

Sutter Health

Alta Bates Summit Medical Center

2014 Community Benefit Plan Update

Based on the 2013 – 2015 Community Benefit Plan

Responding to the 2013 Community Health Needs Assessment

Submitted to the Office of Statewide Health Planning and Development May 2015

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This document serves as an annual update to the 2013 – 2015 Community Benefit Plan for Alta Bates Summit Medical Center. The update describes impact from community benefit programs/initiatives/activities conducted in the reporting year, along with the economic values of community benefits for fiscal year 2014.

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The implementation strategy is written in accordance with proposed Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document has also been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

This implementation strategy describes how Alta Bates Summit Medical Center, a Sutter Health affiliate, plans to address significant needs identified in the Community Health Needs Assessment (CHNA) published by the hospital on October 5, 2013. The document describes how the hospital plans to address identified needs in calendar (tax) years 2013 through 2015.

The 2013 CHNA and this implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

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

About Sutter Health

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

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health has committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2014 commitment of \$767 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- To provide care to Medi-Cal patients in 2014, Sutter Health invested \$535 million more than the state paid. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- In 2014, Sutter Health's commitment to delivering charity care to patients was \$91 million. Our charity care investment represented an average of nearly \$1.8 million per week.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. We also support children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

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

For more facts and information about Alta Bates Summit Medical Center, please visit www.altabatessummit.org.

2013 Community Health Needs Assessment Summary

The Community Health Needs Assessment (CHNA) was commissioned by five local nonprofit hospitals in the East Bay – Alta Bates Summit Medical Center, Sutter Medical Center Castro Valley, Children’s Hospital and Research Center of Oakland, St. Rose Hospital, and Washington Hospital Healthcare System. These hospitals retained Valley Vision, Inc., to lead the assessment process over ten months. Valley Vision (www.valleyvision.org) is a nonprofit 501(c)(3) consulting firm with over seven years of experience in conducting CHNAs. The organization’s mission is to improve quality of life through the delivery of research on important topics such as health care, economic development, and sustainable environmental practices.

The CHNA provided necessary information for the Alta Bates Summit Medical Center community health improvement plan, identified communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identified contributing factors that create both barriers and opportunities for these populations to live healthier lives.

The CHNA defined health needs as a poor health outcome and its associated driver. A health driver is a behavioral, environmental, and /or clinical factor, as well as more upstream social economic factors, that impact health.

Primary data collection for the assessment included input from more than 195 members of the hospital service area, expert interviews with 35 key informants, and focus group interviews with 169 community members. In addition, a community health assessment collected data on more than 309 assets in the greater East Bay area. Secondary data included health outcome data, socio-demographic data, and behavioral and environmental data at the ZIP code or census tract level. Health outcome data included emergency department (ED) visits, hospitalization, and mortality rates. Socio-demographic data included data on race and ethnicity, poverty (female-headed households, families with children, people over 65 years of age), educational attainment, health insurance status, and housing arrangement (own or rent). Behavioral and environmental data helped describe general living conditions of the service area such as crime rates, pollution, access to parks, and availability of healthy food.

The health needs identified through analysis of both quantitative and qualitative data are as follows:

1. Lack of access to mental health services/treatment
2. Safety as a health issue
3. Limited access to quality primary health care services
4. Lack of access to affordable, healthy food
5. Lack of safe places to be physically active
6. Lack of access to dental care and preventive services
7. Pollution as a health issue
8. Limited access to basic needs: food, housing, jobs
9. Limited access to affordable, safe, and reliable transportation

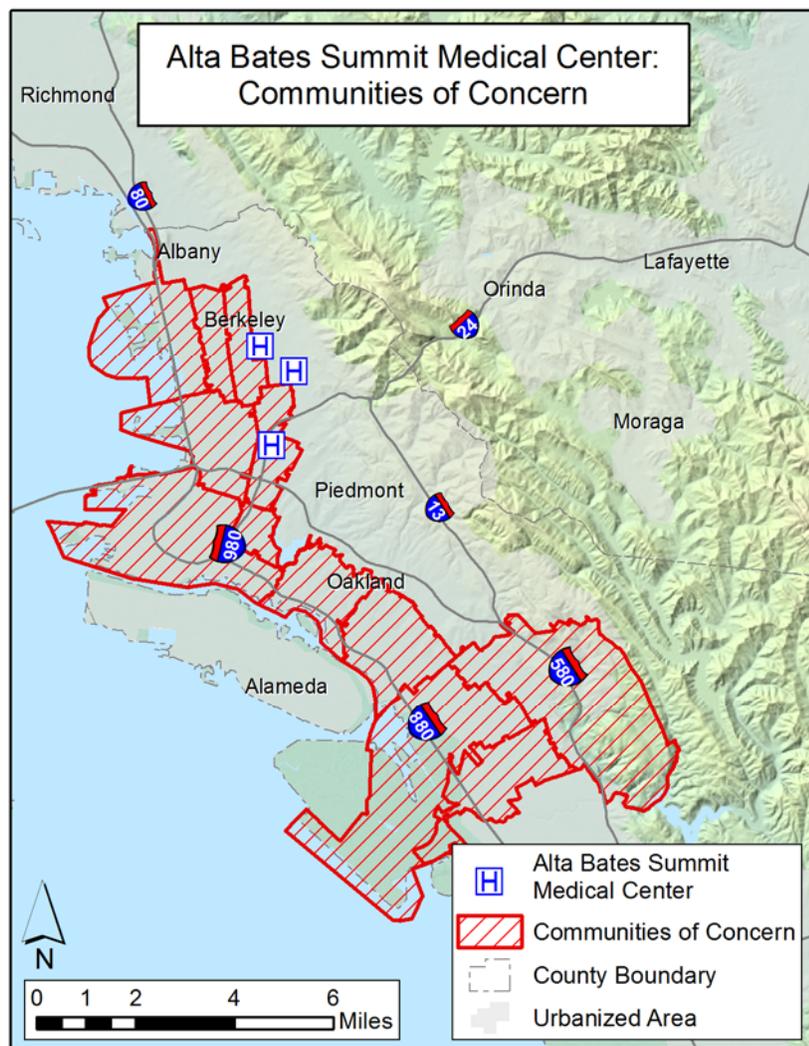
The full 2013 Community Health Needs Assessment report conducted by Alta Bates Summit Medical Center is available at <http://www.sutterhealth.org/communitybenefit/community-needs-assessment.html>.

Definition of Community Served by the Hospital

The Alta Bates Summit Medical Center primary service area is comprised of 24 ZIP codes. Analysis of both primary and secondary data revealed Communities of Concern in the service area that were living with a high burden of disease.

ZIP codes with rates that consistently exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, and mortality were identified as preliminary Communities of Concern, particularly those ZIP codes with rates that consistently fell in the top 20%. These ZIP codes were then confirmed with the hospital CHNA workgroup for modification, and in some instances additional ZIP codes were added.

The Communities of Concern are outlined in the figure below:



The Alta Bates Summit Medical Center Communities of Concern are home to more than 330,000 community residents. The area consists of 12 ZIP codes, all located in Alameda County and in the cities of Berkeley, Oakland, and Emeryville. The Communities of Concern sit adjacent to the San Francisco Bay and are situated along the Interstate 80, 880, 580, 980 corridors, which run north and south through the East Bay area.

An online resource, called the Health Needs Map, developed by Valley Vision showing emergency room, hospitalization, and mortality rates for a number of diseases and health indicators at the ZIP code level for the service area, is available at www.healthneedsmap.com. The Health Needs Map gives users several points of view of an area's health status. Each ZIP code is assigned a Community Health Vulnerability Index (CHVI). A higher number ranking reflects those areas with the least modeled barriers, or less vulnerability. A lower number ranking indicates the areas with more modeled barriers, or higher vulnerability.

The CHNA along with the Health Needs Map will be used to guide the ongoing work of Alta Bates Summit Medical Center in strategically focusing community benefit and system resources to address health needs in the community.

Significant Health Needs Identified

Data on the socio-demographics of residents in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing arrangement, employment status, and health insurance status, were examined. Area health needs were determined via in-depth analysis of qualitative and quantitative data and then confirmed with socio-demographic data. As noted earlier, a health need was defined as *a poor health outcome and its associated driver*. A health need was included as a priority if it was represented by rates worse than the established quantitative benchmarks or was consistently mentioned in the qualitative data.

The following significant health needs were identified by the 2013 CHNA:

Significant Community Health Need	Intends to Address
<p>Lack of access to mental health services/treatment Area experts and community members consistently reported the immense struggle service area residents had in maintaining positive mental health and in accessing treatment for mental illness. Mental health issues were the number one most commonly reported health issue, according to key informants and community members. In addition, all ZIP code Communities of Concern exceeded both county and state benchmarks for ED visits and hospitalizations due to substance abuse issues. It is notable that Alameda County had a county rate that was one and one-half times the state rate.</p>	Yes
<p>Safety as a health issue Local experts and community members stressed the impact of safety on the health of residents. Participants shared countless stories about feeling unsafe in their daily lives – at school, taking public transportation, and walking through their community. The majority of the qualitative findings focused on the impact of community violence on young people in the service area. The importance of targeting violence, specifically for young people, is vital for the health of the area.</p>	No
<p>Limited access to quality primary health care services Lack of access to health care was mentioned consistently by key informants and community members as a major barrier to healthy living, ranking second in frequency mentioned in the qualitative data. Specifically, adequate access to health care (primary and specialty), access to health insurance, and a lack of access to affordable, culturally competent, high quality health care were stressed. Community members emphasized the difficulties they had with gaining access to care in a timely fashion, indicating that most of the time spent accessing care for health problems is reactive and not preventative, largely due to affordability and ease of access.</p>	Yes
<p>Lack of access to affordable, healthy food Healthy eating was the most commonly mentioned topic by key informants and community members as a major contributor to negative health outcomes for the community. The main concerns regarding healthy eating for the service area focused on access to affordable, quality healthy foods and on issues of food insecurity as evidenced by many liquor stores and convenience stores but few accessible grocery stores in the community.</p>	No
<p>Lack of safe places to be physically active Area residents consistently expressed pronounced concerns over safety in their neighborhood and community parks. This presents a major barrier for community members to get exercise. Many neighborhoods have loose dogs on the street, high crime, a lack of sidewalks, and illegal activities that prevent regular physical activity. Many residents feel their parks are unsafe as well.</p>	No
<p>Lack of access to dental care and preventive services Dental health issues were the fourth most commonly mentioned health issue affecting residents in the service area. Community members stressed the immense lack of dental preventative services in the area, resulting in having teeth pulled merely to reduce pain. In addition, untreated dental issues lead to other health problems, which include heart disease and immune system infections.</p>	No
<p>Pollution as a health issue Both key informants and community members mentioned area pollution and air quality as a major contributor to poor health. The western part of the service area closest to the San Francisco Bay is disproportionately burdened by multiple sources of pollution. Environmental factors that produce this pollution burden include ozone and PM2.5 concentrations, diesel PM emissions, pesticide use, toxic emissions from facilities, traffic density, cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities.</p>	No

<p>Lack of access to basic needs: food, housing, jobs Poverty was ranked third by key informants and community members as a major cause of ill health for the area. Many key informants noted that those who are poor and impoverished in the service area tend to struggle the most with health issues. Many community members spoke of living in crowded housing in order to make ends meet. It is notable that 11 out of the 12 ZIP code Communities of Concern exceed benchmarks for the percentage of families with children living in poverty.</p>	<p>Yes</p>
<p>Limited access to affordable, safe, reliable transportation Concerns over affordable and safe transportation were expressed by key informants and community members and were listed as the seventh most commonly mentioned contributor to poor health outcomes in the service area. Most of the concerns centered on not being able to afford public transportation and on safety issues when using it.</p>	<p>No</p>

2013 – 2015 Implementation Strategy

On December 12, 2013, Sutter East Bay Hospital's Board of Directors passed resolution #13-12004 approving this Community Benefit IRS Implementation Strategy designed to respond to community health needs, defined as health drivers and health outcomes. Different than past community health needs assessments, the 2013 assessment focused on identifying specific vulnerable ZIP codes as communities most in need of support. In addition to the many community benefit programs and services provided throughout Sutter Health East Bay Region, this 2013-2015 implementation strategy is focused on responding to specific health needs of specific zip codes, including, but not limited to, those most vulnerable ZIP codes of West Oakland, East Oakland, and South and West Berkeley. For a comprehensive list of Alta Bates Summit Medical Center community benefit programs and activities, please visit http://www.altabatessummit.org/about/communitybenefit/cb_programs.html.

All Sutter Health East Bay Region Community Benefit Initiatives align with the following pillars:

- 1) Connect patients to the right care, place and time through access to primary care and mental health services
- 2) Invest in vulnerable areas to ensure capacity of care meets demands of vulnerable populations
- 3) Collaborate to influence behavior to utilize preventive care, chronic disease management and community services
- 4) Build community capacity and improve health

This implementation strategy describes how Alta Bates Summit Medical Center plans to address significant health needs identified in its 2013 Community Health Needs Assessment and consistent with its 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.

Lack of Access to Mental Health Services/Treatment – Substance Abuse

Name of Program, Initiative or Activity	MPI collaboration with local Federally Qualified Health Centers for education, outreach, and assessment
Description	<p>MPI Treatment Services, Inc., a community benefit program of Alta Bates Summit Medical Center, offers a complete range of chemical dependence treatment in five distinct levels of care:</p> <ul style="list-style-type: none"> • Detoxification (MPI uses special detoxification protocols for detoxification from certain medicines) • Inpatient Rehabilitation • Residential Rehabilitation • Day Treatment • Morning and Evening Intensive Outpatient Programs <p>MPI will work with ABSMC Community Benefits to develop a strategic plan to collaborate with Federally Qualified Health Centers in West Oakland, East Oakland, and Emeryville to support and enhance education, outreach, and assessment.</p>
Anticipated Impact and Plan to Evaluate	A written plan will be completed by July 1, 2014 and will align with regional and system initiatives designed to support our local Federally Qualified Health Centers.
2014 Impact	A written plan was completed in September of 2014 in collaboration with LifeLong Medical Care. The partnership between MPI and LifeLong will facilitate supporting members of the community who would otherwise not have access and connect motivated and qualified individuals by referral to MPI treatment services. MPI will also provide professional development events for LifeLong staff to receive training on how to conduct more effective assessments and treatments. These professional development experiences will allow staff to more accurately identify patients with chemical dependencies, intervene, and link the patient to the appropriate services.
Mechanism(s) Used to Measure Impact	No mechanisms were used because implementation was scheduled to begin in 2015.
Community Benefit Contribution/Expense	Not Applicable
Program, Initiative, or Activity Refinement	Implementation will occur in 2015.

Limited Access to Quality Primary Health Care Services

Name of Program, Initiative or Activity

ED Utilization and Care Transitions Initiative

Description

In order to connect patients to the right care at the right place and time through access to primary care, Alta Bates Summit, in collaboration with the Community Health Center Network, La Clinica, Asian Health Services and Lifelong, will improve the care transition for targeted uninsured and underinsured patients between the medical center and each of these three local health centers. Initiative objectives aim to 1) provide warm hand-offs; 2) establish and monitor compliance and outpatient hospitalizations follow-up appointment; and 3) establish care plans for patients at highest risk.

Anticipated Impact and Plan to Evaluate

- Care plans will be developed for a total of at least 100 highest at-risk patients from La Clinica, Lifelong, and Asian Health Services by **December 31, 2014**.
 - There will be a 10% reduction in non-urgent use of Alta Bates emergency department by clinic patients.
-

2014 Impact

Through collaboration with three of the local federally qualified health centers, Asian Health, Lifelong and La Clinica, along with the Community Health Center Network (CHCN), Care Transitions Registered Nurses (CTRN) were placed in each of the three clinics. The primary role of the nurse is to provide warm handoffs for both inpatients and patients visiting the ED, to provide telephonic clinical assessment, including medication reconciliation, and to ensure that patients make appropriate follow up appointments. In 2014, a total of 3,477 patients were contacted following a hospital stay or ED visit. Of those, 2,391 had appointments and on average, 75% of those appointments were kept. An evaluation by CHCN indicated a 17% decrease in emergency department visits within 30 days, a 32% increase in follow up appointments and a 17% decrease in readmissions within 30 days, among these 3,477 patients.

A total of 84 care plans were developed for the highest at-risk patients. Five cohorts of patients were tracked. While there was an increase in the number of visits by these patients, there was a reduction in the number of non-urgent visits to the ED.

In addition, two ED Navigators, one from La Clinica and another from Lifelong, funded by Community Benefit, were placed in each of the medical center's EDs. The primary goal of these non-clinical workers is to assist with making follow up appointments with a primary care physician at a clinic home, assist with eligibility enrollment and provide linkages to community resources, such as shelter, food or transportation. The program was launched in December 2014. Through March of 2015, more than 400 patients have been assisted.

Mechanism(s) Used to

CHCN provided program evaluation for the CTRN initiative. A cohort was

Measure Impact	identified based on claims data and divided with half receiving intervention and half receiving no intervention. Each CTRN has access to EPIC and is able to identify not only patients from a designated clinic, but uninsured patients as well. Patient encounters are captured in EPIC and also tracked through CHCN claims data. Care plans for frequent utilizers are tracked in EPIC. Navigators track and record all encounters and services provided.
Community Benefit Contribution/Expense	\$371,801
Program, Initiative, or Activity Refinement	Program refinement will continue as needed.
Name of Program, Initiative or Activity	West Oakland Health Center ED and Care Transitions Initiative
Description	West Oakland ZIP code 94607 has the most vulnerable residents than those living in any other ZIP code in both Alameda and Contra Costa counties. More community members from West Oakland receive non-urgent care in the ED than from any other ZIP code in the service area. In order to connect patients to the right care in the right place at the right time, ABSMC will collaborate with the West Oakland Health Center to improve the care transition for targeted uninsured and underinsured patients as appropriate between the medical center and West Oakland Health Center. Initiative objectives aim to 1) provide warm hand-offs; 2) establish and monitor compliance and outpatient hospitalization follow-up appointments; and 3) establish care plans for patients at highest risk.
Anticipated Impact and Plan to Evaluate	<ul style="list-style-type: none"> There will be a reduction in non-urgent use of ABSMC ED and a reduction in readmissions of West Oakland Health Center patients. Determination and implementation of a model of improved care transitions between ABSMC and WOHC. A written plan will be completed by June 14, 2014 with implementation to begin no later than December 31, 2014.
2014 Impact	Unfortunately, West Oakland Health Center struggled with anticipated loss of its Federally Qualified Health Status and this initiative was not implemented.
Mechanism(s) Used to Measure Impact	No mechanisms were used because the program was not implemented.
Community Benefit	Not Applicable

Contribution/Expense

Program, Initiative, or Activity Refinement

Pending new leadership at West Oakland Health Center, ABSMC anticipates moving forward with placement of a Care Transitions RN in 2015-2016.

Name of Program, Initiative or Activity

West Oakland Education and Outreach Initiative

Description

Working with West Oakland partners, Alta Bates Summit will develop and implement a model that replicates best practices of community engagement and community capacity building. Focus will be on access to care, chronic disease management, and reducing health disparities.

Anticipated Impact and Plan to Evaluate

Increased connection to community resources

- Target population and existing community resources within the West Oakland ZIP code will be identified by **March 31, 2014**.
- A strategic plan will be completed by **June 30, 2014**. This plan will include a specific matrix for evaluation and further program development in 2015.
- Implementation will begin no later than **December 31, 2014**.

Increased awareness of how to manage chronic disease and associated risk factors of diabetes, asthma, and hypertension in West Oakland

- A strategic plan will be completed by **June 30, 2014**. This plan will be developed by leveraging the expertise of ABSMC Community Benefit programs, such as the Asthma Management Resource Center, Diabetes Resource Center, and the Ethnic Health Institute and will include a specific matrix for evaluation and further program development in 2015.
 - Implementation will begin no later than **December 31, 2014**.
-

2014 Impact

A partnership with East Bay Asian Local Development Corporation, (EBALDC) to work with residents along the San Pablo Avenue Corridor in West Oakland, was established in 2014. The partnership has united 12 cross-sector stakeholder groups representing health care, housing, social services, agenda organizing, food justice, public health, economic development, and local residents. A 5-year action plan was developed to transform the San Pablo Avenue community into a healthier neighborhood. The initial focus for the health care work group will be to identify residents who have or are at-risk of having high blood pressure and connect them to neighborhood clinics, healthy foods, exercise, and health education. A collective impact framework will be used to align partnering organizations expertise, programs, and services to reduce hypertension. A small pilot will be tested before expanding to the entire neighborhood.

Mechanism(s) Used to Measure Impact	A shared measurement system and an evaluation plan are currently being developed to measure the impact on resident health beginning with hypertension.
Community Benefit Contribution/Expense	\$25,000
Program, Initiative, or Activity Refinement	Implementation will begin in 2015.
Name of Program, Initiative or Activity	Collaboration with existing Heart2Heart (H2H) Hypertension and Heart Disease Initiative in South Berkeley
Description	The H2H neighborhood program targets a specific South Berkeley neighborhood selected for both its assets and challenges. H2H, now in its 5 th year, uses a community-based approach to address health inequities in high blood pressure and heart disease. H2H activities include monthly mobile health van events, blood-pressure screening and education in partnership with local businesses, national drug take-back days, and mini-grants for local organizations. The program seeks to empower residents and build community cohesion and capacity. Alta Bates Summit will collaborate with Lifelong Medical Care, the City of Berkeley Health Department, and other partners to expand the South Berkeley H2H initiative in order to address disparities in cardiovascular disease, especially in hypertensive heart disease.
Anticipated Impact and Plan to Evaluate	A strategic plan designed to link the H2H existing efforts to Alta Bates Summit Medical Center initiatives will be developed by June 31, 2014 with implementation to begin no later than July 31, 2014 . This plan will include, but is not limited to, a community capacity building leadership training and a formal evaluation of the existing efforts.
2014 Impact	Alta Bates Summit Medical Center underwrote a Community Engagement position for H2H to train Health Advocates to lead community building efforts, provide health promotion messages to individuals and community groups, and link residents to health services and health insurance as appropriate. These training topics empower local leaders to promote social connection and engagement among community members, which is one of the critical elements of community health. The training will focus on prevention, navigating the health care system, and recognizing the difference between emergency care, primary care, and urgent care visits. Health advocates will raise awareness in the community with an emphasis on prevention and reducing improper emergency visits.

Mechanism(s) Used to Measure Impact	No mechanisms were used in 2014 due to the position being filled in early 2015. Tracking mechanisms will be in the form of # of health advocates trained, pre and post tests, and outreach to community members with # of individuals who receive messages and/or linkages to health services and health insurance each year.
Community Benefit Contribution/Expense	\$57,640
Program, Initiative, or Activity Refinement	The position was funded in 2014 and was filled by LifeLong Medical in Q1 of 2015. Implementation and tracking will occur throughout 2015.

Lack of Access to Basic Needs: Food, Housing, Jobs

Name of Program, Initiative or Activity	Youth Bridge Career Development Program
Description	Youth Bridge is a year-round career development program designed to provide high school and college students with support and guidance to complete high school, pursue higher education, and ultimately obtain gainful employment. The program provides mentors and paid summer internships at the medical center and throughout the community.
Anticipated Impact and Plan to Evaluate	A total of 90 students from West and East Oakland and other vulnerable communities will participate in Youth Bridge and will be provided paid summer internships by December 31, 2014 .
2014 Impact	In 2014, 125 at-risk youth from the two most vulnerable communities in Alameda and Contra Costa County, East and West Oakland, participated in the year-long program. A total of 75 high school and college students, including students returning for 2 nd and 3 rd years, participated in a health career activities class for four months, received mentorship placement followed by paid summer internships. A total of 50 middle school students participated in a five-week summer Youth in Medicine program. In collaboration with Samuel Merritt University, these students were exposed to interactive training labs and various health professions, while also engaging in fun summer activities.
Mechanism(s) Used to Measure Impact	Students must sign-in for all activities. All attendance is tracked through CitySpan software. All students must complete timesheets for all hours in mentorships, internships, or apprenticeships.
Community Benefit Contribution/Expense	\$149,866
Program, Initiative, or Activity Refinement	Now in its 26 th year, Youth Bridge will continue to serve no less than 90 students in 2015, providing a variety of health career exploration opportunities and ultimately paid internships. Program was expanded to Eden last year.
Name of Program, Initiative or Activity	Interim Care Program (ICP) for Homeless
Description	This new community benefit program is designed to provide homeless patients temporary housing after their hospital discharge. This allows

patients to recuperate in a clean and stable environment. Patients may stay up to six weeks, are provided three meals a day, and have access to support services, such as substance abuse counseling and other wrap-around services. This pilot project is in collaboration with Lifelong Medical, Inc. and consists of two dedicated shelter beds in Berkeley and three in Oakland.

Anticipated Impact and Plan to Evaluate

- Connection to a medical home for all ICP clients
 - Connection to community resources for all ICP clients
 - Reduction in the average length of inpatient stay for homeless patients
 - 10% reduction in ED utilization for non-urgent visits by homeless patients
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2014 Impact

During the ICP's first full year of operation, 228 homeless inpatients were referred from Alta Bates Summit Medical Center. Of those, 86 entered a shelter. The average length of stay at the shelter was 27 days. Only three of these patients were readmitted within a 30 day time period and only 18 were readmitted during that year. The program was so successful and the need so great, it was expanded first from five shelter beds to seven and then ultimately to ten, in three different shelters located in Berkeley and Oakland.

Mechanism(s) Used to Measure Impact

A tracking sheet was kept by Lifelong Medical, Inc., Care Transitions Nurse and included all pertinent information including follow up, primary care appointment and disposition from the shelter.

Community Benefit Contribution/Expense

\$179,688

Program, Initiative, or Activity Refinement

The program will continue in 2015 and we will explore its expansion to Southern Alameda County in collaboration with Eden Medical Center.

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. This implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2013 Community Health Needs Assessment:

1. Safety as a health issue
2. Lack of access to affordable, healthy food
3. Lack of safe places to be physically active
4. Lack of access to dental care and preventive services
5. Pollution as a health issue
6. Limited access to affordable, safe, and reliable transportation

Alta Bates Summit Medical Center does not have the expertise or resources to respond to these community needs at this time. The medical center has more than 27 community benefit programs and services including, but not limited to, chronic disease management for asthma and diabetes, breast cancer, prostate cancer, stroke, and hypertension. The medical center is a collaborative partner to more than 350 community organizations and on occasion will sponsor programs and initiatives that address the needs listed above. However, these needs will not be the area of focus for 2013-2015. For a comprehensive list of Alta Bates Summit Medical Center community benefit programs and activities, please visit http://www.altabatesummit.org/about/communitybenefit/cb_programs.html.

Approval by Governing Board

This implementation strategy was approved by the Sutter East Bay Hospital's Board of Directors on December 12, 2013.

Appendix: 2014 Community Benefit Financials

Sutter Health hospitals and many other health care 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.

The community benefit values for Sutter East Bay Hospitals are calculated in two categories: **Services for the Poor and Underserved** and **Benefits for the Broader Community**.

Services for the poor and underserved include traditional charity care which covers health care 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. Services for the poor and underserved also include the cost of other services provided to persons who cannot afford health care because of inadequate resources and are uninsured or underinsured, and cash donations on behalf of the poor and needy.

Benefits for the broader community includes costs of providing the following services: health screenings and other non-related services, training health professionals, educating the community with various seminars and classes, the cost of performing medical research and the costs associated with providing free clinics and community services. Benefits for the broader community also include contributions Sutter Health makes to community agencies to fund charitable activities.

2014 Community Benefit Value	Sutter East Bay Hospitals
Services for the Poor and Underserved	\$106,760,453
Benefits for the Broader Community	\$3,883,788
Total Quantifiable Community Benefit	\$110,644,241

This reflects the community benefit values for Sutter East Bay Hospitals (SEBH), the legal entity that includes Alta Bates Summit Medical Center and Sutter Delta Medical Center. For further details regarding these community benefit values, please contact Deborah Pitts at (510) 869-8230 or PittsD@sutterhealth.org.

2014 Community Benefit Financials
Sutter East Bay Hospitals

Services for the Poor and Underserved	
Traditional charity care	\$10,323,481
Unpaid costs of public programs:	
Medi-Cal	\$89,690,641
Other public programs	\$2,564
Other benefits	\$6,743,767
Total services for the poor and underserved	\$106,760,453
 Benefits for the Broader Community	
Nonbilled services	\$1,377,655
Education and research	\$675,378
Cash and in-kind donations	\$1,603,281
Other community benefits	\$227,474
Total benefits for the broader community	\$3,883,788

This reflects the community benefit values for Sutter East Bay Hospitals (SEBH), the legal entity that includes Alta Bates Summit Medical Center and Sutter Delta Medical Center. For further details regarding these community benefit values, please contact Deborah Pitts at (510) 869-8230 or PittsD@sutterhealth.org.