Sutter Health

Sutter Health
Alta Bates Summit Medical Center – Alta Bates/Herrick Campus

2022–2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

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Introduction

The Implementation Strategy Plan describes how Alta Bates Summit Medical Center – Alta Bates/Herrick Campus, a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022-2024 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

Alta Bates Summit Medical Center – Alta Bates/Herrick Campus welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022-2024 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail to 2000 Powell Street, 10th Floor, Emeryville, CA 94608, Attention: Sutter Health Bay Area Community Benefit department; and
- In-person at the hospital's Information Desk.

Executive Summary

Alta Bates Summit Medical Center is affiliated with Sutter Health, a 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.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2022 Community Health Needs Assessment process the following significant community health needs were identified:

1. Behavioral health
2. Housing and homelessness
3. Healthcare access and delivery
4. Economic security
5. Community and family safety
6. Dismantling structural racism
7. Food security
8. Transportation

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

2022 Community Health Needs Assessment Summary

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

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

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

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

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

Definition of the Community Served by the Hospital

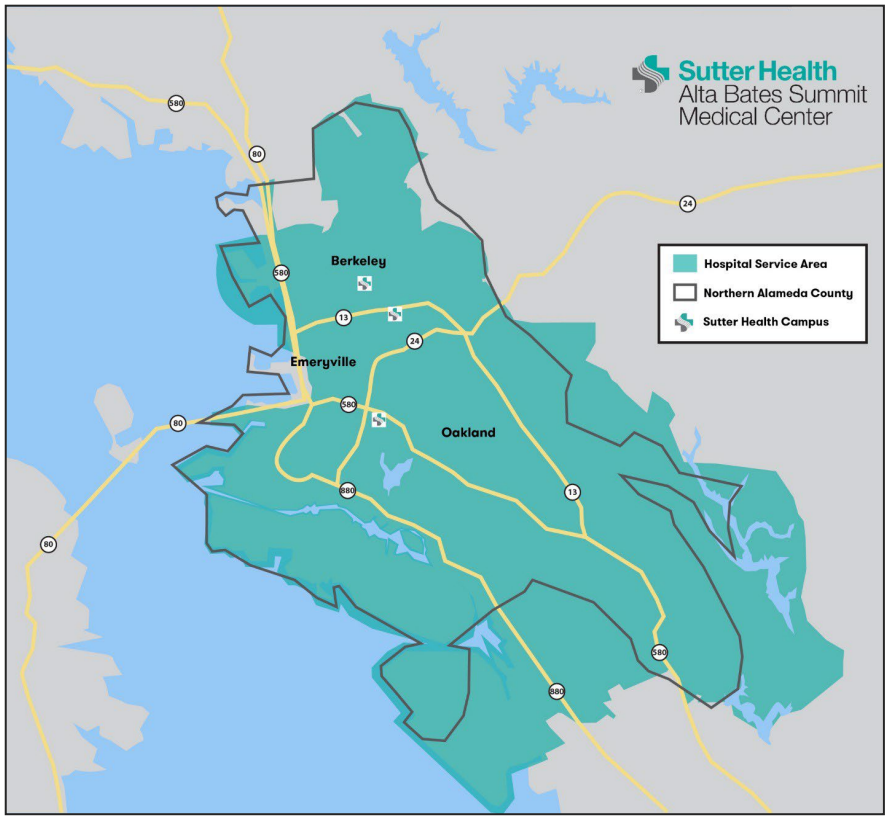
Each hospital participating in the Alameda and Contra Costa Counties Hospital CHNA Group defines its service area to include all individuals residing within a defined geographic area surrounding the hospital. For this collaborative CHNA, Alameda County was the overall service area, with each hospital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

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

Alta Bates Summit Medical Center's campuses are located in the cities of Berkeley and Oakland in the Northern Alameda County region of Alameda County. Alta Bates Summit Medical Center's hospital service area includes 25 ZIP codes surrounding the hospital and its neighboring communities.[2] As previously noted, the hospital collaborated on the 2022 CHNA with other healthcare facilities serving Alameda County. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, which include the cities of Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont.

The map below (Figure 1) shows the alignment of the Northern Alameda County region with Alta Bates Summit Medical Center's service area.

Figure 1. Alta Bates Summit Medical Service Area Map, Northern Alameda County Region



Berkeley and Oakland are the largest cities in Northern Alameda County. Berkeley is home to 121,353 people as well as University of California, Berkeley with a large student population. Berkeley's overall

[2] The hospital's service area covers ZIP codes 94501, 94601, 94602, 94603, 94605, 94606, 94607, 94608, 94609, 94610, 94611, 94612, 94613, 94618, 94619, 94621, 94702, 94703, 94704, 94705, 94707, 94708, 94709, 94710, and 94720.

racial and ethnic composition is majority White (60%) and Non-Hispanic (88%), with less than a quarter of residents identifying as Asian and smaller population segments identifying as Hispanic (Latinx) (12%), Multiracial (8%) and Black/African American (6%). Berkeley has a higher percentage of residents living in poverty than Alameda County (19% versus 9%), though a smaller percentage of children (0-18) in poverty than the county (6% versus 10%). Only 4% of adults do not have a high school diploma compared to 12% of adults county-wide.

Oakland is home to 425,097 people and has significant representation from several racial groups. White is the largest racial group at 35%; Black/African American (25%) and Hispanic (Latinx) (27%) populations each account for approximately a quarter of Oakland residents and Asian residents represent 14% of the Oakland population. Oakland residents fare worse than the county on almost all socioeconomic indicators, including 25% of Oakland children living in poverty compared to 10% of children living in poverty county-wide. Seniors in Oakland fare worse than the county overall, with 16% living in poverty compared to 10% living in poverty county-wide. The proportion of adults without a high school diploma (15%) in Oakland is higher than the Alameda County percentage (12%).

Significant Health Needs Identified in the 2022 CHNA

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

1. *Behavioral Health*. Behavioral health, which refers to both mental health and substance use, affects many Americans. Anxiety, depression, and suicidal ideation are on the rise, and heightened further due to the COVID-19 pandemic, particularly among Black/African American and Latinx community members. Key informants serving Alameda County described behavioral health concerns as a number one issue for the communities they serve, reporting intense distress about the level of behavioral health needs going untreated. Focus group participants reported inadequate mental health services for non-English speakers, immigrants, children/teens, and residents who identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, allies and others). In Northern Alameda County, key informants noted high levels of intergenerational trauma in their community, yet significant stigma around accessing behavioral healthcare. Northern Alameda County focus group participants also cited insufficient availability of behavioral health services, specifically for low-income families. They discussed that teens are experiencing increased rates of anxiety, depression, and fear, and are suffering due to the social isolation caused by the pandemic.
2. *Housing and Homelessness*. The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. The expenditure of greater sums can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with health, well-being, educational achievement, and economic success. Almost all Alameda County key informants and nearly half of focus groups identified housing and homelessness as a top priority health need for Alameda County; they described a variety of housing challenges including a concern that specific populations are at highest risk of becoming unhoused, such as Black/African American, Latinx, and LGBTQIA+ community members, immigrants, seniors, women fleeing domestic violence, people with disabilities, and those experiencing mental illness or addiction. According to key informants, seniors are increasingly likely to face housing instability or become unhoused and need targeted assistance to preserve existing housing or find an appropriate senior living setting. Focus group participants echoed this concern and specifically noted a surge in unhoused LGBTQIA+ seniors. Focus group participants from Northern Alameda County noted that housing discrimination is prevalent, particularly towards Black/African American and transgender residents.
3. *Healthcare Access and Delivery.* Access to comprehensive, quality healthcare has a profound impact on health and quality of life. Components of access to and delivery of care include insurance coverage, adequate numbers of primary and specialty care providers, health care timeliness, quality and transparency, and cultural competence/cultural humility. The majority of key informants and nearly half of focus groups identified healthcare access and delivery as a top priority health need for Alameda County, describing that too few healthcare providers with

specialized training for working with specific populations serves as a barrier to care, particularly for LGBTQIA+ residents, people with certain disabilities, non-English speakers, and undocumented residents. Additionally, while the shift to telehealth during the pandemic was helpful for many, it presented barriers to low-income families and seniors, who struggle to use technology or have little or no internet access. Increasing Medicaid/public insurance enrollment is a big need in Alameda County with enrollment eight percentage points below the state. Key informants stated that many residents in this region forego any health insurance because of high costs. Both key informants and focus group participants in Northern Alameda County discussed inequities in care, noting that people of color are more likely to be on Medi-Cal and have access to fewer high quality services. Infant mortality is substantially higher for Northern Alameda County multiracial residents and Black/African Americans than the county overall. Additionally, Black/African American and multiracial residents had substantially higher rates of death from COVID-19 than Northern Alameda County overall and multiracial residents have much lower COVID-19 vaccination rates than Northern Alameda County overall (34% versus 74%).

4. *Economic Security*. People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of high-quality schools and an adequate concentration of well-paying jobs. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The majority of key informants and focus groups listed economic security as a top priority health need. Key informants reported that Alameda County residents struggle to find living wage jobs given the county's extremely high cost of living. They also reported extensive job loss because of the COVID-19 pandemic, reporting that despite a strong job market, many residents are still not working. Key informants in Northern Alameda County noted that the Latinx population was one of the hardest hit due to COVID-19, with many having to choose between continuing to go into work with an increased risk of exposure or losing their jobs. Latinx and Black/African American residents in Oakland and Berkeley face significant income and employment disparities; many measures are worse than the state in ZIP codes with larger proportions of residents of color, including median household income, unemployment rate, young people not in school and not working, children living in poverty, poverty rate, and high-speed internet access.

5. *Community and Family Safety*. Safe communities promote community cohesion, economic development, and opportunities to be active while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to poorer physical and mental health outcomes. Children and adolescents exposed to violence are at risk for poorer long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color — particularly males — is disproportionately affected by juvenile arrests and incarceration related to policing practices. A quarter of key informants and nearly half of focus groups identified community and family safety as a top priority health need for Alameda County. This health need is linked closely with transportation, as key informants believed this was an area where community and family safety could be improved. Two key measures of community and family safety, violent crime, and injury deaths, were substantially higher in Alameda County than the state overall. Key informants in Northern Alameda County described violence in their community as a symptom and a cause of behavioral health issues and stated that violence disproportionately affects young men of color (teens-30s). The number of violent crimes is 50% higher in Northern Alameda County than the state overall and rates of death by all injuries are highest among Black/African Americans compared to Northern Alameda County overall.

6. *Dismantling Structural Racism.* Structural racism refers to social, economic, and political systems and institutions that have resulted in health inequities through policies, practices, and norms. Centuries of racism in this country have had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. Data show that racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions. The COVID-19 pandemic, which has disproportionately impacted racial and ethnic minority populations, is another example of these enduring health disparities. Many key

informants named structural racism as a significant concern affecting health in their communities, namely as a contributor to the other health needs. Key informants described race-based inequalities in access to and provision of healthcare, resulting in many children and adults of color not receiving necessary physical or behavioral healthcare that is often not culturally or linguistically competent. Key informants noted that housing discrimination is prevalent, particularly towards Black/African American residents. Black/African American and multiracial residents had substantially higher rates of COVID-19 deaths than Northern Alameda County overall and in 2020, infant mortality was more than twice as high for Black/African American residents than for the rest of Northern Alameda County.

7. *Food Security.* Food insecurity is the lack of consistent access to enough food for an active, healthy life. Food insecurity encompasses household food shortages; reduced quality, variety, or desirability of food; diminished nutrient intake; disrupted eating patterns; and anxiety about food insufficiency. Black/African American and Latinx households have higher rates of food insecurity than other racial/ethnic groups. The COVID-19 pandemic substantially increased food insecurity due to job losses, closure/changes to feeding programs, and increased demand on food banks. According to key informants, many Alameda County families experienced such an increase in food insecurity during the pandemic. Despite robust food distribution programs in several sectors (schools, food banks, healthcare, mobile clinics, community organizations), key informants reported that not all populations in need are reached, particularly unhoused county residents and populations that may be reluctant to seek out food assistance due to the stigma of being "needy." In Northern Alameda County, 9% of residents are food insecure. Key informants stated that CalFresh, California's Supplemental Nutrition Assistance Program (SNAP), is an underutilized resource in Northern Alameda County.

8. *Transportation.* Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing healthcare, and securing food. For households without access to a car, including many low-income individuals and people of color, walking, biking, and using public transportation provide critical links to jobs and essential services. Key informants and focus group participants noted that many low-income families are dependent on public transportation and, therefore, experience this as a barrier to accessing healthcare; many people have to travel outside of their immediate community for appointments and to access specialty care and resources. Safety when using public transportation was an additional concern voiced by focus group participants; this concern was further exacerbated by the COVID-19 pandemic, as county residents were fearful that using public transportation would increase their risk of virus exposure. Key informants from Northern Alameda County stated that the lack of reliable, accessible, and affordable transportation is a barrier to accessing healthcare, and noted that public transit in West Oakland is particularly inadequate.

Health Need Identification

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

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

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

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

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

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

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

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Alta Bates Summit Medical Center plans to address significant health needs identified in the 2022 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2022 CHNA.

Prioritized Significant Health Needs the Hospital will Address
The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Alta Bates Summit 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. Housing and homelessness
3. Healthcare access and delivery

Behavioral Health

Name of program/activity/initiative	Partnerships to Address Behavioral Health
Description	Alta Bates Summit Medical Center (ABSMC) partners with nonprofit organizations and schools to address behavioral health (mental health and/or substance use) in Northern Alameda County. ABSMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[3] Below are examples of evidence-supported strategies to address behavioral health: • Focus on childhood and youth, critical ages for preventing mental illness and promoting mental health.[4] Specifically, building continuums of behavioral health supports in school-based, after-school, and family settings are recommended approaches to addressing child and youth mental health.[5] • Enhance access to culturally responsive behavioral health services, which can improve patient/client retention and treatment outcomes.[6] • Support integrated behavioral health services, which is patient-centered care provided by a team of primary care and behavioral health clinicians. A growing evidence base demonstrates improvements in access to care and patient outcomes resulting from integrated behavioral health.[7] • Address individuals' health-related social needs associated with the social determinants of health, which greatly impact physical and behavioral health and well-being.[8] • Focus on behavioral health workforce development strategies, including provider/staff/student training in evidence-based practices to improve promotion, prevention, and care, and pipeline programs to develop a workforce that is racially/ethnically, culturally, and linguistically diverse, which are essential to behavioral health equity efforts.[9]

[3] U.S. Department of Health and Human Services. Health Equity and Health Disparities Environmental Scan. Rockville, MD: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion; 2022. Retrieved June 23, 2022, from: https://health.gov/sites/default/files/2022-04/HP2030-HealthEquityEnvironmentalScan.pdf.
[4] National Academies of Sciences, Engineering, and Medicine. 2020. Children's Mental Health and the Life Course Model: A Virtual Workshop Series: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/25941.
[5] Surgeon General of the United States. Protecting youth mental health: The U.S. Surgeon General's advisory. Retrieved June 10, 2022, from: https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A treatment improvement protocol: Improving cultural competence. Retrieved August 15, 2019, from https://store.samhsa.gov/system/files/sma14-4849.pdf.
[7] Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Retrieved June 23, 2022, from: https://integrationacademy.ahrq.gov/sites/default/files/2020-06/AHRQ_AcadLitReview.pdf.
[8] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved June 23, 2022, from: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.
[9] Alves-Bradford, J. M., Trinh, N. H., Bath, E., Coombs, A., & Mangurian, C. (2020). Mental health equity in the twenty-first century: Setting the stage. *Psychiatric Clinics*, *43*(3), 415-428.

	Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents experience improved behavioral health and wellbeing, at all stages of the life-course. The behavioral health workforce is equipped to address the behavioral health needs of residents.
Anticipated Outcomes	Residents experience improved access to affordable, evidence-based, and culturally responsive behavioral health resources and services. Residents increase behavioral health and wellness knowledge and skills. Providers, staff and trainees increase their knowledge of and skills in evidenced-based, culturally responsive, and/or trauma-informed behavioral health resources and services.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics that are used to evaluate efforts to address behavioral health. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # of encounters # who received mental health services directly from the program # who received substance use services directly from the program # who received case management services directly from the program # of class, workshop, or support group sessions provided by the program # referred out to social services

Housing and Homelessness

Name of program/activity/initiative	Partnerships to Address Housing and Homelessness
Description	Alta Bates Summit Medical Center (ABSMC) partners with nonprofit organizations that address housing and homelessness in Northern Alameda County. ABSMC invests in Community Health partnerships with the overarching goals of achieving health equity and reducing health disparities; health equity is the attainment of the highest level of health for all people and health disparities are health differences that are closely linked with social, economic, and/or environmental disadvantage.[10] Below are examples of evidence-supported strategies to address housing and homelessness, a social determinant of health: • Housing First approach, which prioritizes access to permanent (non-time-limited) housing with minimal preconditions, thereby reducing barriers to housing for people experiencing

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

	homelessness.[11] Housing First approaches can include improving access to affordable housing, rapid-rehousing, and supportive housing.[12] • Homelessness prevention, including short-term financial assistance, employment services, and benefits enrollment, to help individuals and families retain housing.[13] • Rapid re-housing (RRH), which connects individuals and families to permanent housing, housing assistance, and support services.[11] RRH has been found to result in positive housing outcomes for those who do not need ongoing supports.[12] • Transitional housing for families, which can provide housing and support services up to two years.[14] • Permanent supportive housing programs (PSH), which provide non-time-limited housing and a variety of voluntary support services tailored to individual needs.[15,16] PSH programs have been found to result in increased housing stability among participants.[16] • Outreach, navigation, and support services for individuals and families currently experiencing homelessness.[17] Investments made through grants and sponsorships are decided annually and based on community health need. Selected executed grants will be reported at year end.
Goals	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well-being.
Anticipated Outcomes	Residents experiencing homelessness or housing instability have access to support services and resources. Residents are placed in permanent housing. Residents retain housing, preventing entry or re-entry into homelessness.

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

Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address housing and homelessness. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. # of persons served (unduplicated) # of encounters # placed in interim housing through the program (emergency shelter or interim housing) # placed in permanent housing through the program # provided with rental assistance # who retained permanent housing through the program (e.g., via rent/utility assistance) # who received case management services directly from the program # who received mental health services directly from the program # who received substance use services directly from the program # provided with employment services by the program (e.g., job/skills training, resume writing, job placement) # referred out to social services

Healthcare Access and Delivery

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	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. Alta Bates Summit Medical Center supports the program, providing funding towards the care of the people who enroll in the East Bay service area. 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.
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
Metrics Used to Evaluate the program/activity/initiative	# of persons enrolled in the program's East Bay service area (including demographics as available) # of persons transitioned to home/self-care from hospital # of persons transitioned to home healthcare service

Name of program/activity/initiative	Cancer Supportive Care Services
Description	Alta Bates Summit Medical Center's Cancer Supportive Care Services offers the following educational, screening, and support group opportunities free to the community.[18] • Community screening and prevention programs are conducted in the community to provide cancer prevention and early detection education, resources and screening clinics for cancers including breast, colorectal, and prostate cancers. • Breast cancer navigation provides one-on-one guidance, education, case-management, resources, and patient advocacy to patients diagnosed with breast cancer. • Disease specific patient and family support groups, such as Metastatic Cancer Support Group, Breast Cancer Support Group, and Caring for the Caregiver Support Group. • Fitness, nutrition, and lifestyle classes and series including Healing Yoga, Qi Gong, Stress Relief, and writing classes. • Cancer treatment and planning classes, workshops, and symposiums, such as Advance Health Care Directives Workshops, and annual highlights from the San Antonio Breast Cancer Symposium.
Goals	Dedicated to decreasing the incidence of cancer through early detection and outreach and the improvement of quality of life for those with cancer.
Anticipated Outcomes	Increased knowledge of cancer risk factors, cancer prevention and early detection strategies. Increased access to cancer screening services. Increased awareness of and access to community resources that promote health and wellness. Increased knowledge of strategies to maximize quality of life. Increased sense of social support.
Metrics Used to Evaluate the program/activity/initiative	# of persons served # of health screenings # of meetings provided for each program: Cancer Classes Cancer Support Groups Cancer Workshops

Name of program/activity/initiative	Carol Ann Read Breast Health Program
Description	Alta Bates Summit Medical Center's Carol Ann Read Breast Health Program (CARBHP) provides a supportive, positive environment dedicated to comprehensive breast health and treatment of breast

[18] More information about Cancer Supportive Care Services can be found at https://www.sutterhealth.org/absmc/services/cancer/special-support

	disease. The CARBHP provides mammography screening services at Alta Bates Summit Medical Center facilities and in the community via the Mobile Mammography Vehicle. The *Mobile Mammography Vehicle* (MMV) is a 40-foot mobile hospital department that brings convenient mammography screening services to community health center patients across the East Bay. Staffed by licensed mammography technologists, the program provides access to the latest 3D mammography equipment and connects patients to appropriate support and navigation services. MMV community health center partners include Asian Health Services, La Clínica, Native American Health Center, Order of Malta, Roots Community Health Center, and West Oakland Health Center, among others.
Goals	To increase access to breast health services and improve early detection for breast cancer. To remove barriers for breast health services.
Anticipated Outcomes	Participants experience increased access to breast health services, including screening, diagnostic procedures, navigation services, and treatment.
Metrics Used to Evaluate the program/activity/initiative	For the Carol Ann Read Breast Health Program (MMV services reported separately): # of persons served Of patients positively screened, # referred for appropriate follow-up For Mobile Mammography Vehicle (MMV) screening events held in partnership with community health centers: # of persons served # of screening events Of patients positively screened, # referred for appropriate follow-up

Name of program/activity/initiative	Women and Infant Services
Description	Alta Bates Summit Medical Center's Women and Infant Services provides educational opportunities and support groups for parents and their children, which are open and free to the community, including the following.[19] • The Breastfeeding Support Group, facilitated by an Alta Bates Summit board-certified Lactation Consultant, provides parents with a caring and supportive environment to ask questions about and receive help with breastfeeding, as well as make social connections in the community. • The Support After Neonatal Death (SAND) Group, facilitated by a Certified Perinatal Educator, provides parents who have lost a baby a space to share information, experiences, and support with other parents.

[19] More information about Women and Infant Services' educational and support group opportunities can be found at https://www.sutterhealth.org/absmc/classes-events

	• Parent Education Lectures, facilitated by a Certified Perinatal Educator, are focused on topics of interest to new and/or expecting parents.
Goals	New and/or expecting parents have the information and support they need to partner in their health and that of their babies. Parents experiencing the loss of a baby have the information and support they need to process their grief.
Anticipated Outcomes	Increased knowledge of strategies related to parenting and/or coping with grief. Increased sense of social support. Increased belief in ability to address challenges experienced in parenting.
Metrics Used to Evaluate the program/activity/initiative	# of persons served # of classes/support group meetings provided for each program below: Breastfeeding Support Groups SAND Group Parent Education Lectures

Name of program/activity/initiative	Operation Access
Description	Alta Bates Summit Medical Center (ABSMC) partners with Operation Access to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. ABSMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms.
Goals	Increase healthcare equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by providing the resources and promoting the medical volunteerism needed for the donation of these services.
Anticipated Outcomes	Timely surgical procedures and diagnostic services are provided to uninsured and underserved patients.
Metrics Used to Evaluate the program/activity/initiative	# of persons served # of surgical and diagnostic procedures provided # of ABSMC medical volunteers % of patients reporting satisfaction with their Operation Access experience % of patients reporting improved health as a result their Operation Access service(s)

Needs Alta Bates Summit Medical Center Plans Not to Address

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

- Economic security
- Community and family safety
- Dismantling structural racism
- Food security
- Transportation

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

Approval by Governing Board

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