Sutter Health
Eden Medical Center

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

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Introduction

The implementation strategy describes how Eden Medical Center, 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.

Eden Medical Center 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 20103 Lake Chabot Road, Castro Valley, CA 94546 Attn: Community Benefit and
- In-person at the hospital's Information Desk.

About Sutter Health

Eden Medical Center 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 Eden Medical Center (EMC), visit www.sutterhealth.org.

2016 Community Health Needs Assessment (CHNA) Summary

This CHNA was conducted by Community Health Insights, on behalf of EMC 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 Foundation'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 Eden Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

EMC is located in Castro Valley, California, a community located in Alameda County. Castro Valley is the largest unincorporated community in Alameda County, and the fifth largest in California. The larger community served by EMC was defined using ZIP code boundaries. The hospital service area (HSA) included a geographic area comprised of 10 ZIP codes, with the majority of patients served by EMC residing within these ZIP codes. The major cities in the HSA include Ashland, Brookshire, Cherryland, Fairview, Hayward, Russell City and San Leandro.

The HSA is home to over 370,000 residents. Median age varied from a low of 32.8 years for ZIP code 94544 (S. Hayward) to a high of 43.6 for ZIP code 94552 (Castro Valley). Median income ranged from $56,656 for ZIP code 94541 (N. Hayward/Cherryland) to $138,447 for 94552 (Castro Valley). Further, the majority of residents in all ZIP codes but one – 94546 – were non-White or Hispanic.

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 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 and are the front line in the prevention and treatment of common diseases and injuries in a community.

- Access to Affordable, Healthy Food. Eating a healthy diet is 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 and intensive health promotion and education strategies around the management of chronic diseases are important for community health improvement.

- Access to Mental, Behavioral and Substance Abuse Services. Individual health and well-being are inseparable from individual mental and 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.

- 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 says that only when members of a 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.

- Safe and Violence-Free Environment. Feeling safe in one's own home and community are fundamental to overall health. Feeling unsafe affects the way people act and react to everyday life occurrences.

- Access to Specialty Care. Specialty care services are those devoted to a particular branch of medicine and focus on the treatment of a particular disease. Primary and specialty care go hand-in-hand, and without access to specialists such as endocrinologists, cardiologists and gastroenterologists, community residents are often left to manage chronic diseases such as diabetes and high blood pressure on their own.

- Access to Transportation and Mobility. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to attain their basic needs, including those that promote and support a healthy life.

- Pollution-Free Living Environment. Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and man-made) and socio-cultural environment, has more impact on individual health than one's lifestyle, heredity or access to medical services.

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 EMC plans to address significant health needs identified in the 2016 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2016 CHNA.

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

The prioritized significant health needs the hospital will address are:

- Access to Quality Primary Care Health Services
- Access to Affordable, Healthy Food
- Access to Mental, Behavioral, and Substance Abuse Services
- Access to Basic Needs, such as Housing and Employment
- Access to Transportation and Mobility

Access to Quality Primary Health Care Services

Name of program/activity/initiative	**Care Transitions**
Description	In order to connect patients to the right care, at the right place and at the right time, Eden Medical Center will continue to work with our FQHC partner, Tiburcio Vasquez Health Center (TVHC), to improve care transitions for targeted patients.
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 the number of people connected to a medical home • Increase the 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	**Prescription Program**
Description	Through an agreement with Walgreens and Safeway, Eden Medical Center provides funding for prescription drugs for up to the first three days of a patient's discharge medication for people who would be otherwise unable to pay for their medications.
Goals	Vulnerable patients will continue their recovery by receiving free prescription medications.
Anticipated Outcomes	• Medical outcomes for patients who might be readmitted or whose recovery would be significantly impeded due to the lack of prescribed medications will be improved
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template
Metrics Used to Evaluate the program/activity/initiative	• Number of prescriptions filled • Readmission rate of patients

Access to Affordable, Healthy Food

Name of program/activity/initiative	**Dig Deep Farms**
Description	Eden Medical Center supports a collaborative program that operates three working farms on plots of land in San Leandro, Ashland and Cherryland. These plots provide bags of fresh produce that are delivered weekly to subscribers in and around Ashland and Cherryland and to pregnant women coming for prenatal services at La Clinica's Fuente Wellness Center.
Goals	Provide bags of fresh produce, nutrition information and recipes to vulnerable members and to prenatal patients of La Clinica Fuente Wellness Center.
Anticipated Outcomes	• Produce bag recipients will increase their consumption of fresh, healthy produce • Recipients will increase their nutrition knowledge and expand their cooking repertoires
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template
Metrics Used to Evaluate the program/activity/initiative	• Number of community members who receive donated bags of produce • Number of La Clinica patients who receive donated bags of produce • Number recipients who eat the produce • Number of recipients who try new recipes

Access to Mental, Behavioral, and Substance Abuse Services

Name of program/activity/initiative	**Davis Street Family Resource Center**
Description	Eden Medical Center is partnering with Davis Street Family Resource

	Center, (DSFRC) an FQHC, to provide warm hand-offs for patients of Eden Medical Center who need mental health care appointments. This partnership allows for increased capacity at DSFRC for mental health care appointments and for increased capacity to provide mental health care services in the local schools.
Goals	Provide access to mental health care services to individuals in the vulnerable communities of Ashland and Cherryland
Anticipated Outcomes	• Individuals who need mental health care services will get a warm handoff and an expedited appointment • An average of 60 patients per week will be seen in the outpatient clinic • An average of 50 children will be seen in the school-based clinics
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template
Metrics Used to Evaluate the program/activity/initiative	• Number of people referred to DSFRC for behavioral health care • Number of people connected to DSFRC behavioral health care services • Number of children seen in DSFRC school-based clinics

Access to Basic Needs, Such as Housing and Employment

Name of program/activity/initiative	**Interim Care Program**
Description	Eden Medical Center is exploring a partnership with Abode Services and a local FQHC to provide homeless patients temporary housing and medical respite care after their hospital discharge. This allows patients to recuperate in a clean, stable environment with nursing care, meals and wraparound services provided.
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 Eden 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 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 be exposed to career paths in the patient care environment along with mentoring and counseling to prepare them for higher education. They will graduate from high school and successfully apply to college.
Anticipated Outcomes	• Ten students will be enrolled in the Youth Bridge program • 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
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 Transportation and Mobility

Name of program/activity/initiative	**Taxi Voucher Program**
Description	Transportation can be a problem for those who have been discharged from the hospital but have no means to return home. This program provides transportation for those patients.
Goals	Program funding will provide taxi vouchers for 500 patients so they can be discharged home.
Anticipated Outcomes	• A total of 500 patients will receive taxi vouchers
Plan to Evaluate	• Collect, refine, and report metrics using Sutter evaluation template
Metrics Used to Evaluate the program/activity/initiative	• Number of vouchers given

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 does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

- Health Education and Health Literacy
- Safe and Violence Free Environment
- Access to Specialty Care

Eden Medical Center 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.