

Community Benefit Plan Progress Report, 2011

Based on the Community Benefit Plan 2010 – 2013

Responding to the 2010 Needs Assessment



June 2012

Alta Bates Summit Medical Center Community Benefit Progress Report Prepared and Submitted by:

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Sutter Health:

Building Healthier Communities and Caring for Those in Need

Alta Bates Summit Medical Center is affiliated with Sutter Health, a not-for-profit network of 48,000 physicians, employees, and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating for a more integrated, seamless and affordable approach to caring for patients.

It's better for patients:

We believe this community-owned, not-for-profit approach to health care best serves our patients and our communities – for multiple reasons. First of all, it's good for patients. According to the Journal of General Internal Medicine (April 2000), patients treated at for-profit or government-owned hospitals were two-to-four times more likely to suffer preventable adverse events than patients treated at not-for-profit institutions.

Our stockholders are our communities:

Investor-owned, for-profit health systems have a financial incentive to avoid caring for uninsured and underinsured patients. They also have a financial incentive to avoid hard-to-serve populations and "undesirable" geographic areas such as rural areas. In many of Northern California's underserved rural locales, Sutter Health is the only provider of hospital and emergency medical services in the community.

Providing charity care and special programs to communities:

Our communities' support helps us expand services, introduce new programs and improve medical technology. Across our network, every Sutter hospital, physician organization and clinic has a special story to tell about fulfilling vital community needs.

Our Commitment to Community Benefit: Meeting the health care needs of our communities is the cornerstone of Sutter Health's not-for-profit mission. This includes directly serving those who cannot afford to pay for health care and supporting programs and services that help those in financial need.

In 2011, our network of physician organizations, hospitals and other health care providers invested \$756 million in health care programs, services and benefits for the poor and underserved. This includes:

- The cost of providing charity care
- The unpaid costs of participating in Medi-Cal
- Investments in medical research, health education and community-based public benefit programs such as school-based clinics and prenatal care for patients.

Sutter Health now provides \$2.7 million in charity care per week.

Executive Summary

In 2011, Alta Bates Summit Medical Center contributed more than \$10.7 million in community benefit programs and services, not including charity care or subsidy of Medi-Cal. The medical center provided more than 27 ongoing community benefit programs and initiatives designed to respond to specific community needs. Each and every one has an impressive success story. Alta Bates Summit's 2010-2013 Areas of Focus include Diabetes, Stroke, Asthma and Senior Fall Prevention. This summary report, which was presented to the Sutter Health East Bay Board of Directors on June 14, 2012, provides an update on goals and objectives established for these specific areas of focus. In addition, a summary of the 2011 outcomes and 2012 measurable goals and objectives of all of our community benefit programs is included in Section III of this report.

Our Diabetes Center Resource Project, now in its' third year, provides education and diabetes management to uninsured and underinsured patients, with the goal of improving these patients' ability to manage their condition and avoid readmission to the medical center. Thus far, there has been a 52 percent reduction in readmissions of uninsured and underinsured patients.

In 2004, 50 percent of stroke patients died before arriving at an emergency department in Alameda County. Among the ways our nationally recognized Regional Primary Stroke Center addresses this challenge is by providing education to thousands of community members. Today, the percent of stroke patients who die before arriving at the ED has decreased by 66 percent, lowering the mortality rate to 17 percent.

Due to the efforts of our Asthma Management Resource Center, created in 2001 in direct response to our community needs assessment, there has been a 60% reduction in the total Alta Bates Summit emergency department visits for the diagnosis of asthma and a continual decline in hospital admissions.

Last year, the Senior Fall Prevention and Screening Project screened 131 individuals at 46 site visits throughout our community, with 100 percent of participants improving in one or more fall risk tests.

Alta Bates Summit provides a wealth of community benefit programs and services, of which we are very proud. We are committed to meeting community needs as we strive to fulfill our mission to enhance the health and well-being of people in the communities we serve through compassion and excellence.

I. 2011 Progress Report on Areas of Focus

The following pages provide a progress report on Alta Bates Summit Medical Center's Community Benefit Areas of Focus, including; Diabetes, Stroke, Asthma and Senior Fall Prevention. A summary of the 2011 outcomes and 2012 measurable goals and objectives of all of our 2011 community benefit programs and services is included in Section III of this report.

For more information about the **2010 Community Needs Assessment**, visit the Alameda County Public Health website at: <http://www.achpd.org>

For more information, or to obtain a copy of the **Alta Bates Summit Community Benefit Plan 2011-2013**, contact Deborah Pitts, Manager of Public Affairs, at pittsD@sutterhealth.org.

Priority Need/Area of Focus : Diabetes

Link to Community Needs Assessment	The incidence of diabetes in the communities surrounding Alta Bates Summit is steadily rising as represented in the 2010 community needs assessment, <i>The Health of Alameda County Cities and Places</i> . Diabetes is a leading cause of death in the county and a strong contributor to many other diseases, including heart attacks and strokes. Diabetes mortality is up to three times higher in poorer parts of Alameda County including Oakland, Cherryland and Hayward.
Program Description	The primary mission of the Diabetes Center is to provide diabetes self-management to people with diabetes in Alameda County. The Diabetes Resource Project, initiated in 2009 in response to community need among uninsured and underinsured community members, provides free comprehensive diabetes self-management training to patients who could otherwise not have access to this education, to teach proper use of medications and prevention of complications.
Goals and Objectives	To provide assessment and intervention to a total of 100 underinsured and uninsured diabetes patients by December of 2011.
Strategy	Strategies employed included 1) providing two in-services to emergency department managers, charge nurses and case managers regarding the Diabetes Resource Project services, 2) providing informational brochures to ED staff for diabetes patients, 3) contacting prospective patients via letter and phone call to offer free educational services. To evaluate the success of the Diabetes Resource Project, a monthly report of ER visits of uninsured and underinsured patients is tracked and monitored for repeat visits and hospital admissions for hyperglycemia and hypoglycemia.
Baseline Information	Diabetes and its complications are an enormous human and financial burden to our community. Reports of Alta Bates Summit Emergency Department visits for diabetes related diagnosis 2008-2010 showed that approximately 50% of the visits were patients that are uninsured or underinsured (MediCal). In 2011, an average 100 uninsured and underinsured patients with a diabetes diagnosis were seen at the ABSMC Emergency Department each month. These patients often present with preventable hypoglycemia or hyperglycemia. We knew that patients could benefit from comprehensive diabetes self-management training in which they would learn the proper use of their medications and prevention of complications.
Contribution or Program Expense	The Diabetes Resource Project is a community benefit program of Alta Bates Summit. The medical center cash contribution is \$52,000.
Results	100 uninsured or underinsured patients were seen through the Diabetes Resource Project. A small random sampling from this 1.5 year of service indicated a 52% reduction in admissions.
Amendment to Community Benefit Plan	Strategies will remain the same and we hope to expand our efforts.

Priority Need/Area of Focus : Stroke Education and Outreach

Link to Community Needs Assessment	In Alameda County, stroke is the third leading cause of death. As reported in the 2010 community needs assessment report, <i>The Health of Alameda Cities and Places</i> , there were 18,725 stroke-related hospitalizations in Alameda County from 2006 through 2008 and 1,794 deaths from stroke.
Program Description	Alta Bates Summit Medical Center Stroke Education and Outreach Committee, a program of our Regional Stroke Center, was created to provide education and outreach throughout our community utilizing multiple tools and venues.
Goals and Objectives	To decrease the morbidity and mortality rates from strokes by educating the community, in a culturally and linguistically appropriate manner, about stroke prevention, risk factors, signs and symptoms. 2011 objectives included enhancing outreach and education through electronic outreach and evaluation of program efficacy through consumer research.
Strategy	In 2009, based on an evaluation of the community's needs, different methods to conduct e-Outreach were chosen based on available educational materials and relevant technologies. Three chosen methods included: (1) publish a biannual newsletter through a web-based service (2) produce a stroke film and then post it on YouTube and (3) develop and pilot a "stand-alone touch-screen computer" (kiosk) program in a church to reach populations that do not regularly use the computer/internet nor attend regular medical appointments. Monthly goals were set at various stages of this process and evaluated to monitor the progress.
Baseline Information	In 2004, a phone-based survey of 800 households in Alameda County found that only 10% of those surveyed held a basic understanding of stroke. In that same year, 50% of stroke patients died before reaching the Emergency Department. Based on this data, a stroke outreach and education committee was created in 2005 at Alta Bates Summit Medical Center.
Affiliate/Region's Contribution or Program Expense	The Stroke Center Education and Outreach Initiative is a community benefit program of Alta Bates Summit Medical Center. The medical center provides staffing and a \$15,000 cash contribution.
Results	Since 2010 the Stroke Center educated more than 6000 community members in five different languages. The use of e-Outreach has proven to be far more effective in reaching a broader population than was previously possible and automated tracking systems made the evaluation process more efficient. Leveraging the free resources available through these technologies has proven an excellent addition to our in-person outreach methods. Results for the three methods of e-outreach for 2011:(1) published a biannual newsletter through a web-based service (~300 readers per issue); (2) produced a stroke film and then posted it on YouTube (~140 views per month and over 4000 views in total, worldwide); and (3) developed and piloted a "stand-alone touch-screen computer" (kiosk) program in a church (~200 users in the first three months)
Amendment to Community Benefit Plan	Our plans to expand our e-Outreach efforts include using text messages for stroke education and developing a computer application that will allow users to do a self-examination using the Act F.A.S.T. test. Additionally, we plan to conduct another survey (incorporating e-Outreach methods) in order to gauge the level of stroke literacy and outcome of stroke death prior to reaching the emergency room.

Priority Need/Area of Focus : Asthma

Link to Community Needs Assessment	The incidence of asthma remains high in our community. The hospitalization and emergency room visit rates for Alameda County rank fifth highest in the State of California.
Program Description	All uninsured and underinsured patients who are seen in the emergency department with an asthma diagnosis are contacted by phone and invited to attend an individual session(s) to assist them with asthma management. The Asthma Resource Center does not provide clinical care, but exists to provide education and tools for asthma management.
Goals and Objectives	The Asthma Resource Center exists to improve the emergency treatment of all patients with asthma, and to decrease hospitalizations and Emergency Room visits, with a focus on uninsured and underinsured individuals.
Strategy	Potential causes for the high rate of emergency department visits and admissions may include poor living conditions, inaccessibility to health care and limited funding for medications, poor understanding of the disease process, noncompliance with the treatment routine or ineffective inhalation medication techniques. By providing easy access to care, education, equipment and medication, patients are able to better manage their asthma and avoid visits to the Emergency Department or hospital admission. Patients are identified in the emergency department and contacted by the Resource Center director for education and free equipment and medication as needed. Not only are patients provided tools and medications, they are provided information about where and how to locate follow-up medical care in the community.
Baseline Information	From 2006-2008, there were 6,534 asthma hospitalizations in Alameda County and 23,006 Emergency Department visits for asthma. Rates of asthma hospitalization were substantially higher in Oakland and Hayward, than in Alameda County as a whole.
Affiliate/Region's Contribution or Program Expense	The Asthma Resource Center is a community benefit program of Alta Bates Summit Medical Center, with a staff of one working 6-8 hours/week. The medical center cash contribution is \$25,000.
Results	Since the inception of the program in 2001, the total emergency department visits have been reduced by 60% and in the targeted population of uninsured or underinsured, by 41%. There has been a continual decline in total asthma hospital admissions by 42% and the targeted population by 37%.
Amendment to Community Benefit Plan	With additional staffing and resources, ARC would be able to provide more follow up to patients. It is difficult to schedule follow up visits with patients in a timely fashion. This represents a problem for patients who are unable to obtain medications immediately following their visit to the emergency department. The program is seeking additional funding.

Priority Need/Area of Focus : Senior Fall Prevention and Screening

Link to Community Needs Assessment	Falls, particularly among seniors, were identified in the 2010 Community Needs Assessment, <i>The Health of Alameda County Cities and Places</i> as a significant issue in our community. In 2005, 2,512 seniors sustained non-fatal falls. Alta Bates Summit initiated a community class on site, but unfortunately there was little participation, as patients could not come to the medical center. In 2009, the Fall Prevention and Screening program was developed.
Program Description	2011 activities included 46 site visits and 131 people served. Visits included screening of fall risk, exercise and gait training.
Goals and Objectives	<p>The Fall Prevention and Screening Project offers outreach to individuals in our community who may otherwise not be able to easily access care by providing education, screening and appropriate intervention for those at risk of falling.</p> <p>2011 Objectives included: 1) Continue to offer community effective fall prevention interventions, 2) Make necessary changes to improve outcomes in 2011, 3) Increase referrals to appropriate practitioners.</p>
Strategy	Exercise and functional activities designed to improve balance and decrease risk of falls were performed at site visits. Participants received a Fall Risk Score on the Biodex Balance System. Additionally, the following outreach was conducted: in-service to inpatient rehab staff at Summit, a meeting with the Summit ED manager, letters mailed to 45 senior and living facilities, and free fall risk screening to the Health Access community.
Baseline Information	In 2005, 2512 seniors sustained non-fatal falls. The average cost of hospitalization due to a fall in Alameda County is \$37,000. While Alta Bates Summit provided fall prevention education and screening there was clearly a need go out into the community to provide that education.
Affiliate/Region's Contribution or Program Expense	The Senior Fall Prevention and Screening Program is a community benefit program of Alta Bates Summit Medical Center. The medical center provides personnel and an \$8,000 cash contribution.
Results	100% of participants improved in one or more of the following risk tests; Functional Reach, 30 second chair stand and timed up and go.
Amendment to Community Benefit Plan	There may be modification and enhancement of the testing and screening moving forward, as appropriate.

II. 2011 Community Benefit Values

Sutter Health affiliates 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 value for Sutter Health East Bay Region, of which Alta Bates Summit Medical Center is an affiliate, is calculated in two categories: **Benefits for the Poor and Underserved** and **Benefits for the Broader Community**. Below are definitions for each community benefit activity:

Benefits to the Poor and Underserved

- **Traditional Charity Care** – Free or discounted health care services provided to the uninsured and underinsured populations.
- **Unreimbursed Cost to Medi-Cal** – The “shortfall” created when the facility receives payment below the costs of treating public beneficiaries.

Benefits for the Broader Community

- **Non-Billed Services** – Activities with no individual patient bill, therefore no deduction from revenue is shown in the traditional statement of revenues and expenses.
- **Cash Donations and In-Kind Donations** – Dollars and other items such as staff time and supplies donated by a facility to a community-based program or agency.
- **Education & Research** – All community, patient, and medical education such as community lectures, nursing student rotations and physician/clinician training.

Community Benefit Summary 2011

2012 Community Benefit Value	Sutter East Bay Hospitals
Benefits for the Poor and Underserved	\$105,244,649
Benefits for the Broader Community	\$ 9,224,855
Total Quantifiable Community Benefit	\$114,469,504

The financial numbers above reflect 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.

III. 2011 Outcomes and 2012 Objectives

In addition to the programs described as Areas of Focus, Alta Bates Summit Medical Center provides community benefit through more than 27 different community benefit programs and services. All of these programs, some with tenure of more than 20 years, were created in direct response to community need and offer a wealth of community outreach and education. A summary of 2011 outcomes and 2012 objectives can be found in this section.

Comprehensive Cancer Center Support Groups

Program Goal: To provide cancer care, education and support groups for Alta Bates Summit Medical Center and the community.

2011 Outcomes

Objective 1

Start planning and implementing a cancer survivorship education panel for a one-day class, topics to include: nutrition, exercise, employment, health and life insurance, stress reduction, and side effects of treatment.

Outcome(s)

Although we did not directly achieve this objective, we did play a part in the planning of such a program for the future. Luanne Ridgley, Psychosocial Manager, is a member of the ABSMC Cancer Committee task force for survivorship program development. The committee had a staff "brainstorming" session in late 2011. This session jumpstarted the planning and development of what will be a survivorship program, including a 1-day class. Our hope is that we will play an active role in the Cancer Committee's survivorship program to help achieve our long-term goal to provide post-treatment care to survivors.

2012 Objectives

Objective 1

The Cancer Center plans to start a caregiver support program.

Objective 2

Chemotherapy-related Neuropathy has the potential to affect mobility and ability to perform daily activities in affected patients. In response to these statistics we will develop an education/discussion series that will reach out to those affected by chemo-related neuropathy. An interdisciplinary team will facilitate this series.

Diabetes Center

Program Goal: To provide diabetes education to underserved populations in Alameda County.

2011 Outcomes

Objective 1

Expand community outreach through church and mobile van health service and education. Provide diabetes education to at least three new community groups in underserved areas. Provide diabetes education on Heart to Heart Health Van and contribute to church education kiosk and Women's Church Group education

Outcome(s)

The Diabetes Center contributed educational materials to Heart to Heart Health Van. Staff assisted with editing of diabetes information on EHI health education kiosk and gave presentations at multiple church and community groups, including Clausen House, Women's Church Group, Northern Lights School and Youth Leadership Forum.

Objective 2

Provide at least three education sessions to nurses to become Diabetes Nurse Champions. Schedule 3 training days and follow up sessions for Diabetes Nurse Champions to learn essentials of diabetes education and transition to care.

Outcome(s)

Three Diabetes Nurse Champion educational sessions were offered and training completed with 60 nurses. Two follow up case study sessions were completed. Very positive evaluation of classes from the participating nurses and significant improvement seen in transition of care of patients leaving the hospital.

2012 Objectives

Objective 1

Expand community outreach through participation in at least 4 health fairs or diabetes presentations in underserved areas.

Objective 2

Develop a PowerPoint presentation on diabetes for use in educating the community on diabetes prevention and treatment.

Disabled Community Health Center

Program Goal: To provide service access through sensitive health education resources and patient information to the disabled community; Access to LCSW for phone consultation and referral to community agencies.

2011 Outcomes

Objective 1

Raise the community's awareness of free social work consultation for persons in the disabled community via phone and e-mail inquiries. Increase phone and e-mail inquiries by 2%.

Outcome(s)

Flyers continue to be provided for community events upon request. Also flyers posted in the community, i.e. farmer markets, Berkeley flea market, Whole Foods, Berkeley Bowl and Trader Joe's. Education provided to Sutter Health staff at the Harvest Fair regarding services offered in the Disabled Community Health and Outpatient rehabilitation departments. The inquiries did not meet the 2% increase possibly due to agency/provider services that consumers are not reaching with the changes in Medi-Cal services.

Objective 2

Assist in establishing a peer support group for Spinal Cord Injury.

Outcome(s)

Time and budgetary constraints were main factors for many Spinal Cord Injury clients. With the additional expenses for travel and services of a caregiver, going to a group was not a priority.

2012 Objectives

Objective 1

Raise the community's awareness of free social work consultation for persons in the disabled community via phone and e-mail inquiries. Increase phone and e/mail inquiries by 1 percent.

Objective 2

Outreach to five community programs to re-establish services the Disabled Community Health Clinic Social Worker provides.

East Bay AIDS Center

Program Goal: To provide a comprehensive program of HIV care and access to clinical trials as well as consultation and support services throughout the continuum of HIV disease.

2011 Outcomes

Objective 1

In collaboration with our Downtown youth clinic, test 300 youth, by holding clinic hours for drop-in testing, as well as holding open-clinic at offsite locations. We hope to gather 20% of the testing data through Social Networking.

Outcome(s)

The Downtown Youth Clinic tested 190 youth (13-24 years) in the 2011 calendar year. While in other years we have tested over 300, in 2011 our HIV testing coordinator was out on maternity leave for 4 months. Of the 190 youth tested in 2011, over 30% were tested through our Social Network Testing program, a program that has been shown to yield a high positivity rate in the past. We found 5 positives among the 190 tested.

Objective 2

Test 3000 people through the Rapid Testing Program at Alta Bates Summit Emergency Departments. Out of those that test positive the goal is to get 10% into care at EBAC.

Outcome(s)

Through the testing program, we tested 2,426 individual patients who were seen through the emergency department at Alta Bates during 2011. Of those 2426, 6 tested positive and we were able about to get 2 into care here at the East Bay AIDS center and link others to care elsewhere.

2012 Objectives

Objective 1

To increase awareness around the stigma and misinformation of HIV/AIDS, by attending 5 events and providing testing and educational materials to the community.

Objective 2

In collaboration with our Downtown Youth Clinic & other community partners, test 300 youth and young adults by holding clinic hours for drop in testing as well as attending community outreach events. Of the percentage that tests positive we hope to get 40% into care at EBAC.

Ethnic Health Institute

Program Goal: We enhance the health and well being of all people in the community, focusing on the underserved and minority populations that experience disparities in healthcare and disease.

2011 Outcomes

Objective 1

Determine the effectiveness of delivering health messages using social media.

Outcome(s)

In 2011, the EHI Stroke Committee hosted its first webinar, *“Creating an Effective Model for Stroke Community Education and Outreach.”* Over 50 healthcare professionals participated. In addition, EHI released two editions of the community e-Newsletter that included a total of 10 articles related to chronic disease prevention, management, and healthcare reform. The newsletters received a total of 2,388 views.

Objective 2

Collaborate with Samuel Merritt University on a series of lectures of community education. Topics may include chronic disease prevention and management and selected topics on health care reform.

Outcome(s)

EHI collaborated with Samuel Merritt University on two community events. Brain Awareness Day, was held on Saturday, May 12, with over 75 community attendees. Participants enjoyed a presentation on brain health, given by Alta Bates Summit Medical Center Neurologist, Brian Richardson, MD. Stroke education was also provided by members of the EHI Stroke Outreach Committee. The second collaboration was EHI’s Third Annual Caregivers Town Hall, held Saturday, November 12, at the Samuel Merritt University Health Education Center. 104 community members participated.

2012 Objectives

Objective 1

Provide chronic disease education programs, on prevention, warning signs, and symptoms of major chronic diseases (cancer, cardiovascular, diabetes, and stroke.)

Objective 2

Increase access to health care, particularly screenings, by providing education about Affordable Care Act provisions.

Health Access

Program Goal: To enhance community access to the medical center and to provide wellness information to community members so that they may better manage their health.

2011 Outcomes

Objective 1

Leverage the skills and knowledge of medical center physicians and clinicians by providing no less than 50 educational events to the community at a low cost or free of charge, specific to ABSMC Centers of Excellence in Cancer, Orthopedics, Woman and Infants, Cardiovascular and Behavioral Health.

Outcome(s)

Health Access provided 75 educational events throughout Alameda and Contra Costa Counties with more than 1,549 participants.

2012 Objectives

Objective 1

Leverage the skills and knowledge of medical center physicians and clinicians by providing ongoing educational events to the community at a low cost or free of charge, specific to ABSMC Centers of Excellence in Cancer, Orthopedics, Woman and Infants, Cardiovascular and Behavioral Health. We will also continue Safe Driving Classes.

Health Ministry

Program Goal: To promote positive behavior change by addressing whole person health care in faith-based organizations and congregations.

2011 Outcomes

Objective 1

Based on the success of our initial model pilot project, we will implement the Hypertension Management Program for a selected group of 20 people by August 1, 2011.

Outcome(s)

The Hypertension Management Program was implemented between August 30th and November 15, 2011, to 25 participants. Many successful results were achieved. ANOVA of the pre and posttest taken at the beginning and end of the 12-week program showed that participants had significantly improved their scores and knowledge in most of the key thematic areas of instruction. Fifteen of the twenty-five participants (60%) lost weight. The range of weight loss was 1 to 13.6 pounds with a mean weight loss of 6.02 pounds. Nine participants (36%) had lower BMI scores after the program and six (24%) had higher scores. Thirteen (52%) participants had lower waist measurements at the end of the program. Participants' blood pressure readings varied a great deal from week to week. Fourteen of the twenty-five participants did have at least one 'normal' blood pressure assessment over the course of the program.

Objective 2

Document the impact of one specific area of service we are providing to the health ministry leaders by December 31, 2011. We will review all of our services to determine the area of focus by July 31, 2011.

Outcome(s)

The service area of community education and awareness was chosen to determine impact. Health Ministry Leaders ranked community education and awareness as the most valuable service we provide based on the 2011 annual evaluations. This service area includes many activities, i.e. Hypertension Management Program, flu vaccines, and hypertension screenings. The Hypertension Management Program data was so convincing that we prioritized the expansion of this program. The impact of the Hypertension Management Program is demonstrated by the numerous requests for similar programs.

2012 Objectives

Objective 1

Develop and implement at least 6 Hypertension Management Program support group sessions by December 30, 2012. 30% participation at the majority of the meetings will be one measure of success. Participant's lifestyle improvements will also continue to be a measure of success.

Objective 2

Develop and begin implementing a systemized evaluation framework that will be tailored to use when supporting our congregations with health ministry activities by April 30, 2012.

Lifeline

Program Goal: To provide peace of mind to relatives and siblings of seniors who are living alone in their homes. To help maintain independence for seniors so that they can live safely and independently in their homes. Lifeline provides education and scholarships.

2011 Outcomes

Objective 1

Because of the high incidence of vulnerable seniors and disabled who are susceptible to falls and live alone, Lifeline will increase community outreach.

Outcome(s)

We attended over 20 community outreach events and provided information to community members about Lifeline and provided more than \$30,000 in scholarships.

Objective 2

Because of the low prescription medicine compliancy rates of our vulnerable seniors, the Lifeline program will increase community outreach in a caring and compassionate way.

Outcome(s)

Lifeline was able to visit 15 independent living facilities and senior centers to educate seniors about the new PMD. We installed several units for the entire year. Philips Lifeline has increased their support for the installations.

2012 Objectives

Objective 1

Because of the high incidence of vulnerable seniors and disabled who are susceptible to falls and live alone, Lifeline will work closely with community partners and referral sources to increase awareness of our Auto-Alert(fall detection) product.

Objective 2

Because of the low prescription medicine compliancy rates of our vulnerable seniors, the Lifeline program will increase community outreach and work with new referral sources to increase awareness of available resources.

Markstein Cancer Services

Program Goal: To decrease the incidence of cancer through education and early intervention (screening) as well as supporting those touched by cancer (educational programs, support groups and therapeutic workshops).

2011 Outcomes

Objective 1

Improve community ABSMC Web access to Markstein services and special events. It is hoped that the community will have an increased awareness of our programs and the latest information to community is posted on ongoing basis.

Outcome(s)

To increase community web awareness of Markstein Cancer Services the website was completely revised and updated adding video clips of staff and educational materials. Along with this links from all ABSMC web tumor sites were revised and included links to a number of Markstein programs as well as home page. Google visits were recorded for a four week period prior to launching the updated website and measured for a same four week period after the launch. Website hits increased by just over 100%.

Objective 2

Continue working /collaborating with funding partners to secure funding for high risk women under 40, who are uninsured, in order to provide breast screening services.

Outcome(s)

Collaborations and contracts developed with both the Breast Cancer Connections Patser Program and the Breast Cancer Emergency Fund to fund diagnostic breast services for uninsured women under forty. Using these relationships we were able to provide 154 diagnostic breast works-ups for women who we would have otherwise not been able to provide services.

2012 Objectives

Objective 1

Develop educational offering plan for cancer caregiver needs and collaborate with oncology nursing units to provide the education on floor prior to patient discharge.

Objective 2

Develop cancer caregivers support group to address the emotional needs of the cancer caregiver. Initiate this support group service and offer minimally one time a month.

Medi-Cal Entitlement Screening

Program Goal: To provide uncompensated care to the uninsured and underinsured patients/families of the Medical Center.

2011 Outcomes

Objective 1

Families who need financial assistance often have trouble with the system and completion of forms to receive Medi-Cal Entitlement. Financial Counselors & Supervisor will assess and assist patients/families for the linkage and completion of the Medi-Cal application to include State Programs, (i.e.) Healthy Families, Medicare and keeping documentation of dollar amount written off monthly per established guidelines.

Outcome(s)

There were a total of 188 Medi-Cal encounters of which 111 Medi-Cal applications were approved, 62 Medi-Cal applications denied and 15 Medi-Cal applications pending for decision.

Objective 2

It is the goal of our Patient Financial Counseling Department to increase the numbers of Medi-Cal referrals by 10% for the next calendar year through personal interviews with patients/families on the completion of the Medi-Cal application process and the collection of essential documentations required for the completion of the Medi-Cal application.

Outcome(s)

Financial Counseling Department met and exceeded this goal by 5%.

Objectives 2012

Objective 1

Financial Counselors and Supervisor will assess and assist patients/families with completion of Medi-Cal application process. Patients often need assistance with completing the application and obtaining essential documents needed for the processing of the application.

Objective 2

As part of our Sutter's Mission we will help to provide awareness and support to patients/families through culturally sensitive, courteous, accurate and timely filing of Medi-Cal applications. It is the goal of our Patient Financial Counseling Department to increase the numbers of Medi-Cal Referrals by 10% for the next calendar year through personal interviews with patients/families on completion of the Medi-Cal application process and the collection of essential documents required for the completion of Medi-Cal application process.

MPI

Program Goal: To provide chemical dependency treatment to adults in Northern California. MPI provides community benefit through outreach and educational activities provided free-of-charge or at low cost, as well as charity care.

2011 Outcomes

Objective 1

Provide Community Benefit: $\geq 1.2\%$ of MPI Net Revenue.

Outcome(s)

Achieved: 1.2%

Objective 2

Provide Charity Care: $\geq 1.81\%$ of MPI Gross Revenue.

Outcome(s)

Achieved: 2.8%

2012 Objectives

Objective 1

Provide Community Benefit $\geq 1.2\%$ of MPI Net Revenue

Objective 2

Provide Charity Care $\geq 1.81\%$ of MPI Gross Revenue

Pharmaceutical Waste Recycling

Program Goal: To educate the public about the proper disposal of unneeded medications. To reduce medication in the waste stream and to collect and dispose of unneeded medications properly.

2011 Outcomes

Objective 1

Collect unwanted medication from the community for proper disposal.

Outcome(s)

During 2011, 25 cases of unwanted medications were sent back through Guaranteed Returns, estimated to weigh approximately 725 pounds in total.

Time spent in administration of this project: 18 hours

Estimated wages: \$1404

No direct expenses incurred for disposal or shipping

2012 Objectives

Objective 1

Collect unwanted medication from the community for proper disposal.

Regional Behavioral Health Services

Program Goal: To increase the awareness of mental health issues in the community and offer referrals to treatment resources.

2011 Outcomes

Objective 1

To continue to work to decrease the issues of stigma and misinformation that interferes with people in need of mental health services getting appropriate and timely treatment.

Outcome(s)

Developed educational DVD; collaboration between the Mental Health Service and NAMI East Bay titled "What Families Should Know About the Treatment of Mental Illness."

A manager from the Mental Health Service quarterly attends meetings with Asian Community Mental Health.

The Mental Health Service provides a 24-hour crisis telephone service.

The Mental Health Service Eating Disorder Program provides a monthly support group for patients and their families.

Objective 2

To work with the Community Benefit Program Coordinator to provide programs to the Oakland Unified School District that address health and mental health education.

Outcome(s)

In July, the Mental Health Service provided a four hour seminar to the Youth Bridge students on the biology of stress.

2012 Objectives

Objective 1

To provide increased access to Behavioral Health Services to the Oakland, Berkeley and the East Bay Community. This will be primarily accomplished by a 24-hour telephone crisis line that is staffed by the Behavioral Health Intake Department. Additionally, patient support groups and educational groups are provided to the community on issues relating to mental health.

Objective 2

To increase support to ABSMC nursing units, other than Behavioral Health units, in order to care for patients treated with medical conditions and behavioral health conditions simultaneously. Professional staff from Behavioral Health is a resource to the medical center to address problems, issues or questions related to psychiatric or mental health issues.

Regional Rehabilitation Services

Program Goal: To provide education and support for patients with chronic disabling conditions.

2011 Outcomes

Objective 1

Increase attendance at Arthritis Education and Support Group.

Outcome(s)

Attendance at the monthly arthritis support group continues to grow. Outreach has been expanded to include the members of the Health Access program and several new topics were presented in 2011. Overall attendance for the year increased from 140 in 2010, to 246 in 2011.

Objective 2

Increase accessibility of Fibromyalgia Support Group for the hearing-impaired members.

Outcome(s)

The fibromyalgia support group started to provide sign language interpreters on an as-needed basis to increase access for the hearing impaired. This service was supplied four times during 2011, and was greatly appreciated.

2012 Objectives

Objective 1

Increase attendance at the Stroke Support Group by 5%.

Objective 2

Advocate for the support groups to be valued as a patient-centered priority activity in the room scheduling system.

Senior Fall Prevention

Program Goal: The Senior Fall Prevention Project will outreach to individuals in our community to identify those at risk of falling and provide them education and appropriate intervention to help decrease their future risk of falling.

2011 Outcomes

Objective 1

Continue to offer community effective fall prevention interventions with excellent customer satisfaction.

Outcome(s)

Increased outreach was performed. In-service was provided to inpatient rehab staff at Summit. Staff met with Summit ED manager to discuss program. Letter was sent to 45 senior center and living facilities. Free fall risk screening was advertised to Health Access community. Flyers were developed and distributed. 131 people were screened and 46 site visits completed. 100% of participants improved in one or more fall risk tests. 100% of participants would recommend the program.

Objective 2

Increase referrals to clinic based programs.

Outcome(s)

Implemented in clinic Fall Risk Screening. Over 50% of those persons screened were screened in the clinic instead of in the community.

2012 Objectives

Objective 1

Continue to offer community effective fall prevention interventions with excellent customer satisfaction - 90% of participants show improvement in fall risk scores and 75% of program participants will not report another fall requiring hospitalization for 6 months after completing the program (self-report).

Objective 2

Increase referrals to clinic based programs - generate 2 new referrals to PT/month

Tele-Care

Program Goal: To provide daily reassurance phone calls to the elderly, frail or isolated and homebound individuals in Alameda, Contra Costa and San Francisco counties.

2011 Objectives

Objective 1

To find and develop new funding sources.

Outcome(s)

We received a grant from the Berkeley Rotary Club. One of our major funders has gone to a biennial plan. We can apply for a new grant with them this year. ABS Foundation and ABS Foundation Associates increased their support.

Objective 2

Increase our volunteer and client base.

Outcome(s)

We targeted senior centers and senior housing for both volunteers and new clients and disseminated flyers to a number of public places. We have increased our volunteers by over 10% percent. Most of the new volunteers are significantly younger than our core and bring fresh energy for our clients. We currently have full volunteer coverage for all our days. Recruitment and retention are on-going. We hosted a workshop in May that focuses on attracting and retaining employees and volunteers over 50. Given our success at promoting prevention and reducing hospital recidivism in the elder population, we feel confident about moving forward to expand the population we serve.

2012 Objectives

Objective 1

Create and implement an in-house patient support program with measurable outcomes for both recidivism and patient satisfaction.

Objective 2

Retain our present clients and volunteers; assessing our needs for implementing the above program in terms of new volunteers along with new protocols and procedures. Once implemented, the program will allow us to track, measure, collate and aggregate information on patient status, adherence to discharge and treatment plans, as well as patient treatment satisfaction.

Thunder Road

Program Goal: To assist youth and their families in the challenges to recover from the abuse of drugs and alcohol.

2011 Outcomes

Objective 1

Our objective is to increase the Community Benefit services for at-risk chemically dependent youth by the end of 2011.

Outcome(s)

We met our goal to increase the total number of clients receiving screening, assessments and treatment by 10% in 2011, resulting in serving 689 clients in 2011 compared to 605 in 2010.

Objective 2

By continuously updating our website, people who are seeking information about substance abuse services for youth will be able to access our Community Benefit Services effectively and efficiently.

Outcome(s)

We have continued to keep the new website up to date with Thunder Road information. We have seen an increase in individuals seeking help through the internet, especially during off business hours and weekends. We continue to research current and helpful links for families looking for resources that can be placed on our website. All of our information has been updated with our new website name.

Objective 3

One of the five most often reported reasons for not receiving substance abuse services is not knowing where to call for help.

Outcome(s)

During 2011, referral tracking reports have continued to be utilized to determine which groups need pertinent information about our Community Benefit programs and other services. We continue to work very closely with local referral sources in order to inform, educate and serve the diverse families of our East Bay Region. This past year we saw an increase in private referrals resulting in a significant increase in our occupancy rate. We will continue to focus on improving referrals from private sources.

2012 Objectives

Objective 1

Our objective is to maintain 2011's increased number of 665 screening and assessments Community Benefit services for at risk chemically dependent youth by the end of 2012.

Objective 2

Develop an expanded mailing list for referrals and begin an e-newsletter in 2012.

Objective 3

Many people utilize the internet to research a program. By continuously updating our website, people who are seeking information about substance abuse services for youth, will be able to access our Community Benefits services effectively and efficiently.

Women and Infants

Neonatal Transport

Program Goal: To ensure the safe stabilization and transport of neonates in our community.

2011 Outcomes

Objective 1

The Neonatal Resuscitation and Transport team members strive to give excellent care to infants and families during the neonatal transport process.

Outcome(s)

Response Time/Accessibility

Was the ABSMC Neonatal Transport Program easy to access: Yes 100% of the time.

The ABSMC Neonatal Transport Team arrived within 90 minutes of patient acceptance: Yes 92%
No 8% of the time.

Assessment

The ABSMC Neonatal Transport Team assessed and stabilized the infant appropriately: Yes 100%
of the time.

Communication

The ABSMC Neonatal Transport Team communicated professionally with parents and hospital staff:
Yes 100% of the time.

Overall Impression

Excellent 92% Average 8% Unsatisfactory 0%

2012 Objectives

Objective 1

The Neonatal Resuscitation and Transport Program will give excellent care to infants and families during the neonatal transport process.

Woman and Infants

Parent Education and Breast Feeding Support Groups

Program Goal: To provide quality education programs to our new and expectant parents so that they are able to make informed choices regarding their labor, delivery and care of their newborn.

2011 Outcomes

Objective 1

To provide quality education programs to our new and expectant parents so that they are able to make informed choices regarding their labor, delivery, and care of their newborn.

Outcome(s)

Our prenatal classes continue to be well attended. The evaluations reflect >85% “very good” responses.

Objective 2

To provide needed support to new mothers experiencing postpartum depression.

Outcome(s)

The decision was made to hold off on our plan for a support group for moms experiencing postpartum depression. This was the opinion of the behavioral health staff at Herrick who felt that the group dynamic is not the best practice for this population. We collaborated with the social workers on a brochure to help increase awareness of postpartum depression.

Objective 3

To provide support to our new breastfeeding mothers who live outside of the Oakland/Berkeley area.

Outcome(s)

We opened up consultation space in Lafayette for new mothers in that area and hope to be able to offer breastfeeding support groups as well. We partnered w/ Alameda Co WIC programs to distribute breastfeeding support resource information for all new mothers.

2012 Objectives

Objective 1

Continue to offer support groups for new mothers and aim for a minimum of 6 new mothers in attendance.

Objective 2

Distribute an evaluation form to be completed quarterly by participants of birth center tours and support groups. Scores to reflect a minimum of 80% satisfaction with the program or tour.

Youth Bridge Program

Program Goal: To introduce sixth through college aged at-risk students to health care professions, by producing educational opportunities, internships, training and employment.

2011 Objectives

Objective 1

As a way to evaluate family health, the intake forms for Youth Bridge students will include questions regarding the family health concerns such as asthma, smoking, stroke, diabetes, hypertension, obesity and recent hospitalization of an immediate family member. Pending this data collection, appropriate health information and referrals can be provided.

Outcome(s)

With the assistance of our Community Benefit Coordinator an intake form was developed for the Health Careers students, the returning students and their families. The data will be compiled to enhance the curriculum and provide referrals when needed.

Objective 2

Youth Bridge will work with the senior leadership of Sutter Health to determine the return on investment to the community and ability to further enhance Youth Bridge.

Outcome(s)

Working with the The California Endowment, the local and regional Sutter staff we continue to evaluate and examine the return on investment. The year of 2011 we served 54 in a five week Youth in Medicine summer camp; placed 70 high school and college students in summer internships at the medical center and community clinics. The Year Round Mentoring program served 20 young women and 20 young men all completed a successful year of school. The Men N' Medicine program conducted 3 workshops for young men in the community and held 3 all day activities. Education and social development of responsible behavior is a huge return of investment in the Oakland community.

2012 Objectives

Objective 1

Youth Bridge will work with Sutter East Bay Medical Foundation to provide more direct contact with doctors during the Health Careers class and summer internships at Alta Bates Summit Medical Center and the Health Centers providing an increased knowledge of necessary education and the daily routines of Doctors.

Objective 2

Youth Bridge will work with La Clinica and the Native American Health Care Center to provide students experience working at community and school health care centers. Students will learn about a wide range of pathways to many different careers that are not found at the medical center.