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PUBLIC NOTICE
Board of Directors
STRATEGIC DIRECTION OVERSIGHT COMMITTEE
1819 Trousdale Dr. (Classroom)
August 12, 2026, 5:00pm

AGENDA

1. **Call to Order & Roll Call:** Chair Cappel
2. **Approval of Minutes:** SDOC May 6, 2026 **Pg. 1-11**
3. **Blue Zones Ignite Assessment Report and Recommendation:** Margaret Brown, VP Business Development and Kelsie Cajka, Operations Director
4. **2026 Strategic Direction Committee Membership:** Ana M. Pulido, Chief Executive Officer **Pg. 12-13**
    a. **New Member Recommendation**
        1. **Cheryl Fama**
5. **Adjournment**

Strategic Direction Oversight Committee Meeting

May 6, 2026 Minutes

1. Call to Order: Chairman Cappel called the meeting to order at 5:01 p.m.

Roll Call: SDOC members present were: Cappel, Emmot, Jurow, Johnson, McDevitt

Absent: Pagliaro, Bandrapalli, Aubry

2. Approval of Minutes: SDOC February 4, 2026

3. Peninsula Volunteers Transportation: Artemis Rong, Chief Operations Officer, Peninsula Volunteers, Inc.

Presentation Highlights

Peninsula Volunteers, Inc. Overview

- Founded in 1947, the organization helped establish what is now Bing Nursery School at Stanford and later opened Little House, the first suburban senior center in the United States.
- The organization received one of the first federal grants for senior housing in the United States and launched one of California's first on-demand transportation services for seniors.
- As a nonprofit serving more than 6,000 families annually across San Mateo and Santa Clara counties, the organization's mission is to help seniors age and engage in place through an integrated continuum of services supporting seniors and their families at every stage of aging.

Services Overview

- PVI provides a continuum of senior support services, including the Little House senior center, adult day services, nutrition services, transportation services, and Quiescence (caregiver support program).
- These services are designed to help seniors maintain independence, engagement, and quality of life throughout the aging process.

Transportation Challenges for Seniors

- Transportation was identified as a major barrier impacting seniors' ability to access healthcare, food, medication, and community engagement.
- When seniors can no longer drive safely, daily activities and medical appointments become increasingly difficult to manage.
- Public transportation is often impractical due to timing, mobility limitations, or destination access, while many seniors are uncomfortable using smartphones or rideshare applications.
- These barriers contribute to missed medical care, reduced independence, increased isolation, and declining physical, mental, and cognitive health.

Importance of Transportation

- Transportation was emphasized as more than a mobility issue—it is fundamentally a healthcare and healthy aging issue.
- Reliable transportation enables seniors to attend medical appointments, maintain access to food and medication, and stay socially connected.
- Reduced mobility and isolation were noted as significant contributors to poor overall well-being among seniors.

Ride PVI Program Overview

- Ride PVI was presented as a transportation solution designed around the needs of seniors.
- Seniors access the service by calling a hotline, while coordinators manage scheduling, confirmations, and ride logistics.
- The service eliminates technological barriers by not requiring smartphones, apps, or digital navigation.

Distinctive Concierge Mode

- Ride PVI operates using a concierge-style transportation model with active staff involvement throughout the process.
- Staff verify ride details, communicate mobility needs, and provide real-time coordination and support.
- Human interaction and personalized assistance were highlighted as key reasons seniors trust and successfully use the program.

Equity, Accessibility, and Program Impact

- The program maintains affordability through a flat $8 fee structure, supporting seniors on fixed incomes.
- Language accessibility and the absence of smartphone requirements help ensure equitable access for diverse populations.
- The program's impact includes increased independence, reduced isolation, and improved ability for seniors to remain engaged in their healthcare and daily lives.

PVI Proposal

Proposal Overview

- The proposed agreement would serve adults aged 65 and older living within the Peninsula Health Care District service area.
- Trips would take place throughout San Mateo County and focus on essential destinations, including medical appointments, grocery stores, pharmacies, fitness centers, and community-based activities.
- The program aims to provide approximately 2,500 rides annually for at least 150 participants.
- Each participant is eligible for up to 12 rides per month.
- These program parameters are intended to balance equitable access with available resources while prioritizing seniors with the greatest transportation needs.

Funding Request

- PVI is requesting $60,000 in annual funding support.
- $40,000 would directly fund ride subsidies, while the remaining $20,000 would support program staffing, including ride coordination, billing support, and program management.
- The organization noted that the program is prepared for immediate implementation, supported by an established operational model, trained staff, and existing systems that have been in place since 2016.
- Because PVI also provides multiple senior services, staff can identify broader client needs and connect participants to additional supportive resources when appropriate.
- District support would help expand access to essential transportation services and reduce barriers impacting seniors' health, independence, and community engagement.

Q & A with Ms. Rong

Chair Cappel asked who the drivers were.

Ms. Rong answered that PVI works with Uber and Lyft.

Mr. Johnson asked how PVI covered the presented geographical area within their proposal and where the funds they are asking would go to.

Ms. Rong clarified that they receive funding from San Mateo County along with Sequoia Healthcare District. There are currently about 800 people registered with 200 people on the waitlist, which equals up to 12 rides a month. The $40,000 of the $60,000 ask will go to individuals on the waitlist to bring the number down.

Ms. McDevitt asked for more information about the $20,000 staffing support whether that is the partnership with Uber and Lyft or a fixed amount from each ride.

Ms. Rong confirmed that the fixed amount comes from the rider.

CEO Pulido asked what else is included with the admin cost aside from the billing specialist they noted in the proposal.

Ms. Rong said they have a program manager, 2 part-time ride coordinators, and 1 full-time coordinator.

Mr. Jurow asked if there was a criterion to get on the waitlist.

Ms. Rong noted that there is a registration form for individuals to fill out. Income is looked at when people register, but PVI prioritizes medical situations (doctor appointments, etc). She added that 85% of their clients have low income or on fixed income, 76% live alone, and 70% are over the age of 80.

Mr. Jurow asked if they offered rides along the coast.

Ms. Rong said the coast has its own program. However, the Villages pay for their participants' rides, so there are some clients along the coast.

Chair Cappel shared that the majority of people discharged from hospitals are over the age of 65. He emphasized that transportation is a significant barrier to access. He said this program is a great start to establishing an area wide transportation system and would like to bring this idea to the board of directors.

Mr. Johnson asked how the public knows how to call PVI for rides.

Mr. Rong said they are on multiple websites, featured on the directory San Mateo County distributes and magazines for resources, and their own outreach efforts. She added that she met with Sutter Health in hopes of getting into physicians' groups to share their program with their patients.

Mr. Jurow appreciates that PVI not only focuses on medical-related situations but also on the engagement aspect of grocery trips, pharmacy trips, workout classes etc., which usually are not covered by insurance and makes them unique.

4. Forever Fit Program: Richard Bergstrom, Health and Fitness Director

<u>Presentation Highlights</u>

Program Overview

- Forever Fit is a year-long CDC-certified, Diabetes Prevention Program focused on lifestyle intervention through weekly exercise and nutrition education classes.
- The program was developed in response to community health research conducted in 2022, which found that approximately 10% of adults in San Mateo County were living with diabetes.
- Additional health data showed that approximately 60% of adults in the county were classified as overweight, while 25% were considered obese based on BMI measurements.

Program Components

- Few organizations in San Mateo County offer diabetes prevention programs, but this program is currently the only CDC-certified program in the area. Comparable programs are primarily located at Stanford and in San Francisco.
- Program components include:
    - Weekly exercise classes.
    - Group discussion sessions on nutrition, healthy physical activity, sleep, stress management, and socialization.
    - Monthly educational topics reinforcing healthy lifestyle habits.
    - Quarterly evaluations including weight, BMI, behavior change surveys, and A1C blood glucose testing.

Participant Information

- The program cohort included 17 participants in total, consisting of 12 members and 5 non-members.
- Participant demographics included 3 males and 14 females ranging in age from 60 to 89 years old.

Program Results

- The program achieved a 100% completion rate, with all 17 participants completing the full year-long program.
- Average class attendance was 64%, with non-members demonstrating slightly higher participation at 68%.
- All participants experienced some level of weight loss, with members averaging 5.74 pounds lost and non-members averaging 6 pounds lost.
- Participants averaged approximately 263 minutes of weekly physical activity, significantly exceeding the CDC recommendation of 150 minutes per week.
- Approximately 65% of participants improved or maintained their A1C levels during the program.

Program Outcomes

- Two participants met all three high-impact CDC criteria:
    - At least 5% weight loss
    - 150 minutes of weekly physical activity
    - Improved or maintained A1C levels
- Eight participants met modified success criteria, including at least 2% weight loss, 150 minutes of activity, and improved A1C levels.
- Eleven participants met two of the three criteria by achieving recommended activity levels and improving or maintaining A1C levels.
- Four participants were identified as outliers, each losing at least 10 pounds during the program.
- Participants achieved the CDC-recommended 150 minutes of physical activity during approximately 79% of the program's 52 weeks, equivalent to roughly 40 weeks.

Behavior Change Outcomes

- Quarterly surveys were conducted using the behavior change model to evaluate

participant progress toward adopting healthier habits.

- The program assessed participants across the stages of behavior change, including pre-contemplation, contemplation, preparation, action, maintenance, and termination.
- The "termination" stage was excluded because it requires long-term habit adoption beyond the scope of the one-year program.
- The "action" stage represented participants maintaining healthy habits for less than six months, while the "maintenance" stage represented sustaining habits for six months or longer.

Key Takeaways

- Most of the participants were already physically active prior to enrollment, including 12 participants who were existing gym members.
- The program reinforced and strengthened existing healthy behaviors while still producing positive outcomes for both members and non-members.
- Average weight loss exceeded 5 pounds across both participant groups.
- Modest improvements were recognized as meaningful because they contributed to reduced health risks and improved wellness indicators, including weight and A1C reductions.
- Maintaining healthy activity levels and stabilizing A1C values should also be considered successful outcomes.
- Educational discussions and lectures played an important role in building participant confidence and supporting healthier behavior adoption.
- Program benefits extended beyond physical health and positively impacted nutrition, sleep, stress management, and social wellness.

Challenges and Opportunities

- It was identified that there was a need to prioritize recruitment of higher-risk individuals in future cohorts to maximize program impact. Many participants were already active gym users or were seeking weight maintenance rather than significant weight loss.
- With PHCD's upcoming health fair, including the collaborations with Chinese Hospital offering blood glucose testing, were identified as opportunities for outreach and recruitment of new participants.
- Measurement consistency was identified as a challenge. Early program testing used portable A1C Now devices, which participants felt produced inconsistent results compared to laboratory testing. As a result, the program transitioned to hospital-based lab testing during the final two quarters.
- Nutrition education was identified as an area for further development. The CDC curriculum provides limited depth on nutrition guidance, creating an opportunity to expand the program curriculum through workshops, partnerships, and additional educational resources.

Discussion

Chair Cappel commented on seeing an expansion to the database for up to 30 participants. He shared that the key to diabetes is bringing down the A1C. He said that it is a great plus that this

program is CDC certified, but this study needs to be done often to have a larger sample size.

Ms. McDevitt shared that it was great that 17 participants completed the year-long program. Regarding the education challenge, she suggested reaching out to Samaritan House about their food pharmacy and connecting organizations together in ways to help.

CEO Pulido commented on building up the program over time. This first iteration of the program was a pilot designed to learn about challenges and opportunities.

Ms. McDevitt asked if there is a follow-up survey for individuals in a year to 6 months from the program completing to keep measuring data.

Mr. Bergstrom answered that the program ended in March, and most of his participants are fitness center members and can follow up with them.

5. Care Solace Update: Jackie Almes, Youth Behavioral Health Program Manager

Purpose

- Provide updates on Care Solace usage, partnership performance, opportunities for improvement, and considerations for continued funding support in the upcoming school year.

Overview of Care Solace

- Care Solace is a 24/7 multilingual, confidential care coordination platform that connects individuals with vetted local mental health, substance use, and social service providers.
- The platform helps reduce the administrative burden on school wellness counselors by conducting referral research and vetting service providers.
- Services are currently available to all elementary school districts within the Peninsula Health Care District service area, except for Burlingame.

PHCD Care Solace Data Review

- Data comparisons were presented for the 2024–2025 and 2025–2026 school years.
- In 2024–2025:
    - 220 student cases were referred
    - 115 appointments were made
    - 17,022 communications occurred between Care Solace, wellness counselors, families, providers, and clients
    - 61 anonymous searches were conducted
- In 2025–2026 to date:
    - 189 student cases were referred
    - 76 appointments were made
    - 10,044 communications occurred between Care Solace, wellness counselors, families, providers, and clients
    - 40 anonymous searches were conducted

- Current utilization trends indicate the program is on track to meet or exceed prior-year usage levels.
- Comparative analysis with other districts showed that PHCD utilization remains aligned with industry standards.

Interpretation of Data

- Utilization rates were described as stable year over year and consistent with industry benchmarks, though there remains room for growth.
- Ongoing staffing and leadership transitions within school districts have impacted district-level engagement and buy-in, despite continued use by wellness counselors.
- Prior partnerships were operated through the San Mateo County Office of Education before transitioning directly between PHCD and Care Solace after grant funding expired.
- The San Mateo County Office of Education has also experienced challenges engaging elementary school districts due to staffing shortages and limited district capacity.
- Outreach efforts to leverage county relationships have been challenging because district staff are often difficult to reach.

Factors Driving Strong Utilization

- Strong superintendent and leadership support were identified as critical factors for increasing program utilization.
- District leadership is vital in promoting awareness among principals, teachers, and school communities, rather than relying solely on wellness counselors.
- The program also requires active and responsive district points of contact to support communication and implementation efforts.
- There is a need to increase regular meetings between Care Solace and school districts to review implementation strategies, gather feedback, and improve school-site engagement.

Key Insights

- Sustained utilization depends heavily on strong relationships across districts and school sites.
- Current program stability is largely driven by wellness counselors who continue using the platform consistently year after year.
- Care Solace staff continue outreach efforts directly with wellness counselors, district contacts, and principals to strengthen engagement.
- There is a need for PHCD to take a more hands-on role in outreach and relationship-building efforts moving forward.

Setting Expectations for Future Funding

- To maximize impact, it was identified the need for:
    - Responsive district points of contact
    - Increased awareness and engagement across school sites
    - Greater integration of Care Solace into district support frameworks
- Districts that integrate Care Solace into their student support systems are seeing stronger utilization rates.

- Some districts outside the PHCD service area are using Care Solace as a formal referral pathway to connect students with needed resources, representing a potential opportunity for local districts.
- Discussion included whether PHCD should establish clearer participation expectations tied to continued funding support, including stronger outreach and engagement requirements for participating districts.

Future Opportunities and Alignment with MARO

- There is an opportunity to align Care Solace with MARO, a digital screening platform that elementary schools plan to implement next year.
- MARO will help identify students with behavioral health or support needs earlier, while Care Solace could serve as the referral and connection pathway to appropriate services.
- Integrating the two systems could significantly increase utilization and improve schools' ability to connect students with timely support and resources.

Discussion

CEO Pulido noted that the Care Solace partnership is currently up for renewal and referenced prior Board concerns regarding lower-than-expected utilization rates. Current usage remains relatively consistent with previous years, leading to discussion about how to move forward while recognizing that Care Solace remains a valuable and needed mental health resource despite ongoing implementation challenges and barriers affecting broader school district engagement and utilization.

Chair Cappel emphasized the importance of the school districts providing sufficient resources to their students to get the support they need.

Mr. Jurow suggested going to the school board and attending their public forum to bring forth this topic.

Chair Cappel suggested further evaluation of the referral process through additional board-level discussion or a dedicated committee to better understand how referral systems function and why some referral processes are more effective than others.

Ms. McDevitt shared she works for Care Solace and posed the question of how they can expand more counselors by utilizing Care Solace. She shared that since the utilization numbers from the data have not dipped is due to the same counselors using this tool and thinking of strategies to have them share it in their learning environments. She also mentioned that PHCD has connections with other community-based organizations which will help leverage sharing the anonymous search opportunity.

Chair Cappel suggested having a discussion to further evaluate the issue and provide the board with additional information to support a more informed decision-making process.

6. Blue Zones Update: Ana M. Pulido, Chief Executive Officer

Project Activities to Date

- Presentations were conducted with the cities of San Mateo and Burlingame, and additional engagement occurred with the City of San Bruno through Mayor Medina and Councilmember Hamilton.
- Over the past several months, more than 20 focus group sessions have been held across cities and agencies to evaluate the built environment and food system sectors.
- A keynote event hosted at the College of San Mateo drew nearly 200 attendees and provided additional community engagement around the project initiative.
- Facilitation of a CEO roundtable discussion focused on the scope and feasibility of bringing a Blue Zones Project to San Mateo County and the Peninsula Health Care District region.
- Windshield tours were conducted with the Blue Zones team and participating city representatives, including Councilmember Lisa Diaz-Nash, Councilmember Tom Hamilton, and Councilmember Donna Colson.

Key Discussions

- The CEO roundtable generated strong interest and positive reception toward bringing a Blue Zones Project to San Mateo County.
- Discussions emphasized that the initiative is intended to extend beyond the Peninsula Health Care District and involve broader countywide collaboration.
- Challenges related to external funding were discussed. County-level partners are approaching funding decisions through a needs-based framework and may not view Peninsula Health Care District communities as the highest-need areas within San Mateo County.
- This perception could make it more difficult to secure substantial outside funding support, potentially requiring the Peninsula Health Care District to serve as the primary funding driver for the initiative.
- Other collaborating organizations are evaluating the initiative from a countywide perspective because many of the participating partners provide services throughout all of San Mateo County.

Next Steps

- A comprehensive assessment report is expected in July, followed by a public report-out and identification of community health priorities.
- Ongoing discussions will focus on whether outside funding partners can be secured and, if not, what level of financial investment the health care district may be willing to commit toward advancing the project.

Discussion

Ms. McDevitt shared that when she recalls higher needs areas that fall outside PHCD and Sequioa Health Care District are South San Francisco, Pacifica, Daly City, and East Palo Alto.

Mr. Jurow added that either the healthcare district, the county, or Sequoia Health Care District needs to take the lead.

CEO Pulido clarified that the county wants to start this project with the most at-need areas if they were to take on this project, which fall outside of the District areas.

Ms. McDevitt asked if the county is funding those areas that fall under the same framework as Blue Zones.

CEO Pulido answered that the Blue Zones project is to identify the gaps instead of duplicating services so the District and associated community partners can come together.

7. Adjournment: 6:30 PM

Cheryl A. Fama, RN, BSN, MPH

August 5, 2026

Dear Ana,

Thank you for your invitation to submit a Letter of Interest to serve on the District Board's Strategic Direction Oversight Committee. I would be honored to have the opportunity to contribute to the Committee's deliberations and recommendations, and believe my extensive healthcare career has given me a broad range of knowledge and experience that could be meaningful to the work of that Committee. One of the most relevant areas is knowing the critical importance of establishing, implementing, and monitoring the progress of a Strategic Plan.

Since retiring from PHCD in April 2023, I have continued to follow PHCD's programs and projects by reviewing meeting minutes on the website, visiting residents in The Trousdale, becoming a member of the Health & Fitness Center, attending both the Allcove anniversary and Blue Zone community events, and enjoying our periodic meetings when you generously take time to provide updates.

I have also volunteered in the community in a variety of ways. Examples:

- Second Harvest food distributions
- San Bruno Foundation Scholarship Committee
- Burlingame /Hillsborough Rotary Community Service and Scholarship Committees
- Sonrisas /Self Help for the Elderly Dental Clinic

Thank you again for the invitation; I would look forward to participating.

Sincerely,

Cheryl A. Fama

BIO BRIEF

CHERYL A. FAMA, RN, BSN, MPH

PHCD Resident for 49 years.

BSN and MPH graduate from the University of San Francisco

1968-1981: Began career at Mary's Help Hospital in Daly City, (Laterally Seton Medical Center) and served as a Critical Nurse, Evening Shift House Supervisor, Manager of the 56 bed Orthopedic Unit, and finally Associate Director of Nursing.

1981-1984: Recruited to Marshall Hale Memorial Hospital in San Francisco to become the Chief Nursing Officer.

1984-2006: Recruited to Saint Francis Memorial Hospital in San Francisco to be Vice President of Nursing, promoted to COO in 1988, promoted to President in 1995, promoted to President/CEO in 2000 and served until retirement in October 2006.

2007: Recruited to serve as consultant to the PHCD Board to launch the implementation of their 2007-2010 Strategic Plan developed after District resident voters approved a ballot measure permitting the tear down and replacement of the District's Peninsula Hospital by the Mills Peninsula/Sutter organization, and approved a 50 year lease of 21 acres of PHCD's property surrounding its hospital.

2009: Recruited by the PHCD Board to become an employee of the District and continue to serve as its CEO.

2023: Retired.