Sutter Health

Alta Bates Summit Medical Center - Summit Campus

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

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Introduction

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

The 2016 CHNA and the 2016 - 2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and 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 ability to pay.

Alta Bates Summit Medical Center - Summit Campus 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 at 350 Hawthorne Avenue, Oakland, CA 94609, ATTN: Community Benefit and
- In-person at the hospital's Information Desk.

About Sutter Health

Alta Bates Summit Medical Center - Summit Campus is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is we enhance the well-being of people in the communities we serve 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 car. 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 Alta Bates Summit Medical Center - Summit Campus, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

This CHNA was conducted by Community Health Insights, on behalf of Alta Bates Summit Medical Center over a period of 8 months, beginning in May of 2015 and concluding in December of 2015. The data used to conduct the CHNA were both identified and organized using the widely recognized Robert Wood Johnson's County Health Rankings model and a defined set of data collection and analytic stages were developed. The data that were collected and analyzed included both primary or qualitative data, and secondary or quantitative data. Primary data included interviews with community health experts as well as focus groups made up of community residents. Secondary data included health outcome and health factor indicators such as measures of mortality and morbidity, and health behaviors including diet and exercise and clinical care access.

The full 2016 Community Health Needs Assessment conducted by Alta Bates Summit Medical Center - Summit Campus is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Alta Bates Summit Medical Center is located in the East Bay area of the San Francisco Bay. The three campuses primarily exist in the major metropolitan areas of Berkeley, Oakland, and Emeryville, California, located in Alameda County. The larger community served by the ABSMC was defined using ZIP code boundaries. The hospital service area (HSA) included a geographic area comprised of 24 ZIP codes. The majority of patients served by the ABSMC reside within these ZIP code boundaries that are included in the ABSMC HSA. The San Francisco Bay borders the western boundary of the HSA.

The HSA was rich with diversity and home to over 500,000 community residents. Median age ranged greatly in the HSA, with ZIP codes 94613 (Mills College) 94720, and 94704 (ZIP codes around the UC Berkeley campus) having the lowest median age at around 20 years; this is in contrast to ZIP codes 94707 (Albany/Kensington) and 94705 (Claremont Canyon/Berkeley Hills) with a median age of more than double that at 60.4 and 52 years respectively. Median income also differed in the HSA area from $26,054 for ZIP code 94612 (Downtown Oakland) residents, to $140,611 for 94708 (Albany Hills). Diversity also varied greatly in the various ZIP codes, with 97% of residents in 94612 (Downtown Oakland) self-identifying as minority (Hispanic and non-White) compared to only 21.7% identifying as part of a minority group in the ZIP code 94707 (Albany/Kensington).

Data were analyzed to identify Communities of Concern within the HSA. These are defined geographic areas (ZIP codes) and populations within the HSA that have the greatest concentration of poor health outcomes and are home to more medically underserved, low income and diverse populations at greater risk for poorer health. Communities of Concern were important to the overall CHNA methodology because, after assessing the HSA more broadly, they allowed for a focus on those portions of the HSA likely experiencing the greatest health disparities.

Significant Health Needs Identified in the 2016 CHNA

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

- Access to Mental, Behavioral, and Substance Abuse Services. Individual health and well-being are inseparable from individual mental emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges also

occur. Adequate access to mental, behavioral, and substance abuse services helps community members to obtain additional support when needed.

- Safe and Violence-Free Environment. Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (food, shelter, clothing) is physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences.

- Access to Affordable, Healthy Food. Eating a healthy diet is extremely important for one's overall health and well-being. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often are overloaded with fast food and other establishments where unhealthy food is sold.

- Health Education and Health Literacy. Knowledge is important for individual health and well-being, and health education interventions are powerful tools to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Health education around infectious disease control (e.g. STI prevention, influenza shots) and intensive health promotion and education strategies around the management of chronic diseases (e.g. diabetes, hypertension, obesity, and heart disease) are important for community health improvement. Health literacy pertains to the extent that people have the knowledge and ability to obtain, process and understand health information and services needed to make appropriate health decisions. Health knowledge and education is important, but equally important is health literacy where the people have the knowledge and ability to understand such health information and are able to navigate the health care system.

- Access to Basic Needs, such as Housing and Employment. Access to affordable and clean housing, stable employment, quality education, and adequate food for health maintenance are vital for survival. Maslow's Hierarchy of Needs states that only when members of society have their basic physiological and safety needs met can they then become engaged members of society and self-actualize or live to their fullest potential, including their health.

- Access to Quality Primary Care Health Services. Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

Significant health needs were identified through an integration of both qualitative and quantitative data. The process began by generating a broad list of 10 potential health needs that could exist within the HSA. The list was based on the health needs identified in previous Sutter East Bay reports during the 2013 CHNA process, as well as a preliminary review of primary data.

Once this list was created, both quantitative and qualitative indicators associated with each potential health need were identified in a crosswalk table. While all of these needs exist within the HSA to a greater or lesser extent, the purpose here was to identify those which were most significant.

Rates for those secondary indicators associated with the potential health needs were reviewed for each Community of Concern to determine which indicators were consistently problematic within the HSA. Next, this set of problematic indicators was compared, via the crosswalk table, to the potential health needs to select a subset of potential health needs for consideration as significant health needs. Primary data sources were also analyzed using the crosswalk table to identify potential health needs for consideration as significant health needs. The results from the primary and secondary potential health needs analyses were then merged to create a final set of significant health needs.

2016 – 2018 Implementation Strategy

The implementation strategy describes how Alta Bates Summit Medical Center - Summit Campus 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 prioritized significant health needs the hospital will address are:
The Implementation Strategy serves as a foundation for further alignment and connection of other Alta Bates Summit Medical Center - Summit Campus initiatives that may not be described herein, but which together advance Alta Bates Summit Medical Center - Summit Campus commitment to improving the health of the communities it serves. Each year, Alta Bates Summit Medical Center - Summit Campus programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue Alta Bates Summit Medical Center - Summit Campus focus on the health needs listed below.

- Access to Mental, Behavioral, and Substance Abuse Services
- Health Education and Health Literacy
- Access to Basic Needs, such as Housing and Employment
- Access to Quality Primary Care Health Services

Access to Mental, Behavioral, and Substance Abuse Services

Name of program/activity/initiative	**Behavioral Health Services**
Description	Develop a pilot project in collaboration with our Federally Qualified Health Center and Public Health partners to address the identified need for access to behavioral health services.
Goals	Vulnerable individuals in the Alta Bates Summit Medical service area will have access to effective behavioral health services, including mental health care and substance abuse treatment.
Anticipated Outcomes	• Plan developed • Pilot project timeline developed • Evaluation metrics developed
Plan to Evaluate	• To be determined
Metrics Used to Evaluate the program/activity/initiative	• To be determined

Health Education and Health Literacy

Name of program/activity/initiative	**Asthma Resource Center**
Description	The Asthma Resource Center is a program designed to help individuals control their asthma and improve their quality of life by providing education

	and tools for asthma management with a focus on the uninsured or underinsured. Individuals learn about basic asthma facts, medications and techniques, environmental controls, and asthma action plans. Efforts are made to also assist individuals who have no follow up medical care with locating ongoing care in the community.
Goals	Assist those who are uninsured or underinsured in better managing their asthma and decrease hospitalizations and emergency department visits.
Anticipated Outcomes	• Increase asthma control • Increase proper medication use • Decrease Emergency Department utilization • Increase clinic use
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • Pre and post Asthma Control Test • Asthma Center Resource database • EPIC Emergency Department utilization logs
Metrics Used to Evaluate the program/activity/initiative	• Number of people served by the Asthma Resource Center • Number of people who self-report asthma control • Number of people properly taking asthma medication • Number of people with asthma seen in the Emergency Department

Name of program/activity/initiative	**Diabetes Resource Project**
Description	The Diabetes Resource Project provides education and case management for individuals with diabetes who are uninsured or underinsured and have recently had an Emergency Department visit or have been hospitalized at Alta Bates Summit Medical Center. The program is designed to assist individuals to optimize their health through Diabetes Self-Management Education (DSME) and support in a variety of individualized and group settings. Individuals learn about the diabetes disease process and treatment options, nutrition and physical activity education, safe medication use, blood glucose monitoring, recognizing and avoiding complications of diabetes, and the development of personal strategies to address psychosocial issues and concerns and promoting health and behavior change. Diabetes Educators/Care Coordinators assist individuals who do not have a primary care physician to locate a medical home for ongoing medical care and to obtain needed diabetes medications.
Goals	Improve diabetes management and avoid unnecessary Emergency Department visits or hospitalizations for uninsured and underinsured individuals with diabetes.
Anticipated Outcomes	• Primary care follow-up will be increased by at least 25% • Emergency Department utilization and re-hospitalization will be reduced by at least 25% • Improved diabetes self-management will be demonstrated by 80% of program participants succeeding in reaching personal action plan set in the second education session • Improved glucose control demonstrated by decreased A1C in at least 50% of the individuals
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • EPIC reports • MIDAS reports

	• Action plans
Metrics Used to Evaluate the program/activity/initiative	• Number of people who attend individual or group classes • Number of people who complete the DSME program • Number of people who follow up with their primary care provider • Number of people who seek treatment in the Emergency Department or are readmitted to the hospital for diabetes-related conditions • Number of people who self-report success in meeting action plan • Number of people with improved A1C level - three months after completing DSME program

Access to Basic Needs, such as Housing and Employment

Name of program/activity/initiative	**San Pablo Area Revitalization Collaborative (SPARC)**
Description	Alta Bates Summit Medical Center is a member of the San Pablo Area Revitalization Collaborative (SPARC), which is focused on advancing actions to improve the health and well-being of 8,000 West Oakland residents along a 1.5 mile stretch of the San Pablo Avenue Corridor and two surrounding neighborhoods in five key ways: housing affordability, reducing hypertension, blight reduction, connecting residents to good jobs and spurring economic development, and housing affordability. Currently, ABSMC is a lead partner along with the East Bay Asian Local Development Corporation and the Alameda County Public Health Department, in a national grant program called the BUILD Health Challenge to support the implementation of SPARC. Alta Bates Summit Medical Center supports the East Bay Asian Local Development Corporation, the backbone organization of SPARC, to mobilize resources, cultivate new partnerships, engage residents, and provide information, resources, and referrals to advance the heart health work. Our partnership also supports the data/evaluation components of the entire initiative.
Goals	Work with community partners and program participants to improve resident health and reduce hypertension
Anticipated Outcomes	• Targeted program participants will be connected to community resources as appropriate • Increased % of targeted program participants who have the resources and support needed to manage their health • Increased % of targeted program participants who report having a supportive, healthy community, and/or trusted allies to support their health • Increased % of hypertension drop-in clinic participants whose blood pressure is within normal range (within age group)
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • Focus groups • Pre and post surveys • In-take forms
Metrics Used to Evaluate the program/activity/initiative	• Number of unduplicated program participants • Number of program participants connected to community resources • Types of community resources provided • Number of referrals provided

	• Number of hypertension drop-in clinic participants at in-take who report diagnosed hypertension • Number of hypertension drop-in clinic participants whose blood pressure is within normal range (within age group)

Name of program/activity/initiative	**Interim Care Program**
Description	Alta Bates Summit Medical Center is partnering with LifeLong Medical Care to provide individuals who are homeless temporary housing after their hospital discharge. This allows individuals to recuperate in a clean, stable environment with nursing care, meals and wraparound services provided. This partnership includes transportation to the center for those who need it.
Goals	Connect vulnerable individuals with respite care to continue recovering while they get connected to permanent housing and employment resources, health insurance, and drug and alcohol recovery counseling, if needed.
Anticipated Outcomes	• Hospital length of stay will be reduced • Emergency Department utilization for non-urgent visits will be reduced • Successful connection to ongoing case management • Successful connection to a medical home
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • EPIC reports
Metrics Used to Evaluate the program/activity/initiative	• Number of people referred to the Interim Care Program • Number of people who are connected to ongoing case management for wraparound services • Number of people who are readmitted to Alta Bates Summit Medical Center • Number of people who are connected to a medical home

Name of program/activity/initiative	**Youth Bridge**
Description	Youth Bridge is a year-round career development program designed to provide 100 vulnerable high school and college students with support and guidance to complete high school, pursue higher education, and ultimately obtain gainful employment. The program provides educational counseling, mentoring, job coaching, leadership development opportunities, and paid summer internships at the medical center and throughout the community.
Goals	Students will graduate from high school and be prepared to enter college or to obtain employment.
Anticipated Outcomes	• Students graduate from high school • Students successfully apply and accepted to college • Students are gainfully employed
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • Pre and post surveys • Evaluation from Oakland Fund for Children
Metrics Used to Evaluate the program/activity/initiative	• Number of students who enroll in Youth Bridge • Number of students who successfully complete nine-week career activities class • Number of students who complete internship program

	• Number of students who graduate from high school • Number of students who are accepted to college • Number of students who are gainfully employed

Access to Quality Primary Care Health Services

Name of program/activity/initiative	**Care Transitions**
Description	In order to connect individuals to the right care, at the right place and at the right time, Alta Bates Summit Medical Center will continue to work with our FQHC partner's, LifeLong Medical Care, La Clinica, and Asian Health Services, to improve care transitions for targeted individuals.
Goals	Provide warm handoffs between individuals being discharged from Alta Bates Summit Medical Center to their primary care home for appropriate follow up to decrease non-urgent (Level 1 and Level 2) Emergency Department visits, decrease readmissions, and provide navigation and access to those who are uninsured and underinsured.
Anticipated Outcomes	• Increase number of people connected to a medical home • Increase number of people connected, as appropriate, to community resources • Decrease in non-urgent Emergency Department visits • Decrease in hospital readmissions
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template • EPIC reports
Metrics Used to Evaluate the program/activity/initiative	• Number of people contacted • Number of follow up appointments made • Number of follow up appointments kept • Number of people readmitted to the Emergency Department or as an inpatient

Name of program/activity/initiative	**Order of Malta Clinic**
Description	The Order of Malta Clinic provides free medical care to the poor and needy who do not have any form of medical insurance, without regard to race or religion. The clinic offers physical exams, laboratory testing, x-rays, electrocardiograms, and immunizations.
Goals	Provide medical care to the homeless and other individuals who cannot afford to pay.
Anticipated Outcomes	• Sponsorship of 125 patient encounters
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template
Metrics Used to Evaluate the program/activity/initiative	• Number of patient encounters

Needs Alta Bates Summit Medical Center - Summit Campus Plans Not to Address

No hospital can address all of the health needs present in its community. Alta Bates Summit Medical Center - Summit Campus 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:

- Safe and Violence-Free Environment
- Access to Affordable, Healthy Food

Alta Bates Summit Medical Center - Summit Campus does not have the resources and/or expertise to respond to these community needs at this time. The medical center is a collaborative partner to numerous community organizations and on occasion will sponsor programs and initiatives that address the needs listed above. However, these needs will not be the area of focus for 2016-2018.

Approval by Governing Board

The implementation strategy was approved by the Sutter Health Bay Area Board on November 16, 2016.