Sutter Health
Eden 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 Eden Medical Center, 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.

Eden Medical Center 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 to 2000 Powell Street, 10th Floor, Emeryville, CA 94608, Attention: Sutter Health Bay Area Community Benefit department; and
- In-person at the hospital's Information Desk.

About Sutter Health

Eden 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. Housing and homelessness
3. Education
4. Community and family safety
5. Food security
6. Economic security
7. Dismantling structural racism
8. Healthcare access and delivery

The 2022 Community Healthy Needs Assessment conducted by Eden Medical Center is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

Eden Medical Center conducted its 2022 Community Health Needs Assessment (CHNA) collaboratively with seven local hospitals in Alameda and Contra Costa Counties, members of the Alameda and Contra Costa Counties Hospital CHNA Group. The Alameda County Public Health Department was an essential partner in collecting primary and secondary data and prioritizing health needs. The CHNA was completed by Ad Lucem Consulting, a public health consulting firm. The key informant interview data and secondary data charts/tables that were included in the report were provided by ASR, the consultant hired by Kaiser Permanente Alameda and Contra Costa service areas to prepare their 2022 CHNAs. ASR also convened community stakeholders and hospital representatives to review service area data and participate in a health need ranking process.

The Hospitals began the CHNA cycle in 2021, with the goal to collectively gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the summer and fall of 2021 through key informant interviews with local health experts, community leaders, and community organizations, and focus groups with community residents. Secondary data were obtained from multiple sources, including the Kaiser Permanente Community Health Data Platform. Data were collected for Alameda County as a whole, as well as for Eden Medical Center's Service Area – Central Alameda County. Significant health needs were identified and prioritized in late 2021, described further below.

The 2022 CHNA assessed the health issues and contributing factors with greatest impact among vulnerable populations[1] whose health is disproportionately affected across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas as well as disparities among the county's diverse ethnic populations.

The full 2022 Community Health Needs Assessment conducted by Eden Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

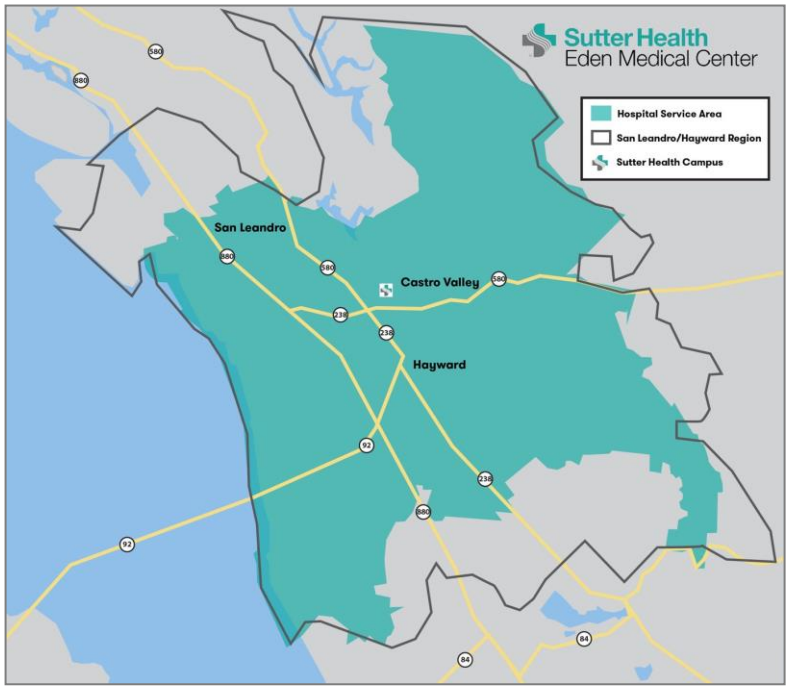
Each hospital participating in the Alameda and Contra Costa Counties Hospital CHNA Group defines its service area to include all individuals residing within a defined geographic area surrounding the hospital. For this collaborative CHNA, Alameda County was the overall service area, with each hospital adding additional focus on their specific service area.

The Internal Revenue Service defines the community served as individuals who live within the hospital's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

Eden Medical Center is located in Castro Valley in the Central Alameda County region. Eden Medical Center's hospital service area includes 10 ZIP codes surrounding the hospital and its neighboring communities.[2] As previously noted, the hospital collaborated on the 2022 CHNA with other healthcare facilities serving Alameda County. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, including the cities of San Leandro and Hayward, as well as unincorporated areas including Castro Valley, Ashland and Cherryland.

The map below (Figure 1) shows the alignment of the Central Alameda County region with Eden Medical Center's service area.

Figure 1. Eden Medical Center Service Area Map, Central Alameda County Region



[1] California Department of Health Care Access and Information (2022). HCAI Factsheet Hospital Community Benefits Plans: Vulnerable Populations. Accessed July 6, 2022 from https://hcai.ca.gov/wp-content/uploads/2022/03/Hospital-Community-Benefits-Plans-Program-Vulnerable-Populations-Fact-Sheet-February-2022-ADA.pdf.

[2] Eden Medical Center's service area covers ZIP codes 94541, 94542, 94544, 94545, 94546, 94552, 94577, 94578, 94579, and 94580

Ashland, Cherryland, Castro Valley and Hayward, located in central Alameda County, reflect the diverse population and geographic disparities existing in the County. Ashland is home to 24,430 people. Ashland's population is 45% Hispanic (Latinx) along with significant White (38%), Asian (24%), Other (16%) and Black/African American (14%) populations. The percentage of people living in poverty is higher in Ashland (14%) than Alameda County overall (9%). Ashland (19%) has double the percentage of children (0-18) in poverty as compared to Alameda County (10%). Nearly a quarter of Ashland residents (24%) do not have a high school diploma.

Cherryland is home to 16,066 residents. Cherryland's population is 56% Hispanic (Latinx) and 45% White. There is significant representation from Other (25%), Black/African American (13%) and Asian (10%) residents. The percentage of residents living in poverty in Cherryland (18%) is twice that of Alameda County. Over a quarter of Cherryland's children live in poverty, substantially higher than the county poverty rate (10%). Unemployment in Cherryland (8%) is double Alameda County's unemployment. A quarter of residents in Cherryland do not have a high school diploma, more than double that of residents in the county.

Castro Valley, the largest unincorporated community in Alameda County, is home to 63,013 people. The population of Castro Valley is just over one quarter Asian and 53% White. There are smaller proportions of Hispanic (Latinx) and Black/African American residents at 15% and 8%. The percentage of Castro Valley residents living in poverty is lower than Alameda County overall for adults (7% versus 9%), children (8% versus 10%) and seniors (6% versus 10%). The Castro Valley population has fewer adults without a high school diploma (8%) and a slightly smaller uninsured population (3%) than Alameda County.

Hayward is home to 159,293 people. Hayward's population is diverse; 39% of the population identify as Hispanic (Latinx), while Asians and Whites each account for approximately 30% of the population; 21% of the population identifies as Other and 9% identify as Black/African American. Hayward has a smaller percentage of seniors in poverty than the county (7% Hayward, 10% Alameda County) and the percentage of children in poverty in both Hayward and the county overall is 10%. Hayward has a larger proportion of adults without a high school diploma compared to the county (17% Hayward, 12% Alameda County); unemployment in both Hayward and the county overall is 4%.

Significant Health Needs Identified in the 2022 CHNA

The following significant health needs were identified in the 2022 CHNA:

1. *Behavioral Health.* Behavioral health, which refers to both mental health and substance use, affects many Americans. Anxiety, depression, and suicidal ideation are on the rise, and heightened further due to the COVID-19 pandemic, particularly among Black/African American and Latinx community members. Key informants serving Alameda County described behavioral health concerns as a number one issue for communities they serve, reporting intense distress about the level of behavioral health needs going untreated. Focus group participants reported inadequate mental health services for non-English speakers, children/teens and residents who identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, allies and others). Focus group participants described language and other cultural barriers that prevent immigrant residents from accessing services. Within Central Alameda County, residents experience higher rate of deaths of despair compared to Alameda County overall, with Black/African American residents having the highest rate. Key informants serving Central Alameda County noted the continuing stigma surrounding mental health issues in their communities, and the need to overcome it. They also reported that bullying and harassment are severe problems, and students would benefit greatly from an increased presence of school-based counselors.

2. *Housing and Homelessness.* The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with health, well-being, educational achievement, and economic success. Almost all Alameda County key informants and nearly half of focus groups identified housing and homelessness as a top priority health need for Alameda County. They described a variety of housing challenges, and concerns that specific

populations are at highest risk of becoming unhoused, including Black/African American, Latinx, and LGBTQIA+ community members, immigrants, seniors, women fleeing domestic violence, people with disabilities, and those experiencing mental illness or addiction. According to key informants, seniors are increasingly likely to face housing instability or become unhoused and need targeted assistance to preserve existing housing or find an appropriate senior living setting. Focus group participants echoed this concern and noted a surge in unhoused LGBTQIA+ seniors. Key informants serving Central Alameda County perceived that issues related to homelessness and unhoused residents are becoming more apparent in a number of communities in the County, including Ashland. Central Alameda County residents with housing face overcrowded conditions, substantial housing cost burdens and the threat of neighborhood gentrification, all of which put families at risk of housing instability.

3. *Education.* The link between education and health is well known — those with higher levels of education are more likely to be healthier and live longer. Pre-school education is positively associated with readiness for and success in school, as well as long-term economic benefits for individuals and society. Individuals with at least a high school diploma do better on a number of measures than those without, including income, health outcomes, life satisfaction, and self-esteem. Moreover, the majority of jobs in the U.S. require more than a high school education. Disruptions in schooling due to the COVID-19 pandemic particularly affected Black/African American and Latinx students and those from low-income households, who suffered the steepest setbacks in learning and achievement. Several key informants from Alameda County noted disparities in educational attainment for children of color, which they felt are directly linked to lack of targeted services for these children. Key informants serving Central Alameda County suggested that school districts incorporate anti-bias and anti-racism training into their employment practices for administrators, teachers, and staff. Another suggestion was to increase the presence of Family Resource Centers, which were perceived to make a noticeable difference in terms of students' health, educational attainment, and parent engagement. Disparities for students within Central Alameda County exist at all educational levels. Some ZIP code areas surrounding Hayward, which have a higher percentage of Latinx residents than the County overall, have preschool enrollment rates that are lower than the CA rate. Hayward (46%) has lower levels of college readiness among high school graduates than Alameda County overall (58%).

4. *Community and Family Safety.* Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to poorer physical and mental health outcomes. Children and adolescents exposed to violence are at risk for poorer long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color, particularly males, is disproportionately affected by juvenile arrests and incarceration related to policing practices. A quarter of key informants and nearly half of focus groups identified community and family safety as a top priority health need for Alameda County. This health need is linked closely with transportation, as Alameda County key informants believed this was an area where community and family safety could be improved. Two key measures of community and family safety, violent crime and injury deaths, were substantially higher in Alameda County than the state overall. Key informants serving Central Alameda County perceived that policing practices in the County criminalize people of color, especially Black/African American residents. Other concerns mentioned by key informants included domestic violence and the fear and trauma caused by anti-Asian harassment and violence since the start of the pandemic. The number of violent crimes is 50% higher in Central Alameda County than CA overall.

5. *Food Security.* Food insecurity is the lack of consistent access to enough food for an active, healthy life. Food insecurity encompasses household food shortages; reduced quality, variety, or desirability of food; diminished nutrient intake; disrupted eating patterns; and anxiety about food insufficiency. Black/African American and Latinx households have higher rates of food insecurity than other racial/ethnic groups. The COVID-19 pandemic substantially increased food insecurity due to job losses, closure/changes to feeding programs, and increased demand on food banks. According to key informants, many Alameda County families experienced such an increase in food insecurity during the pandemic. Despite robust food distribution programs in several sectors (schools, food banks, healthcare, mobile clinics, community organizations), key informants reported that not all

populations in need are reached, particularly unhoused county residents and populations that may be reluctant to seek out food assistance due to the stigma of being "needy." Data indicate that within Central Alameda County, residents are likely to be impacted by the presence of food deserts and have a higher rate of Supplemental Nutrition Assistance Program (SNAP) enrollment than California overall. Supermarket access in Cherryland's least healthy Census Tract (according to the Healthy Places Index) is in the bottom half of CA communities (45%), substantially worse than Alameda County overall which ranks better than 93% of CA communities.

6. *Economic Security.* People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The majority of key informants and focus groups listed economic security as a top priority health need. Key informants reported that Alameda County residents struggle to find living wage jobs given the County's extremely high cost of living. Key informants and focus group participants reported extensive job loss because of the pandemic, noting that despite a strong job market, many residents are still not working. White residents of Central Alameda County have the highest average incomes of all racial/ethnic groups, almost twice as much as Latinx residents ($73,358 for White men compared to $41,245 for Latinx men). Hayward's least healthy Census Tract (according to the Healthy Places Index) performs worse than 84% of CA communities on measures of income and employment.

7. *Dismantling Structural Racism.* Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms. Centuries of racism in this country have had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. Data show that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions. The COVID-19 pandemic, which has disproportionately impacted racial and ethnic minority populations, is another example of these enduring health disparities. Many key informants named structural racism as a significant concern affecting health in their communities and as a contributor to the other health needs. Key informants described race-based inequities in access to and provision of healthcare, resulting in many children and adults of color not receiving necessary physical or behavioral health treatment. Key informants also reported that care received is often not culturally or linguistically competent. Black/African American, Asian Pacific Islander, Multiracial and Latinx residents in Central Alameda County all have lower median incomes than White residents, and Black/African American residents experience substantially higher rates of deaths of despair and COVID-19 deaths than their White neighbors. Key informants consistently noted that the lack of diverse ethnic/racial representation among care providers limits trust in the healthcare system, inhibits preventive care and contributes to poor mental and physical health outcomes for people of color.

8. *Healthcare Access and Delivery.* Access to comprehensive, quality healthcare has a profound impact on health and quality of life. Components of access to and delivery of care include insurance coverage; adequate numbers of primary and specialty care providers; health care timeliness, quality and transparency; and cultural competence/cultural humility. The majority of key informants and nearly half of focus groups identified healthcare access and delivery as a top priority health need for Alameda County, describing that too few healthcare providers with specialized training for working with specific populations serves as a barrier to care, particularly for LGBTQIA+ residents, people with certain disabilities, non-English speakers, and undocumented residents. Additionally, while the shift to telehealth during the pandemic was helpful for many, it presented barriers to low-income families and seniors, who struggle to use technology or have little or no internet access. Medicaid/public insurance enrollment is a big need in Alameda County with enrollment eight percentage points below the state. Key informants stated that many residents in this region forego any health insurance because of high costs. Those who live and work in Central Alameda County described shortfalls and biases in healthcare services and delivery for both prevention and treatment, which often disproportionately affect the region's most vulnerable residents.

Health Need Identification
Through a comprehensive process combining findings from primary and secondary data, health needs were scored to identify a list of the top eight health needs for the service area. Measures in the Kaiser Permanente Community Health Data Platform, a CHNA data source, were clustered into 16 potential health needs, which formed the backbone of a prioritization tool to identify significant health needs in Alameda County.

For secondary data, a score was assigned to each need (4: very high, 3: high, 2: medium, 1: lower, 0: no need) based on how many measures were 20% or more worse than the California overall.

Themes from key informant interviews and other primary data sources were identified, clustered, and assigned scores on a 0-4-point scale, based on the number of times the theme was mentioned. Both the Data Platform and primary data informed scores for geographic, racial/ethnic, and other disparities.

Each data collection method was assigned a weight, based on rigor of the data collection method, timeliness, and ability to describe inequities/disparities. Primary data (key informant interviews and focus groups) were weighted significantly more than the secondary data to prioritize timely input from diverse, underserved communities. Weighted values for each potential need were summed, converted to a percentile score for easy comparison, and then ranked highest to lowest.

Health Need Prioritization
In December 2021, Eden Medical Center participated in a meeting with key leaders in Alameda County to rank top health needs for service areas within the county. Representatives included Alameda County Public Health Department, Community Health Center Network, Alameda County Office of Education, The California Endowment, and partner hospitals. Qualitative and quantitative findings for the top eight health needs identified were presented. Representatives considered a set of criteria in prioritizing the list of health needs. The criteria chosen by the health systems before beginning the prioritization process were:

- *Severity:* How severe the health need is (potential to cause death or disability)
- *Magnitude or scale:* The number of people affected by the health need
- *Clear disparities or inequities:* Differences in health outcomes by subgroups (based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others)
- *Community priority:* The community prioritizes the issue over other issues
- *Multiplier effect:* A successful solution to the health need has the potential to solve multiple problems

Representatives affiliated with each service area ranked the top eight health needs according to their interpretation of the criteria. Rankings were then averaged across all representatives to obtain a final rank order of the health needs. Eden Medical Center then selected the top three health needs to address in its 2022-2024 Implementation Strategy.

2022–2024 Implementation Strategy Plan

The implementation strategy plan describes how Eden Medical Center plans to address significant health needs identified in the 2022 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 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 Eden Medical Center initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation or discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Behavioral health
2. Housing and homelessness
3. Education

Behavioral Health

Name of program/activity/initiative	Partnerships to Address Behavioral Health
Description	Eden Medical Center (EMC) partners with nonprofit organizations and schools to address behavioral health (mental health and/or substance use) in Central Alameda County. EMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[3] Below are examples of evidence-supported strategies to address behavioral health: • Focus on childhood and youth, critical ages for preventing mental illness and promoting mental health.[4] Specifically, building continuums of behavioral health supports in school-based, after-school, and family settings are recommended approaches to addressing child and youth mental health.[5] • Enhance access to culturally responsive behavioral health services, which can improve patient/client retention and treatment outcomes.[6] • Support integrated behavioral health services, which is patient-centered care provided by a team of primary care and behavioral health clinicians. A growing evidence base demonstrates improvements in access to care and patient outcomes resulting from integrated behavioral health.[7] • Address individuals' health-related social needs associated with the

[3] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.
[4] National Academies of Sciences, Engineering, and Medicine. 2020. Children's Mental Health and the Life Course Model: A Virtual Workshop Series: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/25941.
[5] Surgeon General of the United States. Protecting youth mental health: The U.S. Surgeon General's advisory. Retrieved June 10, 2022, from: https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A treatment improvement protocol: Improving cultural competence. Retrieved August 15, 2019, from https://store.samhsa.gov/system/files/sma14-4849.pdf.
[7] Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Retrieved June 23, 2022, from: https://integrationacademy.ahrq.gov/sites/default/files/2020-06/AHRQ_AcadLitReview.pdf.

	social determinants of health, which greatly impact physical and behavioral health and well-being.[8] • Focus on behavioral health workforce development strategies, including provider/staff/student training in evidence-based practices to improve promotion, prevention, and care, and pipeline programs to develop a workforce that is racially/ethnically, culturally, and linguistically diverse, which are essential to behavioral health equity efforts.[9] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents experience improved behavioral health and wellbeing, at all stages of the life-course. The behavioral health workforce is equipped to address the behavioral health needs of residents.
Anticipated Outcomes	Residents experience improved access to affordable, evidence-based, and culturally responsive behavioral health resources and services. Residents increase behavioral health and wellness knowledge and skills. Providers, staff and trainees increase their knowledge of and skills in evidenced-based, culturally responsive, and/or trauma- informed behavioral health resources and services
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics that are used to evaluate efforts to address behavioral health. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # of encounters # who received mental health services directly from the program # who received substance use services directly from the program # of class, workshop, or support group sessions provided by the program # of participants demonstrating increased mental health and wellness knowledge # who received case management services directly from the program # referred out to social services

[8] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved June 23, 2022, from: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.
[9] Alves-Bradford, J. M., Trinh, N. H., Bath, E., Coombs, A., & Mangurian, C. (2020). Mental health equity in the twenty-first century: Setting the stage. *Psychiatric Clinics*, *43*(3), 415-428.

Housing and Homelessness

Name of program/activity/initiative	Partnerships to Address Housing and Homelessness
Description	Eden Medical Center (EMC) partners with nonprofit organizations that address housing and homelessness in Central Alameda County. EMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[10] Below are examples of evidence-supported strategies to address housing and homelessness, a social determinant of health: • Housing First approach, which prioritizes access to permanent (non-time-limited) housing with minimal preconditions, thereby reducing barriers to housing for people experiencing homelessness.[11] Housing First approaches can include improving access to affordable housing, rapid-rehousing, and supportive housing.[12] • Homelessness prevention, including short-term financial assistance, employment services, and benefits enrollment, to help individuals and families retain housing.[13] • Rapid re-housing (RRH), which connects individuals and families to permanent housing, housing assistance, and support services.[11] RRH has been found to result in positive housing outcomes for those who do not need ongoing supports.[12] • Transitional housing for families, which can provide housing and support services up to two years.[14] • Permanent supportive housing programs (PSH), which provide non-time-limited housing and a variety of voluntary support services tailored to individual needs.[15,16] PSH programs have been found to result in increased housing stability among participants.[16] • Outreach, navigation, and support services for individuals and

[10] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.
[11] United States Interagency Council on Homelessness. Home, together: Federal strategic plan to prevent and end homelessness. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.
[12] United States Interagency Council on Homelessness. (2017). The Evidence Behind Approaches that Drive an End to Homelessness. Retrieved July 8, 2022, from https://www.usich.gov/resources/uploads/asset_library/evidence-behind-approaches-that-end-homelessness.pdf.
[13] Shinn, M., & Cohen, R. (2019). Homelessness prevention: A review of the literature. Center for Evidenced-based Solutions to Homelessness. Retrieved July 11, 2022 from: http://www.evidenceonhomelessness.com/wp-content/uploads/2019/02/Homelessness_Prevention_Literature_Synthesis.pdf.
[14] The National Alliance to End Homelessness and U.S. Interagency Council on Homelessness. (2015). Role of Long-Term, Congregate Transitional Housing in Ending Homelessness. Retrieved July 11, 2018 from https://www.usich.gov/tools-for-action/role-of-long-term-congregate-transitional-housing-in-ending-homelessness/.
[15] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved June 23, 2022, from: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.
[16] National Academies of Sciences, Engineering, and Medicine 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. Washington, DC: The National Academies Press. https://doi.org/10.17226/25133

	families currently experiencing homelessness.[17] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well-being.
Anticipated Outcomes	Residents experiencing homelessness or housing instability have access to support services and resources. Residents are placed in permanent housing. Residents retain housing, preventing entry or re-entry into homelessness.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address housing and homelessness. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # placed in interim housing through the program (emergency shelter or interim housing) # placed in permanent housing through the program # who retained permanent housing through the program (e.g., via rent/utility assistance) # who received case management services directly from the program # who received mental health services directly from the program # who received substance use services directly from the program # referred out to social services

Education

Name of program/activity/initiative	Partnerships to Address Education
Description	Eden Medical Center (EMC) partners with organizations, programs, and initiatives that address education in Central Alameda County. EMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[18] Below are examples of evidence-supported strategies to address education, a social determinant of health: • High-quality early care and education, a key determinant of

[17]United States Interagency Council on Homelessness. (2019). Core Elements of Effective Street Outreach to People Experiencing Homelessness. Retrieved July 12, 2022 from https://www.usich.gov/resources/uploads/asset_library/Core-Components-of-Outreach-2019.pdf

[18] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.

	educational and health outcomes.[19] • Social and emotional learning (SEL) strategies. A growing evidence base identifies SEL as foundational to student learning and the well-being of the school community.[20] Applying an equity lens to SEL can promote equitable learning environments, ensuring that all students benefit from SEL strategies.[21] • Integrated health and social services for students and families that contribute to educational success. Evidence suggests that implementation of integrated support services models contribute to positive academic outcomes.[22] • Education-to-career pathways for children and youth in support of graduation from high school and enrollment in higher education, outcomes which are positively associated with future employment opportunities, income, and mental and physical health and well-being.[23,24,25] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Children and youth are supported to learn, grow, and reach their full potential.
Anticipated Outcomes	Families access high-quality early care and education opportunities. Children and youth develop social and emotional knowledge, skills, and behaviors. Students and families access health and social services that contribute to educational success. Students are supported in navigating their education-to-career path.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics that are used to evaluate efforts to address education. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end.

[19] U.S. Department of Health and Human Services. (n.d.) Healthy People 2030: Early Childhood Development and Education. Retrieved July 19, 2022 from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/early-childhood-development-and-education.
[20] Jones, S. M., & Kahn, J. (2017). The Evidence Base for How We Learn: Supporting Students' Social, Emotional, and Academic Development. Consensus Statements of Evidence from the Council of Distinguished Scientists. Aspen Institute. Retrieved July 19, 2022 from https://www.aspeninstitute.org/wp-content/uploads/2017/09/SEAD-Research-Brief-9.12_updated-web.pdf.
[21] Gagnier, K.M, Okawa, A., & Jones-Manson, S. (2022). Designing and Implementing Social Emotional Learning Programs to Promote Equity. White paper produced by AnLar and the Office of Elementary and Secondary Education; Education, Innovation, and Research Program (EIR). Retrieved July 20, 2022, from https://oese.ed.gov/files/2022/03/FINAL-EIR_SEL-Programs-White-Paper.pdf.
[22] Moore, K. A., Lantos, H., Jones, R., Schindler, A., Belford, J., & Sacks, V. (2017). Making the Grade: A Progress Report and Next Steps for Integrated Student Supports. Child Trends. Retrieved July 20, 2022, from https://www.childtrends.org/wp-content/uploads/2017/12/ISS_ChildTrends_February2018.pdf.
[23] Hahn, R. A., Knopf, J. A., Wilson, S. J., Truman, B. I., Milstein, B., Johnson, R. L., Fielding, J.E., Muntaner, C. J. M. Jones, C. P. Fullilove, M. T. K., Moss, R.D., Ueffing, E., Hunt, P.C., & Community Preventive Services Task Force. (2015). Programs to increase high school completion: a community guide systematic health equity review. *American Journal of Preventive Medicine*, *48*(5), 599-608. Retrieved July 21, 2022, from https://www.thecommunityguide.org/sites/default/files/publications/he-ajpm-evrev-highschoolcompletion.pdf.
[24] U.S. Department of Health and Human Services. (n.d.) Healthy People 2030: High School Graduation. Retrieved July 21, 2022 from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/high-school-graduation.
[25] U.S. Department of Health and Human Services. (n.d.) Healthy People 2030: Enrollment in Higher Education. Retrieved July 21, 2022 from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/enrollment-higher-education.

	# of persons served (unduplicated) # of class, workshop, or support group sessions provided by the program # referred out to social services

Needs Eden Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Eden Medical Center is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy plan does not include specific plans to address the following significant health needs that were identified in the 2022 Community Health Needs Assessment for the following reasons:

- Community and family safety
- Food security
- Economic security
- Dismantling structural racism
- Healthcare access and delivery

Due to the magnitude and scale of health needs and resources available, Eden Medical Center will focus its strategy on the top three health needs that were identified and prioritized through the 2022 Community Health Needs Assessment process.

Approval by Governing Board

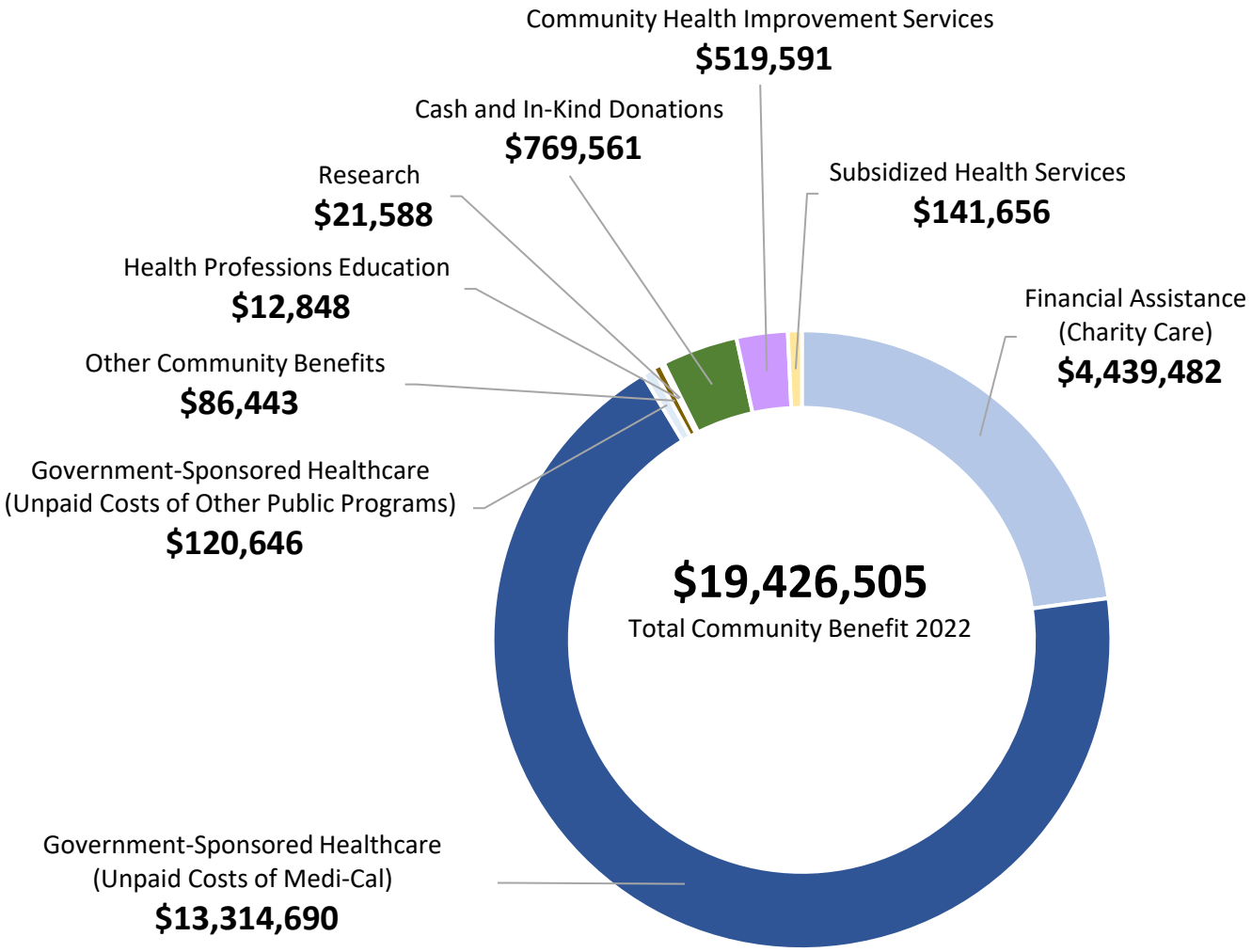
The Community Health Needs Assessment and Implementation Strategy Plan were approved by the Sutter Health Bay Hospitals Board on October 19, 2022.

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.

Eden Medical Center
2022 Total Community Benefit & Unpaid Costs of Medicare



2022 unpaid costs of Medicare were $55,864,788