, psychological services and personal care. Socialization, recreational activities, transportation and meals are also provided. These services are provided in collaboration with San Mateo County Aging and Adult Services, SamTrans, Health Plan of San Mateo, the San Mateo Adult School and the personal medical providers of those enrolled. Senior Focus also receives grant funding from the Mills Peninsula Hospital Foundation and the Peninsula Health Care District. Miis-Peninsula Medical Center provide the meals served, many support services, as well as funding that subsidizes grants and fees that are received for the program by outside funders, insurers and participants themselves. Treatments are provided that help to improve and/or maintain a level of physical, emotional and cognitive functioning that permits the individual to remain living outside of an institutional setting.
Goals	The goal of the program is to provide health, education and supportive services that permit frail older adults to remain living in the community instead of in institutions and to provide family caregivers respite from the stresses of caregiving, as well as information and support from members of the multidisciplinary care team.
Anticipated Outcomes	• Maintain the number of enrollees who remain living in community settings rather than in skilled nursing facilities. • Maintain the percentage of enrollees who self-report improvement in mood, functioning and/or behavior. • Maintain the percentage of caregivers who self-report improvement in their own stress, health or mood.
Plan to Evaluate	• Report on retention level of enrollees (living in community settings versus institutionalization), • Conduct a client satisfaction survey annually to evaluate the value of the program as perceived by the participants and/or caregivers. • Report the level of improvement in mood, functioning and/or behavior of enrollees. • Report the level of improvement of caregivers stress, health or mood.
Metrics Used to Evaluate the program activity/initiative	Annual metrics: • Approximately 150 participants to remain enrolled in the program annually • Participants to receive 13,000 days of care in the adult day health care setting. • Based on 2016 baseline data, the Senior Focus Patient Satisfaction Survey will maintain a weighted score of 90% or higher in the reported levels cited in the "Plan to Evaluate" section.

Name of program/activity/initiative	Senior Focus – Wise and Well Heart Smart Program
Description	The Wise and Well Program has been offered by Senior Focus since 1993. It provides health education and screenings to low income, high-risk, medically underserved older adults in San Mateo County. The targeted conditions are heart disease and diabetes, two of the largest causes of death, dysfunction and disability. Services are provided throughout the county at locations where the target population receives other services such as low cost meals, Brown Bag groceries, etc. These services are provided in collaboration with San Mateo County Aging and Adult Services and a network of senior centers. Miis-Peninsula Medical Center provides significant support services such as advertising, staffing and materials, as well as funds that subsidize other services that are not covered by grants (ex: health screening equipment and supplies). The program also collaborates with Health Services Advisory Group (HSAG) and California Medicare Quality Improvement Organization (QIO) to provide the Diabetes Empowerment Education Program (DEEP) to the community. This is a Medicare approved evidence-based program targeting people with diabetes and pre-diabetes. The faculty receive specialized training and are certified to teach the program.
Goals	The goal is to prevent the onset of disease when possible, to help older adults with heart disease and/or diabetes to better manage these conditions when they occur.
Anticipated Outcomes	To increase health knowledge, skills and self-care ability among older adults who participate in the program.
Plan to Evaluate	➢ Class participants will complete an oral or written test of their knowledge prior to attending the class, as well as afterward to determine if learning has occurred: pre/post testing. ➢ Screened participants will be asked to complete an evaluation form to help gage whether they learned new techniques to improve their health ➢ Screened participants will be asked to circle the specific health education that they learned – listed on the evaluation form
Metrics Used to Evaluate the program/activity/initiative	Annual metrics: ➢ Serve 750 people, 500 attending program classes and 250 participating in one-on-one screenings/health education for the next three years. ➢ 25% increase in knowledge is expected for those attending classes ➢ 80% of the screenings and health education participants are expected to increase their self-care knowledge about heart disease and diabetes prevention/management.

Name of program/activity/initiative	North County Express Care Expansion- San Mateo Medical Centers
Description	Express Care was developed utilizing LEAN principles to ensure urgent (non-emergency) needs of patients are met within 48 hours. Express Care has been running for three years at San Mateo Medical Center/Daly City and the service focuses on increasing access to urgent care and decreasing referrals to Emergency Departments. In the past year, referrals to EDs have on average been 5%. MPMC plans to continue to financially support this service at the Daly City Health Center as well as the replication of the model at South San Francisco Health Center. South San Francisco Health Center is currently undergoing an increase in demand which poses a risk for over-empanelment. The aim is to expand Express Care to South San Francisco and pro-actively limit the negative impact demand could have on primary care access and in-appropriate ED utilization.
Goals	Many patients end up in the Emergency Department or cycle through multiple visits with their primary care provider because clinics have inadequate urgent care resources. Express Care will increase urgent care access for assigned-established patients for Daly City and South San Francisco patients.
Anticipated Outcomes	• Express Care will support education, triage and urgent care provision. • Patients will be informed of a variety of concerns that can be addressed via phone-based care, triage nurse and/or during a clinic visit with a provider. • This service would support primary care continuity and reduce ED referrals and utilizations.
Plan to Evaluate and Metrics	Annual Metrics: • <10 days- Time to Third Next Available for established patients (weekly) • <5% of patients referred to ED due to lack of access (weekly) • >10% of patient needs met over the phone (weekly) • 40 or more number of appointments scheduled with provider and seen (weekly)

Name of program/activity/initiative	Operation Access.
Description	For 23 years, Operation Access (OA) has addressed unmet health needs of underserved populations and promoted medical volunteerism. OA and a network of 75 Bay Area community clinics have identified more than 10,000 clients in need of care, and matched them with volunteer medical professionals who have donated over 15,000 vital surgical procedures and diagnostic services. The OA program in San Mateo was launched in 2001. It has provided over 1,500 surgical procedures and diagnostic services to San Mateo residents. MPMC is a key contributor to OA's program in San Mateo, providing roughly half of the services for the local population. OA participatns must live in SMC, be uninsured, have less than $5,000 in savings, and be referred for an outpatient surgery or specialty procedure by a primary care provider. While eligible clients may earn up to 250 percent of the federal poverty level, the average annual income of OA patients is around the federal poverty level - (individual: $12,475; family of 4: $24,280) OA's menu of services is designed to meet the needs of the beneficiary population, with an emphasis on procedures that prevent serious medical complications and cancer. MPMC's 15 volunteer physicians provide services including, general surgery, gastroenterology, specialist evaluations, minor and radiology. Typical services include hernia repair, cataract and pterygium removal to prevent blindness, and targeted colonoscopy to prevent colon cancer.
Goals	- Treat patients as close to home and as quickly as possible - Patients who do not have access to insurance provided through the ACA receive access to quality surgical & specialty care that they need. - Individual physicians, nurses and technical staff have the opportunity to make a difference in their own communities
Anticipated Outcomes	MPMC to provide at least 50 surgical procedures and diagnostic services annually to San Mateo residents referred by OA
Plan to Evaluate	- OA identifies and reports outcomes of metrics designed to measure program impact on clients' lives - OA monitors its program efficiency using detailed monthly and quarterly program reports that provide data regarding referral status (eligibility for services), services provided (where, when, by whom), and queuing (number in queue, time in queue, wait time by specialty). - OA uses survey data to evaluate client, volunteer, and clinic experiences
Metrics Used to Evaluate the program/activity/initiative	OA's main annual metrics involve the following: - A minimum of 50 donated services - 32 or more individuals served - 96% or greater of patient compliance rate (patients who arrive on-time and prepared for appointments) - 60-75 days wait time between patient referral and first appointment - 75-90 days wait time between patient referral and procedure - Report on patient satisfaction with OA services (post-survey) - Report on medical volunteer satisfaction with OA program (annual survey)

Name of program/activity/initiative	Grants Program
Description	MPMC's grants program supports -profit organizations whose programs and/or projects address the health needs of the most vulnerable residents including the LGTBQI population. Through the grants program, MPMC strives to benefit the community by addressing issues and concerns that affect overall community health.
Goals	Improve health care services and support the safety net delivery system that serves low income, uninsured people and LGTBQI communities.
Anticipated Outcomes	Support interventions and programs addressing critical health drivers with evidence-based interventions
Plan to Evaluate	Each program funded will be evaluated according to the following: • Targets a need within underserved populations • Evidence-based case for the intervention and a strategy chosen to achieve the outcomes • Has the ability to track services and measure impact through appropriate evaluation measures • Has a detailed work plan with process and impact objectives
Metrics Used to Evaluate the program/activity/initiative	The metrics used to evaluate the programs, activities and/or initiatives will be discussed and agreed upon annually with each applicant prior to the grant awards.

Oral/Dental Health

Name of program/activity/initiative	Apple Tree Dental San Mateo and Sonrisas Centers for Dental Health
Description	In May of 2015, the Sonrisas Dental Clinic in Half Moon Bay joined forces with the Apple Tree Dental San Mateo to expand dental care to underserved and special needs populations in the Coastside region of San Mateo County. Becoming part of Apple Tree's program allowed the Sonrisas Center to expand its leadership, share clinical staff, and mobile dental care delivery systems laying a foundation to increasing access to dental care for low-income and uninsured residents of the Coastside community. Apple Tree mission is to improve the oral health of all people, including those facing barriers to care. Apple Tree operates six Centers for Dental Health in Minnesota and two in California. Apple Tree is nationally recognized for its pioneering approach to integrating oral health care as part of one's overall health and wellbeing transcending age, disability, and need. Prevention and early intervention are key goals, and all patients receive oral health education and hygiene supplies appropriate to their needs. The Coastside is home to nearly 6,000 low-income agricultural, fishing, and service workers and their families, 49% of whom live at or below 200% of the federal poverty level. The Sonrisas Center's service area includes the South Coast where many families are isolated geographically, culturally, and linguistically. Subsequently, Sonrisas service area extends from Montara to Pescadero, a population of approximately 30,000. Its patients

	are Latino (74%), Caucasian (21%), Asian (4%), and African-American (1%). 55% of the Sonrisas Center's patients are children, 10% seniors, and 35% adults between the ages of 25 and 55. For the poorest residents, who depend on Denti-Cal, there are few dental providers in the county who participate. According to recent study, in 2014, California was ranked 45th of 50 states with the lowest Medicaid (Denti-Cal) reimbursements, paying only about 29% of average dental fees. Apple Tree serves patients with Denti-Cal coverage, and provides affordable plans at greatly reduced costs for low income families, as well as, charity care when there are no other alternatives. Apple Tree's Sonrisas Center delivers a full range of dental services in partnership with community organizations to reach targeted Coastside populations groups. Delivering on-site dental care helps patients overcome a host of transportation barriers and leverages the expertise of community partners. Apple Tree's San Mateo Center provides the advanced services when needed as well as transportation to its San Mateo Center. The Sonrisas Center teamed up with Puente, an organization providing services to farm workers in Pescadero, to deploy on-site mobile dental units - bringing dentists, dental hygienists, and all the equipment needed to serve people in need.
Goals	To expand the reach of dental services, making it easier for underserved children and families in the Coastside community to gain access to affordable, quality dental care.
Anticipated Outcomes	➢ Equip additional mobile units to be deployed on the Coast ➢ Expand the community-based oral health programs to care for children and youth living at or below 200% of the federal poverty level (target population) ➢ Provide dental hygiene materials to preschool aged children in the Coastside region to create positive oral health care habits.
Plan to Evaluate	➢ Track patients and monitor services using the Open Dental software ➢ Patients surveys which are used for ongoing improvement of services. ➢ Evaluate the contribution of partnerships towards the success of the program
Metrics Used to Evaluate the program/activity/initiative	➢ 10% increase in number of patients receiving treatment and services 60% of patients to restore oral health function without extractions ➢ 10% increase in patients who participate in prevention and hygiene instruction classes ➢ 72% of patients follow up after their initial screening ➢ Reduce the number of emergency procedures and extractions that result from preventative care – currently at 6-15%

Behavioral Health and Well Being

Name of program/activity/initiative	Grants Program
Description	The percentage of adults who report mental and emotional health problems is rising and suicide is the top 10 leading causes of death in the County. MPMC plans to fund non-profit organizations addressing the drivers of mental and emotional illnesses amongst ethnic groups, low income households of all ages and the LGTBQI population.
Goals	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services
Anticipated Outcomes	• Reduce the proportion of adolescent and adult persons who experience major depressive episodes • Support Programs addressing critical health drivers with evidence-based interventions • Invest in case management services and bridges and wellness programs for those with mental and behavioral health issues
Plan to Evaluate	• Emphasized collaboration among stakeholders and/or MPMC engagement as a partner • Targets underserved populations • Evidence-based case for the intervention and a strategy chosen to achieve the outcomes • Has the ability to track services and measure impact through appropriate evaluation measures • Has a detailed work plan with process and impact objectives
Metrics Used to Evaluate the program/activity/initiative	The metrics used to evaluate the programs, activities and/or initiatives will be discussed and agreed upon annually with each applicant prior to the grant awards.

Needs Mills-Peninsula Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. 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 does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

1. Alzheimer's Disease and Dementia - Indirectly through other organizations
2. Arthritis - Other organizations are better equipped to address this need
3. Birth Outcome - Other organizations are better equipped to address this need
4. Cancer - Indirectly through other organizations
5. Childhood Obesity - Indirectly through other organizations
6. Climate Change - Other organizations are better equipped to address this need
7. Communicable diseases - Indirectly through other organizations

8. Diabetes - Indirectly through other organizations
9. Fitness, diet & Nutrition - Indirectly through other organizations
10. Heart disease and stroke - Indirectly through other organizations
11. Housing and Homelessness - Indirectly through other organizations
12. Income and Employment - Indirectly through other organizations
13. Respiratory conditions - Other organizations are better equipped to address this need
14. Sexually Transmitted Diseases – Indirectly through other organizations
15. Transportation and Traffic - Indirectly through other organizations
16. Unintended Injuries - Other organizations are better equipped to address this need
17. Violence and Abuse - Indirectly through other organizations

18. Approval by Governing Board

The implementation strategy was approved by the Sutter Health [INSERT: VALLEY AREA, BAY AREA, COAST HOSPITAL OR KAHI] Board on [INSERT: DAY, MONTH, YEAR].