Sutter Health

Sutter Tracy Community Hospital

2016 – 2018 Community Benefit Plan
Responding to the 2016 Community Health Needs Assessment
Submitted to the Office of Statewide Health Planning and Development May 2019

This document serves as an annual update to the 2016 - 2018 Community Benefit Plan for Sutter Tracy Community Hospital. 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 2018.

1420 N. Tracy Boulevard, Tracy, CA 95376, FACILITY LICENSE # **30000105**
www.sutterhealth.org

Table of Contents

Note: This community benefit plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

The implementation strategy describes how Sutter Tracy Community Hospital (STCH), a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016 - 2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

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

Sutter Tracy Community Hospital welcomes comments from the public on the 2016 Community Health Needs Assessment and 2016 – 2018 implementation strategy. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail by sending to 2700 Gateway Oaks, Suite 2200, Sacramento, CA 95833 ATTN: Community Benefit and Brooke Galas
- In-person at the hospital's Information Desk.

About Sutter Health

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

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

At Sutter Health, we believe there should be no barriers to receiving top-quality medical care. We strive to provide access to excellent healthcare services for Northern Californians, regardless of ability to pay. As part of our not-for-profit mission, Sutter Health invests millions of dollars back into the communities we serve – and beyond. Through these investments and community partnerships, we're providing and preserving vital programs and services, thereby improving the health and well-being of the communities we serve.

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 2018 commitment of $734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2018, Sutter Health invested $435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter Health's gross patient service revenues in 2018.
- Throughout our healthcare 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 address real community needs.

For more facts and information visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

The development of the 2016 CHNA was driven by the Mobilizing for Action through Planning and Partnerships (MAPP) framework, which is a community-driven strategic planning process for improving community health. This highly inclusive and comprehensive process was led by consultants, Harder and Company and MIG and guided by a Core Planning Group along with a broadly representative Steering Committee, both of which Sutter Tracy Community Hospital Community Benefit staff greatly participated in.

This year's CHNA process included surveys of nearly 3,000 residents, interviews with key informants, 29 focus group discussions in the community, and data analysis of over 150 indicators, creating a robust picture of the issues affecting people's health where they live, work, and play.

The full 2016 Community Health Needs Assessment conducted by Sutter Tracy Community Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Each hospital participating in the San Joaquin CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. While each hospital serves specific geographic regions of the county, for the purpose of collaboration in the CHNA, all of San Joaquin County is included. When considering the specific service area of Sutter Tracy Community Hospital, the locations are identified based on the percentage of residents accessing the hospital as well as the geographic location of the cities situated within a 15 mile radius of the hospital. This includes the San Joaquin County cities of Tracy, Mountain House, Banta, Lathrop and Manteca.

Although Tracy, Manteca and Lathrop cities score higher than some other parts of the county in the Human Development Index (HDI), they still fall below the California average. The HDI score for this area is 5.05 compared to the California score of 5.39. Tracy and Manteca have many of the same priority health needs as San Joaquin County overall. Further analysis of the data revealed ten specific Communities of Concern, including ZIP code 95376 (Tracy). ZIP code 95376 is home to 49,859 residents. Within this ZIP code, 62% of the population were considered non-White or Hispanic. 8.2% were uninsured and 13.8% did not have health insurance. 17% of individuals over the age of 25 did not have a high school diploma.

Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. Obesity and Diabetes
2. Education
3. Youth Growth and Development
4. Economic Security
5. Violence and Injury
6. Substance Abuse

7. Access to Housing
8. Access to Medical Care
9. Mental Health
10. Oral Health
11. Asthma/Air Quality

The above listed needs are ranked in the order of priority as determined from the County-wide Prioritization Meeting that took place on November 12, 2015. The meeting convened key community stakeholders from various sectors and cities within San Joaquin County. Attendees were informed of the CHNA findings and had the opportunity to learn of the primary and secondary data discoveries for each identified health need. After each issue was reviewed and discussed, participants voted on each individual need using the following criteria, which resulted in the order of priority as listed above.

Severity:	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected;
Disparities:	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations;
Impact:	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.
Prevention:	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes.

2016 – 2018 Implementation Strategy

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

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

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

1. Obesity & Diabetes
2. Youth Growth and Development
3. Economic Security
4. Violence and Injury
5. Access to Housing
6. Access to Medical Care

7. Mental Health

8. Oral Health

Obesity & Diabetes

Name of program/activity/initiative	Increasing Access to Fresh Fruit and Vegetables for Underserved
Description	STCH will make community investments in agencies with the capacity to efficiently and effectively deliver supplemental sources of fresh fruits and vegetables to low-income neighborhoods within the hospital service area in an effort to promote healthier eating. Along with the fresh produce, programs will also provide culturally sensitive, nutritional information for the population it serves.
Goals	Increase access to and consumption of fresh produce among at-risk and underserved populations
Anticipated Outcomes	Increase access to fresh fruits and vegetables Increase access to the consumption of fresh fruits and vegetables Increase program participants' general knowledge of healthy eating
Plan to Evaluate	Intake questions, pre and post surveys, participant and produce counts
2018 Impact	The Mobile Farmer's Market is one of the Emergency Food Bank's most visible programs. Two Mobile Farmer's Market van's travel to 62 sites once a month throughout San Joaquin County to distribute free of charge, fresh fruits and vegetables, nutrition education and food preparation demonstrations to families with children, individuals and seniors who have limited resources and transportation options. In 2018, approximately 2,116 families suffering from food insecurities were helped and through these services 14,533 pounds of food was distributed throughout the community.
Metrics Used to Evaluate the program/activity/initiative	Number of people served Number of pounds of fresh fruits and vegetables distributed Quantity of nutritional handouts provided % of increase in participants' knowledge on nutritional education provided % of participants noting increased daily consumption of fruits and vegetables

Name of program/activity/initiative	Youth Health and Wellness Programs
Description	In an effort to reduce incidents of diabetes and obesity among the next generation of adults, the hospital will invest in programs that offer awareness and prevention services for elementary and middle school youth. By financially supporting programs that focus on nutrition and fitness education as well as the encouragement of healthy behaviors, the hospital hopes to reduce the future rates of obesity and diabetes.
Goals	Promote healthy eating and active living among youth.
Anticipated Outcomes	Increased physical activity among youth participants Increased consumption of fruits and vegetables among youth participants
Plan to Evaluate	Participant and produce tracking logs, pre and post assessments
2018 Impact	Give Every Child a Chance's Health Horizons program aims to educate youth, staff and students on the importance of health choices and living a healthy lifestyle. In 2018, the program was presented at several sites with 3,115 students served.

Metrics Used to Evaluate the program/activity/initiative	% of youth participants engaging in physical activity 4 or more days per week % of youth participants consuming 3 or more daily servings of fruit and vegetables Number of pounds of fresh produce distributed to youth and their families

Name of program/activity/initiative	Diabetes Prevention and Care Management
Description	The hospital will be exploring ways to provide impactful programs that can directly target the disparity of diabetes prevention and intervention services for residents of the hospital's service area. Rates of diabetes span across various demographics, although with higher incidents of disease among the Latino community, the hospital will consider
Goals	Increase local resources for diabetes education and disease management
Anticipated Outcomes	Increased access to low cost diabetes education and disease management resources for underserved and at-risk individuals
Plan to Evaluate	To be determined
2018 Impact	This program ended in 2018.
Metrics Used to Evaluate the program/activity/initiative	# of established partner agreement(s) to deliver services

Youth Growth and Development

Name of program/activity/initiative	Youth Strengthening
Description	Through community investments, the hospital will support programs and services that will develop socially and emotionally strong youth, and strengthen their ability to manage stress and anger. In partnership with the Tracy Unified School District and community based organizations, at-risk youth will be identified and referred to local youth development or mentoring programs.
Goals	Promote healthy behaviors among youth Increase access to services that provide youth with healthy emotional, social and physical development.
Anticipated Outcomes	Improve stress and conflict management skills among youth participants Promote constructive use of extracurricular time among program participants Increase access to mental/behavioral health services
Plan to Evaluate	Individual assessments, internal data collection, participant surveys, pre and post tests
2018 Impact	The goal of the Sow a Seed Community Foundation's Bright Future's youth development program is to improve the outcomes for youth and their families by providing mental/behavioral health, social/emotional development and access to safe activities. In 2018, the program served 312 individuals with 18 referrals to behavioral health services and 26 participants having their basic needs met.
Metrics Used to Evaluate the program/activity/initiative	# of individuals served # of referrals to mental/behavioral health services % of referred individuals that accessed mental/behavioral health services # of classes/activities provided

	% of youth expressing positive use of extracurricular time % of youth expressing knowledge and participation of positive and safe activities % of youth expressing knowledge of ways to manage stress and anger

Name of program/activity/initiative	Family Strengthening
Description	The hospital will offer funding to support programs that provide families with the needed resources to support self-sufficiency and promote safe and healthy home environments for their children.
Goals	Improve overall outcomes for families by providing needed resources to support healthy home environments. Improve access for families to improve parenting skills
Anticipated Outcomes	Parents will gain access to resources that will directly or indirectly improve their children's well-being.
Plan to Evaluate	Internal data collection, individual/family assessments
2018 Impact	Catholic Charities' Family Wellness Prevention and Early Intervention (PEI) program has been created to increase access to family counseling services when possible and to connect individuals to additional resources according to their needs. In 2018, 68 individuals contacted the program seeking counseling with 51 individuals being referred to Behavioral Health Services or other resources and 46 people reached by different events.
Metrics Used to Evaluate the program/activity/initiative	# of families case managed # of parenting classes/programs provided # of parents attending parenting classes/programs % of parents expressing increased knowledge of parenting styles and skills to address child misbehaviors % of change in family assessment indicators (over 20 indicators to assess home environment)

Economic Security

Name of program/activity/initiative	Individual and Family Self-Sufficiency
Description	The hospital will offer funding to support programs that provide families with the needed resources to support self-sufficiency, promote job skill training and/or higher learning.
Goals	Increase access to resources and support individuals and families seeking to achieve set goals.
Anticipated Outcomes	Increase access to community resources Increase access to employment or job training opportunities Increase budgeting knowledge
Plan to Evaluate	Internal data collection, referrals and individual/family assessments
2018 Impact	The Tracy Family Resource Center (TFRC) helps families build protective factors such as child development knowledge, parent/youth resilience, and access to concrete supports—primarily through parent skill building, resource referral, and working with other organizations to improve service access. The TFRC during this reporting period had a substitutional impact on the community. The TFRC completed approximately 4,742

	unique individual or family initial assessments reaching 2,568 adults and 2,174 children. In 2018, 5,250 referral were made including 1,199 to primary health care, 1,251 to basic needs and 1,810 to support services. In addition, 244 individuals were connect to health insurance resources and 249 to income assistance programs
Metrics Used to Evaluate the program/activity/initiative	# of resources/referrals provided # of case management individuals/families % of change in community resource knowledge % of change in employment % of change in budgeting knowledge

Injury and Violence

Name of program/activity/initiative	Domestic Violence Counseling and Support Services
Description	In an effort to break the cycle of violence, the hospital will support programs and services that will provide a safe haven and counseling for victims of domestic violence, sexual assault and human trafficking.
Goals	Support individuals and families in crisis
Anticipated Outcomes	Provide housing/shelter for victims of violence Improve knowledge of the cycle of violence among program participants Improve ability to express emotions without using violence
Plan to Evaluate	Intake assessments, pre and post surveys, observations
2018 Impact	Serenity House is a 12- bed undisclosed emergency shelter for domestic violence victims and their children. In 2018, the shelter provided services to 38 adults and 33 children including referrals to basic needs, transportation services, and crisis services. 85 individuals obtained shelter in 2018.
Metrics Used to Evaluate the program/activity/initiative	# of sheltered individuals escaping violence % of participants that demonstrate knowledge of phases of violence % of participants that demonstrate improvement in their ability to communicate and express emotions in a healthy ways

Access to Housing

Name of program/activity/initiative	Temporary and Transitional Housing
Description	Investments will be made to support local shelters and other temporary housing services that provide homeless individuals and families with basic needs as well as the wrap around services to promote self-sufficiency.
Goals	Support local shelter services so that they can continue to house the homeless seeking refuge and increase the ability for the individual/family to sustain permanent housing.
Anticipated Outcomes	Basic needs of shelter residents will be met Shelter residents will transition to permanent housing
Plan to Evaluate	Internal data collection
2018 Impact	McHenry House Tracy Family Shelter offers an opportunity to families to have a safe place to live while they turn their situation around by securing employment, saving their money and finding a place of their own to live.

	McHenry House can provide shelter for seven families daily for a period of 8 – 10 weeks. In 2018, 175 individuals including 65 adults and 110 children received services from the shelter including over 260 service referrals to housing, health education and other basic needs.
Metrics Used to Evaluate the program/activity/initiative	# of persons served # of referrals to social services # of referrals to mental health services % of shelter residents receiving counseling services % of shelter residents that transition to permanent housing

Access to Medical Care

Name of program/activity/initiative	Support of no or low cost medical and specialty care for uninsured
Description	Despite the increased access of medical care through the expansion of Medi-Cal and exchanges, there remains a population of uninsured individuals without the ability to pay for medical care. The hospital will support free and low cost clinics through grants to help ensure that affordable care remains available for those otherwise unable to afford medical attention.
Goals	Provide access to medical services for uninsured
Anticipated Outcomes	Provide medical care to uninsured individuals
Plan to Evaluate	Internal data collection
2018 Impact	No data available at time of report.
Metrics Used to Evaluate the program/activity/initiative	# of persons receiving professional medical care

Name of program/activity/initiative	Recuperative Care
Description	STCH will provide financial support to post-hospital recuperative care programs serving the homeless and indigent individuals.
Goals	Homeless individuals will recover from illness and injury in a supportive setting versus on the street.
Anticipated Outcomes	Individuals will successfully complete medical recovery. Individuals will not return to the referring hospital for the same issue within 30 days. Individuals will be discharged to permanent housing Individuals will be linked to a primary care physician for ongoing care Individuals will receive access to public assistance as eligible
Plan to Evaluate	Internal data collection
2018 Impact	The Recuperative Care Program provides post-hospital discharge recuperative care for homeless and indigent persons equivalent to the level of care normally provided by a responsible family member or friend. The program also provides social services case management to facilitate the recovered person being discharged from recuperative care into permanent housing utilizing all forms of available public assistance. In 2018, 171 unduplicated, homeless/indigent individuals were successfully referred from area hospitals to complete their medical recovery in a recuperative care environment. 124 of those individuals successfully completed their medical recovery and were discharged to safe,

	permanent housing with the necessary resources in place to sustain their housing placement indefinitely.
Metrics Used to Evaluate the program/activity/initiative	# of people served # of people connected to PCP # of encounters Average length of stay at homeless shelter # of persons case managed % of individuals completing recovery % of individuals discharged to permanent housing % of individuals being readmitted in 30 days post recovery

Name of program/activity/initiative	Transitional Care Services
Description	STCH will provide financial support to post-hospital, in-home, transitional care services to aid high risk patients in reaching an optimal recovery. So often individuals with chronic and highly complex disease states, who lack resources and family support, often fail to fully recover after discharge. Transitional care services provide the needed wrap around services to stabilize the individual's medical and social issues to increase their chances of a successful recovery.
Goals	Expanded access to services and social support
Anticipated Outcomes	Individuals will not return to the referring hospital for the same issue within 30 days. Individuals will be discharged to permanent housing Individuals will be linked to a primary care physician for ongoing care Individuals will receive access to public assistance as eligible
Plan to Evaluate	Internal data collection
2018 Impact	Tracy Community Connections Center (TCC) Inc, provides homeless persons and those at risk of homelessness with safety net of services, programs to improve their quality of life and reconnect them with the community. During this reporting period Tracy CCC served 69 adults and children with case management, emergency shelter, showers and/or hygiene supplies.
Metrics Used to Evaluate the program/activity/initiative	# of people case managed # of people connected to PCP # of people provided with transportation assistance # of people connected to other social services

Mental Health

Name of program/activity/initiative	Mental Health Services Expansion
Description	Behavioral and mental health services remain very limited within the hospital's service area. Most often, local residents are required to travel approximately 20 miles to access mental health services. STCH will be dedicating staff time to explore potential partnerships that will result in offering local services.
Goals	Increase mental health services in Tracy
Anticipated Outcomes	Provide a minimum of one new mental health service or program not currently existing in the Tracy area
Plan to Evaluate	Internal tracking

2018 Impact	In 2018, the partnership with Los Banos Unified School District Mental Health School Counseling Services partnership ended.
Metrics Used to Evaluate the program/activity/initiative	# of new mental health services/programs in Tracy

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
Plan to Evaluate	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.
2018 Impact	In 2018, through the Steinberg Institute and Sutter Health partnership, over 300 meetings were hosted, $2 billion was secured via Prop 2 for the “No Place Like Home” initiative that will fund up to 20,000 permanent supportive housing units across California and forged alliances that brought tech entrepreneurs together with county providers to advance approaches to treatment of mental illness.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

Oral Health

Name of program/activity/initiative	Tele Dentistry
Description	The CHNA found that tooth decay is the most common chronic disease among children ages 6-18. To address that issue, STCH will explore options that can efficiently and effectively deliver awareness and preventative dental hygiene services to youth in school.
Goals	Increase oral hygiene services among school aged children
Anticipated Outcomes	Increased dental services
Plan to Evaluate	Program data collection
2018 Impact	The Virtual Dental Home program has allowed many children the opportunity to receive much needed dental services at their home school

	site. These children would not have otherwise received these services due to obstacles such as transportation, or lack of education on the importance of oral health care. In 2018, 469 individuals received services through this program.
Metrics Used to Evaluate the program/activity/initiative	# of persons served # of services provided Types of services provided % of youth linked to dentist for ongoing care

Name of program/activity/initiative	Support of no or low cost dental care for uninsured
Description	STCH will support free and low cost clinics through grants to help ensure that dental care remains available for those otherwise unable to afford treatment.
Goals	Provide access to dental care services for uninsured
Anticipated Outcomes	Provide dental care to uninsured individuals
Plan to Evaluate	Internal data collection
2018 Impact	St. Mary's Dining Room provides medical and dental care to uninsured homeless and working poor individuals and families with a focus on the communities of Tracy, Banta, Mountain House, Lathrop and Manteca. In 2018, 225 people were served through this program.
Metrics Used to Evaluate the program/activity/initiative	# of persons receiving professional dental care

Needs Sutter Tracy Community Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Tracy Community Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

1. Education: When further evaluating the disparities regarding high school graduation and drop-out rates for residents in the hospital's service area, it was found that local residents are performing better than neighbors throughout the San Joaquin County in general. Tracy Unified School District data notes a significant reduction in drop-out rates and an increase in graduation rates within the last three years, and metrics are better than state rates. Based on these findings, there is no need for the hospital to implement plans to address this need.

2. Substance Use: Although the hospital does not have a specific strategy to confront this health issue head on, it does intend to indirectly address the priority finding through the various other interventions as mentioned in this report. Many of the strategies in this plan look to provide whole-person care, and will offer referrals to substance abuse resources to individuals as necessary.

3. Asthma/Air Quality: Due to limited resources and ability to impact environmental policies, the hospital does not intend to directly address this health issue. However, community benefit staff will remain engaged in building awareness, increasing prevention, and growing educational opportunities through involvement in the San Joaquin County Chronic Disease and Obesity Taskforce – Asthma and COPD Subcommittee.

Approval by Governing Board

The implementation strategy was approved by the Sutter Health Valley Area Board on November 17, 2016.

Appendix: 2018 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

The community benefit values for Sutter Valley 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 healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Services for the poor and underserved also include the cost of other services provided to persons who cannot afford healthcare 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.

2018 Community Benefit Value	Sutter Health Valley Hospitals
Services for the Poor and Underserved	$166,617,899
Benefits for the Broader Community	$18,902,651
Total Quantifiable Community Benefit	$185,520,550

This reflects the community benefit values for Sutter Health Valley Hospitals, the legal entity that includes Sutter Medical Center, Sacramento (including Sutter Center for Psychiatry), Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Davis Hospital, Sutter Roseville Medical Center, Sutter Solano Medical Center, Sutter Surgical Hospital North Valley, Memorial Hospital Los Banos, Memorial Medical Center, Sutter Tracy Community Hospital and Stanislaus Surgical Hospital. For details regarding the community benefit values please contact Kelly Brenk at (916) 541-0519 or BrenkKM@sutterhealth.org.

2018 Community Benefit Financials

Sutter Health Valley Hospitals

Services for the Poor and Underserved	
Traditional charity care	$32,030,397
Unpaid costs of public programs:	
Medi-Cal	$93,586,712
Other public programs	$27,680,690
Other benefits	$13,320,100
Total services for the poor and underserved	$166,617,899
Benefits for the Broader Community	
Nonbilled services	$8,273,490
Education and research	$2,437,624
Cash and in-kind donations	$7,591,258
Other community benefits	$600,279
Total benefits for the broader community	$18,902,651

This reflects the community benefit values for Sutter Health Valley Hospitals, the legal entity that includes Sutter Medical Center, Sacramento (including Sutter Center for Psychiatry), Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Davis Hospital, Sutter Roseville Medical Center, Sutter Solano Medical Center, Sutter Surgical Hospital North Valley, Memorial Hospital Los Banos, Memorial Medical Center, Sutter Tracy Community Hospital and Stanislaus Surgical Hospital. For details regarding the community benefit values please contact Kelly Brenk at (916) 541-0519 or BrenkKM@sutterhealth.org.