

Sutter Health

Eden Medical Center

2019 – 2021 Community Benefit Plan

Responding to the 2019 Community Health Needs Assessment

Submitted to the Office of Statewide Health Planning and Development May 2022

20103 Lake Chabot Road
Castro Valley, CA 94546
Facility License #1400000030
www.sutterhealth.org

Table of Contents

About Sutter Health	3
2019 Community Health Needs Assessment Summary	4
Definition of the Community Served by the Hospital	4
Significant Health Needs Identified in the 2019 CHNA	6
2019 – 2021 Implementation Strategy Plan	8
Behavioral Health	9
Economic Security	11
Housing and Homelessness	13
Healthcare Access and Delivery	15
Needs Eden Medical Center Plans Not to Address	22
Approval by Governing Board	22
Appendix: 2021 Community Benefit Financials.....	23

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 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 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 2019 Community Health Needs Assessment and 2019 - 2021 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 using the hospital's address at 3012 Summit Street, 3rd Floor, Oakland, CA 94609, ATTN: Community Benefit; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Health is the not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, 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 2021 was \$872 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 network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested \$91 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 and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested \$557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped 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 by visiting sutterpartners.org.

In addition, every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local healthcare priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and addresses real community needs.

Through the 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Behavioral Health
2. Economic Security
3. Housing and Homelessness
4. Healthcare Access and Delivery
5. Education and Literacy
6. Community and Family Safety
7. Healthy Eating/Active Living
8. Transportation and Traffic
9. Climate/Natural Environment

The 2019 Community Health Needs Assessment conducted by Eden Medical Center is publicly available at sutterhealth.org.

2019 Community Health Needs Assessment Summary

Eden Medical Center (EMC) conducted its 2019 Community Health Needs Assessment (CHNA) collaboratively with local hospitals serving Alameda County, which included Kaiser Permanente, St. Rose Hospital, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System. The CHNA was completed by Actionable Insights (AI), LLC, an independent local research firm.

The Hospitals began the CHNA cycle in 2018 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 2018 through key informant interviews with local health experts and focus groups with community leaders, residents, and representatives. Secondary data were obtained from the Community Commons data platform and other online sources such as the California Department of Public Health and the U.S. Census Bureau. Data were available for Alameda County and, in many cases, for the hospitals' service areas specifically. Significant health needs were identified and prioritized in early 2019, described further below.

The full 2019 Community Health Needs Assessment conducted by Eden Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

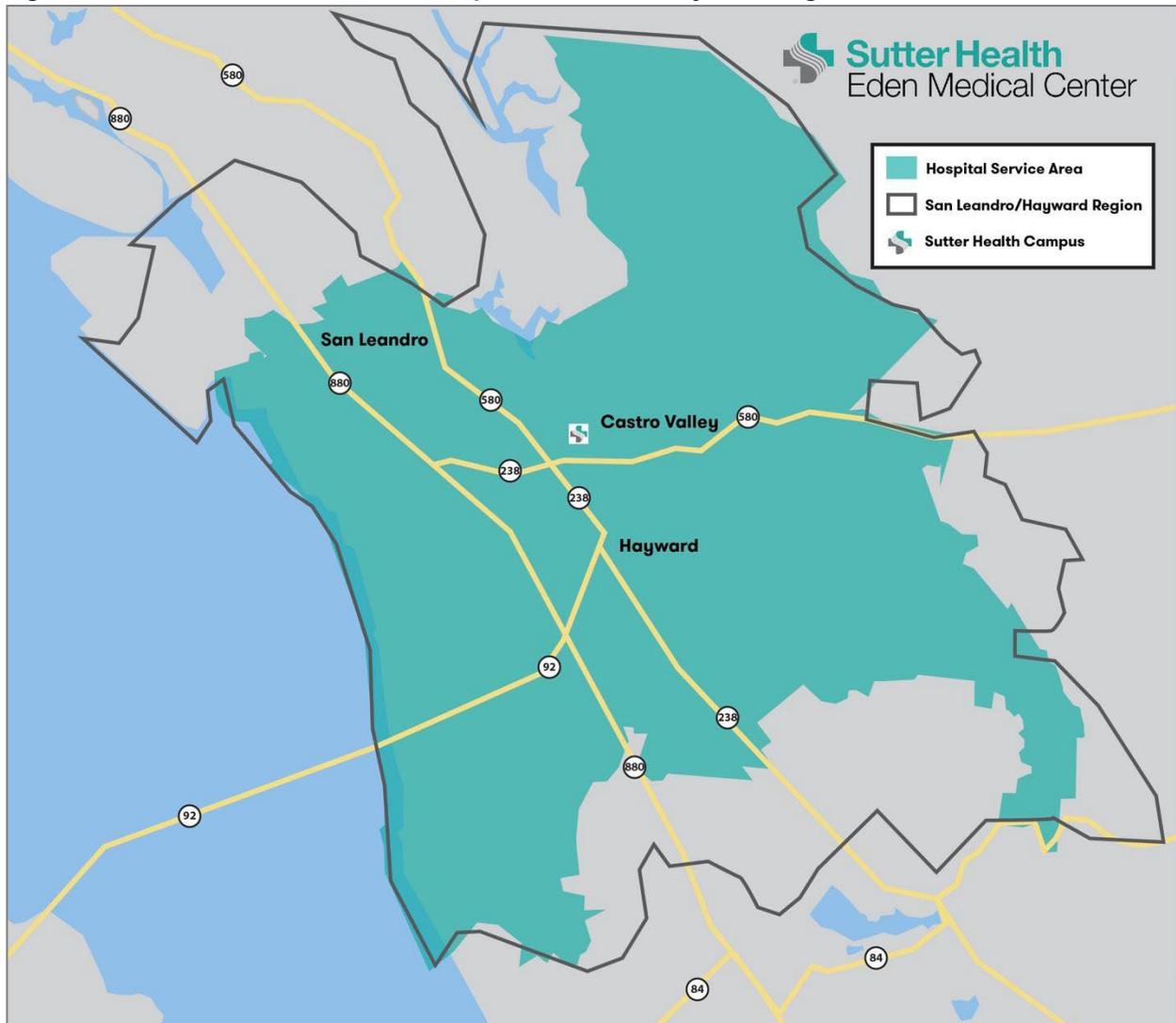
The Internal Revenue Service defines the community served as individuals who live within the hospital's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

Eden Medical Center is located in the city of Castro Valley in the San Leandro/Hayward region of

Alameda County. Eden Medical Center’s hospital service area includes 10 zip codes surrounding the hospital and its neighboring communities. As previously noted, the medical center collaborated on the 2019 CHNA with other healthcare facilities serving the San Leandro/Hayward region. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, which include Castro Valley, Hayward, San Leandro, San Lorenzo, and Union City, as well as unincorporated areas.

The map below (Figure 1) shows the alignment of the San Leandro/Hayward region with Eden Medical Center’s service area.

Figure 1. Eden Medical Service Area Map, San Leandro/Hayward Region



The U.S. Census estimates a population of nearly 530,000 in the San Leandro/Hayward region. About 13 percent of residents overall and nearly 20 percent of children live in poverty. Approximately 11 percent of people in the region are uninsured. The median household income in Alameda County is about \$80,000; by comparison, the 2018 Self-Sufficiency Standard for a two-adult family with two children in Alameda County was about \$98,300. About 39% of residents in the San Leandro/Hayward region are White, 35% are Latinx¹, 27% percent are Asian, 13% are African American, and individuals of multiple races account for about 6% of residents.

¹ The term “Latinx” is employed as a gender-neutral way to refer to Latin American and Hispanic individuals of any race.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

1. *Behavioral Health.* The community prioritized behavioral health, which refers to both mental health and substance use, as its top health need in focus groups and interviews. Depression and stress were the most common issues raised. Alameda County mental health statistics underscore the community's concerns: The rates of emergency room (ER) visits for severe mental illness and substance use, respectively, are significantly higher in the county than the state averages. Mental health hospitalizations for children and youth countywide are also significantly higher—and both are trending up.
2. *Economic Security.* Economic environments are important determinants of population health and economic security was one of the top priorities of the community. In focus groups, residents emphasized that local jobs often do not pay enough to afford the high cost of living in Alameda County. The percentage of older adults living in poverty countywide has been increasing. Additionally, disparities exist between ethnic groups in educational attainment, the rate of uninsured individuals, and people living in poverty, factors associated with economic security.
3. *Housing and Homelessness.* Access to safe, affordable, and stable housing is associated with physical and mental health and well-being. Maintaining safe and healthy housing ranked high as a community priority. The median rent in the county is significantly higher than the state average—and increasing. The proportion of local children living in crowded housing has been increasing as well. The overall number of individuals experiencing homelessness in Alameda County increased in the 2017 point-in-time count. In addition, blood lead levels for children and youth in Alameda County exceed the state average as do child and youth asthma diagnoses and hospitalizations, indicators that are associated with poor housing quality.
4. *Healthcare Access and Delivery.* Community members expressed strong concerns about this health need, including the affordability of care and the lack of access to specialty care, especially for Medi-Cal patients. Poor access to healthcare is associated with higher rates of many health conditions due to lack of preventive screenings and early treatment. A smaller proportion of county residents have a regular source for primary care, and a larger proportion delay or have difficulty obtaining care, compared to Healthy People 2020 aspirational goals.² Additionally, ethnic disparities were found in cancer mortality rates, cervical cancer incidence, stroke deaths, and screenings for breast and colorectal cancers.
5. *Education and Literacy.* The relationship of educational attainment, employment, wages, and health have been well documented; limited literacy is correlated with low educational attainment. A larger proportion of children live in linguistically isolated households than compared with the state.³ This, combined with the comparatively high cost of childcare for children ages 0 to 5, means that children in the county may have greater barriers to literacy than kids elsewhere. Additionally, a smaller proportion of local students graduate high school on time compared to the state average.
6. *Community and Family Safety.* Community and family safety ranked as one of the top health needs in the San Leandro/Hayward region. Focus group and interview participants most frequently talked about domestic violence. Participants were concerned most about children and youth, especially when it came to being bullied, becoming victims of violence, and acting out trauma. Domestic violence hospitalization rates are significantly higher in the San Leandro/Hayward region than the state average. Alameda County's ER visits and deaths due to unintentional injury are increasing. Furthermore, traumatic injury (intentional and unintentional) hospitalizations among children and youth, firearm fatalities (intentional and unintentional), bicycle-involved collisions, and motor vehicle crash ER visits all exceed state benchmarks.

² Healthy People is an endeavor of the U.S. Department of Health and Human Services that has provided 10-year national objectives for improving the health of Americans based on scientific data spanning 30 years. Healthy People sets national objectives, which serve as or targets for improvement. The most recent set of objectives are for the year 2020; year 2030 objectives are currently under development.

³ Defined as a household where no one aged 14 years or older speaks English "very well." U.S. Census Bureau. American Community Survey, 5-Year Estimates, 2012–2016.

7. *Healthy Eating/Active Living.* This health need is comprised of access to food and recreation, food insecurity (also identified in Economic Security), diabetes, obesity, nutrition, diet, and fitness. There are fewer grocery stores and produce vendors per capita in the San Leandro/Hayward region compared to the state benchmark. In addition, the percentage of county children experiencing food insecurity who are ineligible for government assistance surpasses the state average. A greater proportion of youth in the San Leandro/Hayward region are physically inactive, compared to the state. Moreover, the rate of diabetes hospitalization among children and youth countywide is above the state average and increasing.
8. *Transportation and Traffic.* The community discussed transportation as a barrier to seeing the doctor and getting to work, and they expressed frustration with the costs and limitations (such as the lack of frequency or service in some areas) of public transportation in Alameda County, particularly BART. Commutes by car can also wear on local residents; a significantly greater proportion of the region's commuters drive alone to work more than 60 minutes in each direction. Additionally, the pedestrian accident death rate in the San Leandro/Hayward region is higher than the state average.
9. *Climate/Natural Environment.* Feedback from the community about the environment primarily related to poor air quality, which they attributed to pollution and identified as a cause of asthma. The respiratory hazard index in the region is significantly worse than the state average. Road network density contributes to greater traffic, which can increase air pollution, and the San Leandro/Hayward region has a significantly higher density of roads than the state average.

Health Need Identification

Health needs were identified by synthesizing primary qualitative research (community input) and secondary data, and then filtering those needs against a set of criteria, below:

1. Meets the definition of a "health need," a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
2. At least two data sources were consulted.
3.
 - a. Prioritized by at least half of key informant interviewees or focus groups.
 - b. If not (a), three or more direct indicators fail the benchmark by $\geq 5\%$ or show a ≥ 0.5 standard deviation.
 - c. If not (b), four or more indicators must show ethnic disparities of $\geq 5\%$ or a ≥ 0.5 standard deviation.

Health Need Prioritization

In February 2019, Sutter Health, John Muir Health, and Kaiser Permanente convened a meeting with key leaders in Alameda County. Participants 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:

- *Clear disparities or inequities.* This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, language, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- *Community priority.* This refers to the extent to which the community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process. This criterion was ranked by Actionable Insights based on the frequency with which the community expressed concern about each health outcome during the CHNA primary data collection.
- *Magnitude/scale of the need.* This refers to the number of people affected by the health need.

- *Multiplier effect.* This refers to the idea that a successful solution to the health need has the potential to solve multiple problems.
- *Severity of need.* This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against relevant benchmarks.

Meeting participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs. Eden Medical Center then selected the top five health needs to address in its 2019-2021 Implementation Strategy.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Eden Medical Center plans to address significant health needs identified in the 2019 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 2019 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, 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. Economic Security
3. Housing and Homelessness
4. Healthcare Access and Delivery

Behavioral Health

Name of program/activity/initiative

Investments in Behavioral Health

Description

Investments made through grants and sponsorships are decided annually and based on community health need.

Eden Medical Center (EMC) seeks to promote behavioral health, in part, by supporting the provision of behavioral health programs, including those focused on the effective delivery of promotion and preventive interventions. Childhood and youth are opportune ages for promotion and preventive behavioral health interventions; schools are promising settings from which to prioritize these age groups and offer opportunities to engage the broader school community, including school staff and administrators, parents and caregivers, and students.⁴ Supporting organizations and programs that provide culturally responsive services, which can improve patient/client retention and treatment outcomes,⁵ is a priority. Further, EMC supports workforce development strategies, which are critical to ensuring that present and future behavioral health needs of the community can be met. EMC partners with programs that promote behavioral health and well-being in collaboration with residents and multi-sector partners. Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting and improving access to wraparound resources that support health and well-being are approaches to behavioral healthcare services that EMC supports.

EMC invests in organizations, programs, and initiatives that work to address behavioral health. Examples of efforts to advance behavioral health by providing evidenced-based, culturally responsive behavioral health services and/or behavioral health workforce development include Castro Valley High School Wellness Center (school-based), Horizon Services' Project Eden (after school-based), and others.

Selected executed grants will be reported at year end

Goals

Youth and adult residents are aware of and easily able to access evidenced-based, culturally responsive behavioral health resources and services through sustainable, prevention-focused interventions

Anticipated Outcomes

Increased coordination and systems among placed-based, multi-sector partners including residents and organizations

Residents experience improved access to evidenced-based, culturally responsive behavioral health resources and services, including promotion and preventive approaches

Behavioral health professionals and trainees report increased knowledge of and skills in evidenced-based, culturally responsive behavioral health resources and strategies, including promotion and preventive approaches.

⁴ U.S. Office of Disease Prevention and Health Promotion, Healthy People 2020. Mental health and mental disorders. Retrieved August 8, 2019, from <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders>

⁵ 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>

2021 Impact

In 2021, EMC provided grants/sponsorships to organizations addressing behavioral health, including the following:

Castro Valley High School's Wellness Center provides prevention and intervention counseling and support in group and individual settings in collaboration with leadership, the school nurse and psychologist, and with mental health professionals from Eden Counseling.

Davis Street's Community Counseling Program is an outpatient mental health clinic specializing in providing culturally relevant intervention and prevention services to enhance the overall quality of life for clients.

Horizon Services, Inc.'s Project Eden Youth Services Program educates youth, adults, schools, and the community about the prevention of alcohol and other drug use among youth in Alameda County through services including individual and group sessions, community and school engagement, workshops, and environmental prevention.

Side by Side's Our Space program provides advocacy and access to services for marginalized, traumatized, and/or isolated LGBTQIA+ youth in Alameda County to support their healthy development and nurture a safe community.

Through the programs funded to address behavioral health, over 2,800 individuals were served in 2021. Of 2,166 individuals assessed, 1,642 made progress towards the intended outcomes. Outcomes assessed varied by organization funded and included reduction in depression, anxiety, and substance use and increase in mental health and wellness knowledge.

Metrics Used to Evaluate the program/activity/initiative

Number of persons served

Number of encounters

Number of classes/workshops provided

Number connected to mental health services

Number of community events provided

Additional metrics to be determined, based on organization/initiative supported. For example,

Number of collaborative relationships

Number of post graduate mental health provider interns trained

Number and percent of mental health provider interns reporting receiving appropriate coaching and strategies to effectively serve students

Economic Security

Name of program/activity/initiative

Investments in Economic Security

Description

Investments made through grants and sponsorships are decided annually and based on community health need.

Financial health is associated with physical and mental health. Eden Medical Center (EMC) works to promote economic security, in part, by supporting the provision of job training and workforce development, financial education and coaching, as well as the connection to income supports including food security programs for low-income families.

Establishing long-term financial security requires a multi-faceted approach; EMC partners with programs that connect their clients to bundled services such as job training, financial coaching, and access to wraparound resources that support health and well-being in collaboration with multi-sector partners. Supporting access to quality educational opportunities, from early childhood through higher education, is also critical to promoting financial security.

EMC invests in organizations, programs, and initiatives that work to address economic security. Selected executed grants will be reported at year end.

Goals

Residents achieve financial security through increased income or other resources and/or improved financial management practices

Anticipated Outcomes

Residents Experience:

- Increased access to financial education and coaching services and/or stable employment opportunities.
- Improved knowledge, skills, and experience to support financial security and/or employability.
- Increased feeling of financial security
- Attainment and retention of new employment opportunities or increased stability and/or wages of existing employment.

2021 Impact

EMC provided grants/sponsorships to organizations addressing economic security, including the following:

ALL-IN Alameda County's Youth Urban Agriculture Internship is a 6-week paid program for youth living in central Alameda County to increase healthy behaviors, generate interest and skills in the local food economy, and improve financial literacy.

Eden Housing Resident Services, Inc.'s Eden Savers Program is an economic empowerment program that pairs residents with a volunteer financial coach and helps fund an emergency savings account.

Through the programs funded to address economic security, a total of 78 individuals were served in 2021.

Metrics Used to Evaluate the program/activity/initiative

Metrics to be determined based on organization/initiative supported. For example,
Number of people served
Number connected to social services
Number of classes/workshops

Housing and Homelessness

Name of program/activity/initiative	Investments in Housing and Homelessness
Description	<p>Investments made through grants and sponsorships are decided annually and based on community health need.</p> <p>Eden Medical Center (EMC) works to address housing and homelessness, in part, by partnering with organizations that provide case management, navigation, and support services to individuals at risk of, currently experiencing, or exiting homelessness and/or housing instability. Programs that prevent homelessness and housing instability through strategies such as developing and facilitating access to affordable housing, housing assistance, and employment supports for low-income residents, are also important preventive Approaches.⁶ Housing and homelessness is a multi-sectoral issue; EMC partners with organizations that convene and participate in collaborative efforts between governmental and nonprofit organizations in service outreach and delivery and/or in developing long-term solutions.</p> <p>EMC invests in organizations, programs, and initiatives that work to address housing and homelessness. Abode Services is one example of an organization, among others, within the hospital service area that addresses housing instability and homelessness by assisting low-income, un-housed people, including those with special needs, to secure stable housing and access support services.</p> <p>Selected executed grants will be reported at year end.</p>
Goals	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well-being.
Anticipated Outcomes	Increased access to services and resources that: Prevent entry into homelessness and alleviate housing instability Shelter and support individuals experiencing homelessness Improve exits from homelessness to stable housing
2021 Impact	<p>EMC provided grants/sponsorships to organizations addressing housing and homelessness, including the following:</p> <p><i>Abode Services' HOPE Project</i> operates a mobile health clinic that provides medical, outreach, and social services, and street outreach teams that provide outreach and linkage to resources for homeless individuals.</p> <p><i>Family Emergency Shelter Coalition's (FESCO)</i> transitional housing program, Banyan House, supports individuals and families experiencing homelessness to gain economic stability and strengthen well-being by providing transitional housing, case</p>

⁶ 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

management, and wrap around support services.

Through the programs funded to address housing and homelessness, 1,046 individuals were served, 518 were placed in interim housing, and 620 were placed in permanent housing in 2021.

Metrics Used to Evaluate the program/activity/initiative

- Number of persons served
 - Number connected to permanent or temporary housing
 - Number of persons housed in homeless shelters
 - Number connected to mental health services
 - Number connected to social services
 - Additional metrics to be determined, based on organization/initiative supported.
-

Healthcare Access and Delivery

Name of program/activity/initiative	Investments in Healthcare Access and Delivery
Description	<p>Investments made through grants and sponsorships are decided annually and based on community health need.</p> <p>Eden Medical Center (EMC) addresses healthcare access and delivery, in part, by partnering with community-based organizations that develop, expand, and promote affordable, culturally, and linguistically appropriate health services for uninsured and underinsured patients. This includes support for initiatives that improve access to primary care, which can offer a usual source of care, preventive care, early detection and treatment of disease, and chronic disease management.⁷ Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting is an approach to care delivery that EMC supports.</p> <p>Primary care has also been identified as an important setting in which to address the social determinants of health,⁸ and EMC partners with organizations that connect patients to additional wraparound resources that promote health and well-being, such as food and housing assistance and employment supports.</p> <p>EMC invests in organizations, programs, and initiatives that work to address healthcare access and delivery. Davis Street and Tiburcio Vasquez Health Center are examples of Federally Qualified Health Centers within the hospital service area that improve access to primary care and connections to wraparound resources to uninsured and underinsured patients.</p> <p>Selected executed grants will be reported at year end.</p>
Goals	To improve community health by expanding access to healthcare for uninsured and underinsured populations.
Anticipated Outcomes	<p>Improve access to primary healthcare services for low-income patients</p> <p>Increase the percentage of primary care physician appointments that are scheduled and kept</p>
2021 Impact	<p>EMC provided grants/sponsorships to organizations addressing healthcare access and delivery, including the following:</p> <p><i>Tiburcio Vasquez Health Center's Care Transitions Nurse Program</i> provides health center patients who have recently been to the emergency department or admitted to EMC with navigation services and warm hand-offs to their primary care home for appropriate follow-up care.</p> <p><i>Tiburcio Vasquez Health Center's Patient Navigation Program</i> served individuals at EMC's Inpatient and Emergency Departments to ensure they were discharged to settings appropriate for their needs and connected to a medical home and primary care provider.</p>

⁷ Healthy People 2020. Access to primary care. Retrieved August 7, 2019, from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary>

⁸ World Health Organization. Primary health care. Retrieved August 7, 2019, from <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

Through the programs funded to address healthcare access and delivery, over 6,100 individuals were served and over 4,000 received services from a primary care provider in 2021.

Metrics Used to Evaluate the program/activity/initiative

Number of persons served

Number of patients seen by a primary care physician

Additional metrics to be determined, based on organization/initiative supported. For example,

Number of primary care physician appointments made

Percent of primary care physician appointments kept

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	<p>Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to improve care transitions and reduce future hospitalization. The program helps patients manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want.</p> <p>Eden Medical Center supports the program, providing funding towards the care of the people who enroll in the East Bay service area.</p> <p>Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.</p>
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs.
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness
2021 Impact	In 2021, 226 individuals were newly enrolled in Advanced Illness Management's East Bay service area. Of those discharged from the hospital, 13% of individuals transitioned to home/self-care from the hospital, and 56% transitioned to home healthcare service.
Metrics Used to Evaluate the program/activity/initiative	<p>Number of persons enrolled in the program's East Bay service area (including demographics as available)</p> <p>Number of persons transitioned to home/self-care from hospital</p> <p>Number of persons transitioned to home healthcare service.</p>

Name of program/activity/initiative	Community Health Education: Cancer
Description	<p>Eden Medical Center (EMC) offers free Community Cancer Prevention and Screening Events, which provide community members with the opportunity to learn about strategies to reduce cancer risk, symptoms to be aware of, and the screenings needed to help avoid being diagnosed with late stage disease.⁹</p> <p>In collaboration with the Cancer Support Community, EMC also offers free Cancer Workshops for people with cancer and for those who want to learn more about cancer prevention strategies. Topics include nutrition, yoga, mindfulness/meditation, and prevention of site-specific cancer such as breast or lung cancer.</p>
Goals	To provide residents with the knowledge to reduce their risk of cancer, detect cancer early, and for those diagnosed with cancer, to improve their quality of life
Anticipated Outcomes	<p>Participants experience increased knowledge of the symptoms that can occur for specific cancers, stress management strategies, nutrition and physical activity recommendations, and how often to be screened</p> <p>Participants experience increased access to cancer screenings</p>
2021 Impact	In 2021, Cancer Support Community (CSC) served 38 individuals and held four virtual workshops for EMC. Community Cancer Prevention and Screening events have been on hold since March 2020 due to the COVID-19 pandemic.
Metrics Used to Evaluate the program/activity/initiative	<p>Number of persons served</p> <p>Number of Community Cancer Prevention and Screening Events provided</p> <p>Number of workshops provided</p> <p>Number of health screenings</p> <p>Of patients positively screened, number referred for appropriate follow-up</p>

⁹ More information about Eden Medical Center's classes and events can be found at <https://www.sutterhealth.org/eden/classes-events>

Name of program/activity/initiative	Stroke Patient Navigation Program
Description	The Stroke Patient Navigation Program provides nurse-directed collaboration with acute stroke patients and their caregivers appropriate to the morbidity, complexity of disease, and treatment course from initial hospitalization through post-acute rehabilitation and community reintegration.
Goals	To facilitate a seamless transition for patients through the healthcare continuum during stroke recovery, prevent stroke recurrence, and alleviate barriers to recovery and health promotion
Anticipated Outcomes	<p>Patients and caregivers develop their understanding of the recovery process, trajectory, patient-specific risks and prevention strategies for recurrent stroke, and health promotion strategies</p> <p>Patients improve knowledge of self-advocacy and problem-solving strategies</p> <p>Patients experience improved functional and adaptive outcomes</p>
2021 Impact	In 2021, 606 individual people were served for a total of 964 encounters.
Metrics Used to Evaluate the program/activity/initiative	<p>Number of persons served</p> <p>Number of encounters</p> <p>Metrics related to self-reported patient experience, such as:</p> <ul style="list-style-type: none"> Percent of patients that strongly agree that their stroke navigator provides them with useful information about their healthcare Percent of patients that strongly agree that they are able to contact their stroke navigator with needs and questions

Name of program/activity/initiative	Support Groups: Breastfeeding, Cancer, and Stroke
Description	Eden Medical Center offers free support groups for the community for breastfeeding parents, stroke survivors, and people with cancer and cancer survivors, among others. ¹⁰
	<p><i>Breastfeeding Support Group</i> The Birth Center at Eden Medical Center offers a free three-hour drop-in Breastfeeding Support Group for all new parents and their babies once per week. Moderated by a Registered Nurse with expertise in post-partum and breastfeeding support, this group provides a caring and supportive setting to discuss relevant topics such as milk production, pumping and storage of milk, post-partum emotions and feelings, returning to work, nursing at night, latch and positioning, and troubleshooting common difficulties. Attendees share experiences and information about resources in the community that are helpful as they navigate parenthood. Each session provides an opportunity for parents to have their baby weighed and, if needed, receive referrals for appropriate care. Parents can continue to come to the group up to one year after they have delivered.</p>
	<p><i>Cancer Support Group</i> Eden Medical Center, in collaboration with the Cancer Support Community, offers Cancer Support Groups that are open to cancer patients with any type of cancer.</p>
	<p><i>Stroke Support Group</i> Eden Medical Center Stroke Support group offers a free support and educational group for stroke survivors and caregivers in the community. Efforts are made to educate participants about coping techniques, stroke prevention, and to provide community resources for stroke survivors to live a balanced and fulfilling lifestyle.</p>
Goals	Provide information, support, and opportunities to share personal experiences in a positive and caring environment
Anticipated Outcomes	<p>Increased sense of social support</p> <p>Increased awareness of community resources that support health and wellness</p> <p><i>Breastfeeding Support Group</i> New parents experience increased knowledge of strategies to overcome challenges with breastfeeding and maintain their health and that of their babies as they transition to parenthood</p> <p><i>Cancer Support Group</i> People with cancer build their understanding of strategies to manage stress during treatment and experience a sense of emotional support</p> <p><i>Stroke Support Group</i> Stroke survivors and their caregivers experience increased awareness of stroke prevention strategies and positive coping techniques</p>

¹⁰ More information about Eden Medical Center's support groups can be found at <https://www.sutterhealth.org/eden/classes-events>

2021 Impact

Sixty-three virtual Cancer Support Group meetings were provided to 32 individuals. The Breastfeeding and Stroke Support Groups have been on hold since March 2020 due to the COVID-19 pandemic.

Metrics Used to Evaluate the program/activity/initiative

Number of persons served

Number of support group meetings provided

Support group-specific metrics to be determined, such as:

Number of pregnant patients who attend the Breastfeeding Support Group prenatally

Number of return Cancer Support Group participants

Number of new Stroke Support Group participants each month

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 2019 Community Health Needs Assessment for the following reasons:

- Education and Literacy
- Community and Family Safety
- Healthy Eating/Active Living
- Transportation and Traffic
- Climate/Natural Environment

Eden Medical Center will focus on the top five health needs that were identified and prioritized through the 2019 Community Health Needs Assessment. The decision to not directly address the remaining four health needs, listed above, was based on the magnitude and scale of health needs, resources available, and commitment to developing a focused strategy in response to the needs assessment.

Approval by Governing Board

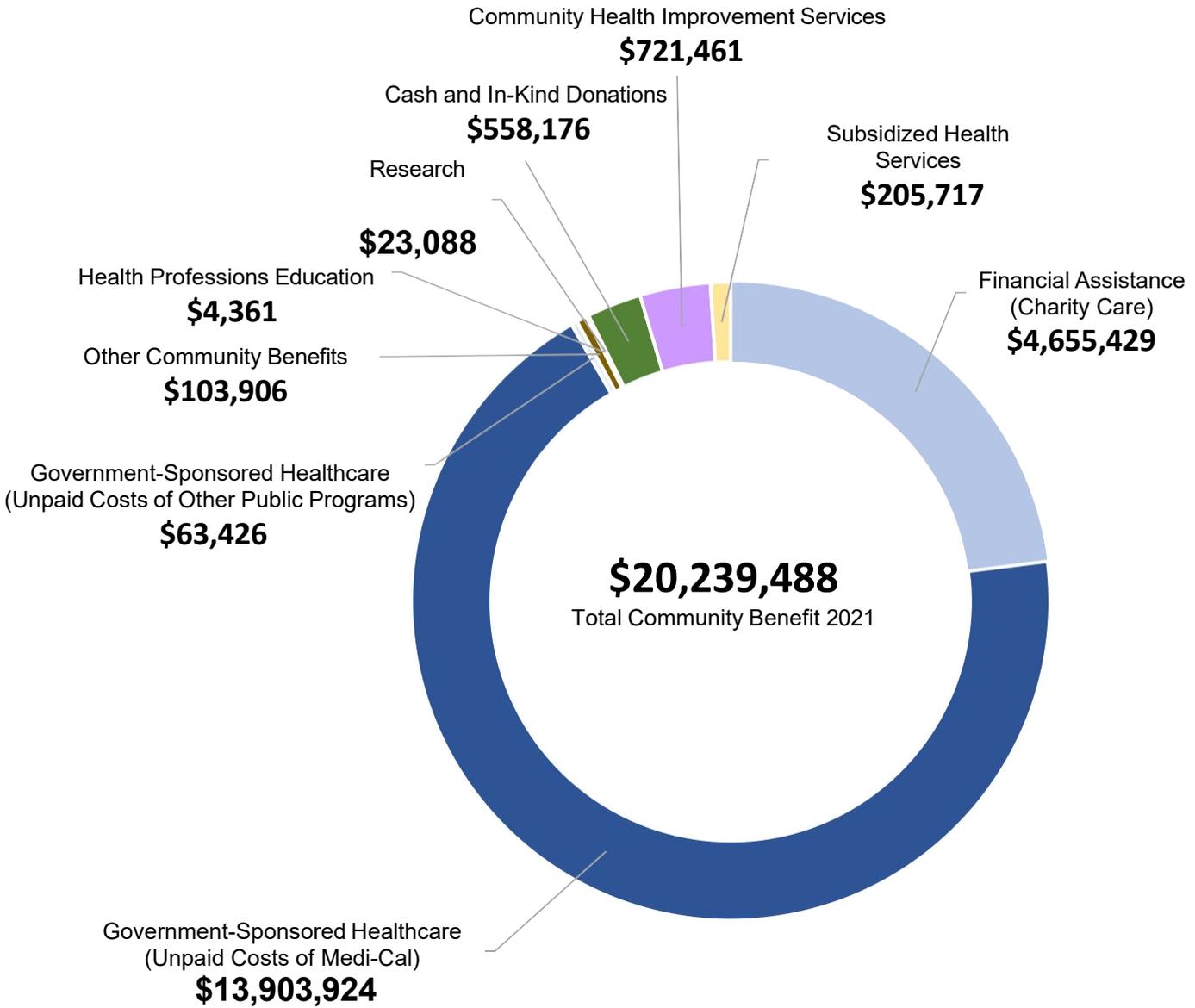
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board on November 20, 2019.

Appendix: 2021 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 2021 Total Community Benefit & Unpaid Costs of Medicare



2021 unpaid costs of Medicare were \$50,700,603