

## **Sutter Health**

### **Sutter Davis Hospital**

#### **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 Sutter Davis 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 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 Sutter Davis Hospital, 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

Sutter Davis 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 health and well-being of people in the communities we serve, through a not-for-profit commitment to compassion and excellence in health care services.

### Vision

Sutter Health leads the transformation of health care to achieve the highest levels of quality, access and affordability.

### Values

Excellence and Quality  
Caring and Compassion  
Honesty and Integrity  
Teamwork  
Community

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 Sutter Davis Hospital, please visit [www.sutterdavis.org](http://www.sutterdavis.org).

## 2013 Community Health Needs Assessment Summary

Every three years nonprofit hospitals are required to conduct community health needs assessments (CHNA) and use the results of these to develop community health improvement implementation plans. These requirements are imposed on virtually all nonprofit hospitals by both state and federal laws.

Beginning in early 2012 through February 2013, Valley Vision, Inc. conducted an assessment of the health needs of residents living in the service area of Sutter Davis Hospital. For the purposes of the assessment, a health need was defined as: “a poor health outcome and its associated driver.” A health driver was defined as: “a behavioral, environmental, and/or clinical factor, as well as more upstream social economic factors, that impact health.”

The objective of the CHNA is to provide necessary information for Sutter Davis Hospital’s community health improvement plan, identify communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.

The full 2013 Community Health Needs Assessment report conducted by Sutter Davis Hospital is available at <http://www.sutterhealth.org/communitybenefit/community-needs-assessment.html>.

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### Definition of Community Served by the Hospital

The assessment study area included the Sutter Davis HSA. A key focus was to show specific communities (defined geographically) experiencing disparities as related to chronic disease and mental health. To this end, ZIP code boundaries were selected as the unit of analysis for most indicators. This level of analysis allowed for examination of health outcomes at the community level that are often hidden when data are aggregated at the county level. Some indicators (demographic, behavioral and environmental in nature) were included in the assessment at the census tract level, census block, or point prevalence, which allowed for deeper community level examination.

The HSA was determined by analyzing patient discharge data. Collecting and analyzing the ZIP codes of patients discharged from the hospital over a six-month period allowed the primary geographic area served by the hospital to be identified. The HSA determined to be the focus of the needs assessment is depicted in Figure 2 in the full CHNA report.

To identify vulnerable communities, the first step was to examine socio-demographics in order to identify areas of the HSA with high vulnerability to chronic disease disparities and poor mental health outcomes. Race and ethnicity, household makeup, income, and age variables were combined into a vulnerability index that described the level of vulnerability of each census tract. This index was then mapped for the entire HSA. A tract was considered more vulnerable, or more likely to have negative or unwanted health outcomes, if it had higher: 1) percent Hispanic or Non-White population; 2) percent single parent headed households; 3) percent population below 125% of the poverty level; 4) percent population under five years old and 5) percent population over 65 years of age living in the census tract. This information was used in combination with input from the CHNA workgroup to identify prioritized areas from which key informants would be sought.

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To identify Communities of Concern, input from the CHNA team, primary data from key informant interviews and focus groups, along with detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. ZIP codes with rates that consistently exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, and mortality were considered. ZIP codes with rates that fell in the top 20% were noted and then triangulated with primary and socio-demographic data to identify specific Communities of Concern. This analytical framework is depicted in Figure 4.

The Sutter Davis HSA four Communities of Concern are home to more than 108,000 residents. The Communities of Concern consist of ZIP codes that include the cities of West Sacramento and Woodland and their outlying areas.

As noted earlier, these four ZIP codes are home to over 108,000 residents. Data indicated that these areas of the HSA included areas with high rates of poverty, low educational attainment, high unemployment, high uninsurance rates, and a high number of residents renting their homes. All four ZIP codes had rates of at least 41% of residents reporting to be either non-White or Hispanic, and in three of the four ZIP codes at least 50% of residents were non-White or Hispanic. The percent of residents over the age of five with limited English proficiency ranged from 7.7% in ZIP code 95691 to 21.3% in 95605.

Two of the four ZIP codes had a higher percent of single female-headed households living in poverty than the national average of 31.2%. Three of the four Communities of Concern had a higher percent of residents over age 65 years living in poverty compared to the national benchmark of 9%. Two of the ZIP codes had a percent of families with children living in poverty higher than the national benchmark of 15.1%.

All but one ZIP code had a higher percent of residents over the age of 25 without a high school diploma compared to the national average, with the highest being 34.4% in ZIP code 95605. All four of the ZIP codes had a higher percent unemployed compared to the national rate of 7.9%. All but one of the ZIP codes had a higher percent uninsured compared to the national rate of 16.3%, with 42.8% of residents in 95605 being uninsured. Looking at the percentage of residents in a ZIP code who rent versus own their place of residence provides a peak into a community's health and financial stability. The percent of residents who rent in the four HSA Communities of Concern ranged from 30% in 95776 to 57% in 95605.

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### Significant Health Needs Identified

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

Significant Community Health Need	Intends to Address
<p><b>Access to primary care and preventative services</b>            Cost of co-pays is prohibitive; Lack of providers who accept Medi-Cal patients; Clinics located mainly in population centers; creating challenges for rural populations; Long wait times or inability to secure appointments; People only seek treatment for acute conditions or serious injuries; Rural areas do not have urgent care facilities</p>	Yes
<p><b>Access to mental health and substance abuse services</b>            Limited services available, especially for uninsured and in rural areas; Stigma around seeking care, especially in professional community; Many programs and services have been cut due to lack of funding; Compliance with treatment can be difficult without support</p>	Yes
<p><b>Access to specialty care</b>            Extreme difficulty getting referrals for specialty care; Lack of chronic disease management support; Many travel out of area to Sacramento, Folsom, and Davis; Conditions requiring specialty services not properly managed (i.e., cancer treatment, pain management)</p>	Yes
<p><b>Access to affordable healthy foods</b>            Abundance of fast food in urban areas; Produce is often expensive or of poor quality in rural areas; Healthy foods are often more expensive; Farmers' markets are not accessible to rural communities</p>	No
<p><b>Improved transportation services</b>            Public transit routes not linked to healthcare or social service delivery points; Rural areas may not have any public transit options; Cost of gas prohibitive to accessing services; Elderly population in rural areas becomes isolated when they can no longer drive</p>	Yes
<p><b>Education on health and chronic disease management</b>            Need for more education about maintaining health and/or managing chronic health conditions; Need for education around healthy lifestyle choices; Many people do not understand how to care for themselves; Many classes are only open to those with insurance or cost is prohibitive; Cultural norms do not support healthy behaviors</p>	Yes
<p><b>Nutrition education</b>            People do not know how to read food labels or use fresh foods to prepare healthy meals; Cultural beliefs and diets may not support positive health outcomes</p>	No
<p><b>Access to dental care</b>            No Medi-Cal coverage for adults; extraction is often the only option; Long wait times for dental appointments; Lack of providers in rural area; Demand for services exceeds number of providers</p>	Yes
<p><b>Access to affordable medical care and medications for all</b>            Cost of prescription medication and equipment to manage chronic conditions; Individuals forced to choose between food, rent, or medication; No pharmacies in some rural communities</p>	Yes
<p><b>Safe places to be active</b>            Classes, gyms, and youth sports are too expensive for many low income families; Young people in rural areas do not have access to sports and activities; Cost of driving to activities is prohibitive, especially in rural areas; Many rural areas and some urban areas lack sidewalks and adequate lighting; Bears and mountain lions near some rural walking paths and parks</p>	No

Data were collected on health programs and support services within the HSA and the specific Communities of Concern. A list of assets was compiled and a master list was created. Next, detailed

information for each asset was gathered through scans of the organization websites and, when possible, direct contact with staff via phone. The assets are organized by ZIP code with brief discussion in the body of the report and detailed as Appendix H in the full report.

To identify Communities of Concern, input from the CHNA team, primary data from key informant interviews and focus groups, along with detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. ZIP codes with rates that consistently exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, and mortality were considered. ZIP codes with rates that fell in the top 20% were noted and then triangulated with primary and socio-demographic data to identify specific Communities of Concern. This analytical framework is depicted in Figure 4 in the full report. Data on socio-demographics of residents in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing status, 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 benchmarks or was consistently mentioned in the qualitative data.

The health needs identified through analysis of both quantitative and qualitative data are listed above. All needs are noted as a “health driver,” or a condition or situation that contributed to a poor health outcome. Health outcome results follow the list below. A full description of each of the health needs listed is provided in Appendix G in the full report.

## 2013 – 2015 Implementation Strategy

This implementation strategy describes how Sutter Davis Hospital 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.

## Access to primary care and preventative services

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Name of Program, Initiative  
or Activity

Investment in CommuniCare

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Description

As we prepare for the implementation of the Affordable Care Act, we understand that nothing is more important than expanding access to care and building capacity for the underserved. Currently, limited access to care remains the top priority in the greater Sacramento region, and while Sutter Davis Hospital funds and supports many initiatives and organizations that do amazing work in our community, the investments we provide to CommuniCare to expand capacity and access to care remain paramount.

SDH has been a longtime partner with CommuniCare and will continue to make strategic investments and provide support to this critically important network, as CommuniCare meets the needs of more and more people throughout Yolo County and the SDH HSA.

CommuniCare provides care to some of the most vulnerable populations in our region. By continuing to make strategic investments in this important health center, we are ensuring the underserved have access to care and a medical home. This Federally Qualified Health Center (FQHC) has been providing health care to those in need since 1972.

CommuniCare offers comprehensive primary medical and dental services, substance abuse treatment, behavioral health services, health education and support services in Yolo County and the surrounding communities through five community clinic sites and outreach programs. CommuniCare provides more than 20,000 behavioral health visits each year. The Behavioral Health department is comprised of four service categories; Adult Services, Adolescent Services, Family Services and Integrated Behavioral Health Services.

Additionally, CommuniCare Health Centers are dedicated to providing a patient centered health home for any individual we serve regardless of their point of entry into our system. The behavioral health team works closely with our medical, dental and perinatal providers to ensure that we are treating the entire individual. Physical examinations are provided to all clients entering our behavioral health programs. In addition, medically supervised detoxification services are offered for opiate and stimulant withdrawal.

One of the best and most cost-effective ways to prevent disease and promote healthy communities is to teach people how to take good care of themselves and their families. CommuniCare Health Centers provides comprehensive health education and outreach services throughout the county.

CommuniCare Health Centers remains committed to its founding purpose, which is to ensure that high quality health care is available to everyone who needs it, and to provide a full range of services from annual exams to pediatric immunizations to treatment for chronic diseases. Over the years, CommuniCare has been able to expand services to include dental, eye care and perinatal programs that meet the needs of our community.

By investing in CommuniCare and supporting this tremendous organization's growth and innovative efforts, we are able to address multiple priority needs in effective and impactful ways.

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**In addition to addressing the lack of access to primary and preventative services, SDH's partnership with CommuniCare helps expand access to affordable medical care and medications for all, access to dental care, access to mental health and substance abuse services, access to specialty care and education on health and chronic disease management.**

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**Anticipated Impact and Plan to Evaluate**

SDH will continue to work with CommuniCare staff to measure the impact of this important FQHC's work by tracking the number of people served, number of linkages to other referrals and services and other indicators, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

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**2014 Impact**

CommuniCare Health Centers January 1, 2014 – December 31, 2014  
Primary Care clinic sites: Davis Community Clinic (Davis), Salud Clinic (West Sacramento), Hansen Family Health Center (Woodland)  
Satellite clinics located at Woodland Community College (Woodland), Cache Creek High School (Yolo), Esparto Dental Clinic (Esparto), and Perinatal-only clinics in Winters and Dixon  
Total patient visits (all sites) : 106,796  
Total unduplicated users: 21,850  
2014 milestones: Opening of Hansen Family Health Center, March 2014  
Located at 215 W. Beamer Street, CommuniCare's new facility in Woodland is named in honor of Dr. Bob and Suzanne Hansen, longtime Woodland residents and supporters of CommuniCare. The new 21,010 square foot Hansen Family Health Center replaced the two sites CommuniCare had long occupied in Woodland, Peterson Clinic and John H. Jones Community Clinic. The Hansen Family Health Center provides 45% more space than CommuniCare's previous clinic facilities in Woodland, and has significantly increased our capacity for providing more patient care by adding exam rooms, dental operatories, behavioral health counseling rooms, and space for an array of health education and patient support services that are essential to improving and sustaining the health of our patients.  
CommuniCare Recognized with Highest Level Patient-Centered Medical Home Designation  
CommuniCare Health Centers received the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition for using evidence-based, patient-centered processes that focus on highly coordinated care and long-term, participative relationships to offer patients the best possible care. CommuniCare's three primary care clinic sites – Davis Community Clinic, Hansen Family Health Center in Woodland, and Salud Clinic in West Sacramento, have all achieved Level Three PCMH recognition, the highest level of recognition. The NCQA Patient-Centered Medical Home is a model of primary care that combines teamwork and information technology to improve care, improve patients' experience of care and reduce costs. Medical homes foster ongoing partnerships between patients and their personal clinicians, instead of approaching care as the sum of episodic office visits.

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<b>Mechanism(s) Used to Measure Impact</b>	We connect with CommuniCare leadership for various meetings, as well as quarterly updates on the number of patients served, types of services provided, recent successes/challenges and any other information that demonstrates the impact CommuniCare has on the greater community.
<b>Community Benefit Contribution/Expense</b>	\$400,000
<b>Program, Initiative, or Activity Refinement</b>	CommuniCare plays a critical role in Yolo County's health safety net and is critical to the underserved in the SDH health service area. We plan to continue our partnership with CommuniCare, constantly looking for new and innovative ways to collaborate and support the important work of this vitally important health clinic.
<b>Name of Program, Initiative or Activity</b>	<b>Free Mammography Screenings</b>
<b>Description</b>	<p>Working with Sutter Diagnostic Imaging Centers throughout the Sutter Health Sacramento Sierra Region, we offer the opportunity for uninsured women to receive free digital mammograms. In 2012, as a result of all of the collaborative events throughout the region, we were able to provide a total of 670 free and low-cost mammograms. At many of our mammography events, we have waiting lists and long lines, demonstrating that access to primary and preventative care continues to be a major issue in our region.</p> <p>Our goal is not only to screen uninsured women, but we also use these events as a connection point for the underserved members of our community, to link them with a primary care provider, follow up resources if needed, insurance enrollment information and other key services. We will have to examine the current model of this program in 2014, as under the Affordable Care Act, all women (with the exception of undocumented immigrants) will have insurance; therefore, we will reassess our process moving forward, as these events have typically targeted the uninsured only.</p> <p>New in 2013, we are integrating our ED Navigators into some of the screening events, as a pilot project, to provide onsite primary care referrals and other community resources to the women. Also, we integrated insurance enrollment specialists from Covered California to provide insurance education, outreach and enrollment to the women who need it most.</p>
<b>Anticipated Impact and Plan to Evaluate</b>	SDH will continue evaluate the impact of our Free Mammography screenings on an annual basis, by tracking the number of people served, number of linkages to other referrals and insurance enrollment, and by assessing the community's access to care needs in its next Community Health Needs Assessment. We will also reexamine this program with a critical eye in 2014, to ensure it evolves with the needs of the community

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after the implementation of the ACA.

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**2014 Impact**

Throughout the month of October, Sutter Diagnostic Imaging centers across the region provided uninsured/underinsured women the opportunity to receive free digital mammograms. As a result of these collaborative events, we were able to screen more than 400 uninsured women.

In 2014, we had Insurance Enrollment Specialists from Covered California attend some of the screening events to educate, connect and enroll patients who need it, in health insurance. As a result, the Covered CA team made many great connections with hundreds of women and will be following up with many of the women to help enroll them in insurance. In addition, we are integrated our ED Navigators into some of the screening events, to provide onsite primary and mental health care referrals and other community resources to the women. Connecting the un- and underinsured population to insurance and a medical home is more critical than ever, as we adapt to the implementation of the Affordable Care Act.

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**Mechanism(s) Used to Measure Impact**

We track the number of women who attend the free mammo events and receive a screening.

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**Community Benefit Contribution/Expense**

In-kind donations are contributed to this effort, including staff time, cost of screening, non-profit organization participation and staff follow up time, if screening is abnormal” instead of a hard number.

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**Program, Initiative, or Activity Refinement**

A major program refinement in 2013 and 2014 was integrating the Insurance Enrollment specialists and the ED Navigators. We continue to look at the model of this program, as it was designed to meet the needs of the uninsured only. With the implementation of the ACA, we see the number of uninsured shrinking, which is making us reconsider the model of this effort, as we want to ensure that we’re meeting the needs of as many underserved women as possible.

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## Improved transportation services

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**Name of Program, Initiative or Activity**

**Connectivity Study of Demand-Response and Supplemental Transportation Services to Improve Health Care Access across the SACOG Region**

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**Description**

In this project, the Sacramento Area Council of Governments (SACOG) will undertake a study to address greater connectivity and seamlessness for demand-response transit and supplemental service users needing to make cross-jurisdictional trips, particularly for health care services. The project includes significant opportunities for community and stakeholder involvement in the planning process, and seeks especially to address transportation barriers in the Sacramento region for senior, disabled, low-income, youth, and minority residents to reach health-care related services.

SACOG will lead this project, with significant participation and input from transit agencies, supplemental transportation providers, health care providers, and community stakeholders. SHSSR community benefit staff members have already begun discussions with SACOG staff and will play a role in the overall plan, to ensure transportation needs outlined in the CHNA are addressed.

This project has 3 overall goals: first to complete a public involvement process, feasibility/financial analysis, and final study for the Sacramento Region providing recommendations and implementation steps to improve connectivity for residents needing to make cross-jurisdictional trips, particularly to reach health care. Second, to create engagement opportunities for stakeholders and the community to inform, review, and prioritize potential improvements, and support implementation of recommendations. And finally, to facilitate discussion and longer term relationships between health care providers and transportation providers to better link planning efforts and foster partnerships to improve transportation access to health care-related services.

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**Anticipated Impact and Plan to Evaluate**

While this project is just getting underway, SDH will evaluate the progress and projected impact of this program as we move forward throughout the planning cycle.

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**2014 Impact**

There is no impact to report because SDH did not implement the program in 2014.

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**Mechanism(s) Used to Measure Impact**

No mechanisms were used because SDH did not implement the program in 2014.

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**Community Benefit Contribution/Expense**

N/A

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**Program, Initiative, or  
Activity Refinement**

At the time this implementation plan was created, this program was in early planning stages and still conceptual. Given the incredible need for expanded access to primary and behavioral health services, building capacity remained the top priority in the SDH health service area.

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## Needs Sutter Davis Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Davis 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. 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:

**Access to affordable healthy foods:** While the Davis Farmers Market is a tremendous step in the right direction, the CHNA cites that Farmers Markets are not accessible to rural communities. Unfortunately there a lack of effective interventions to address this need at this time, so we are focusing our resources elsewhere.

**Nutrition education:** While nutrition education is important, this need is not our primary focus, which is expanding access to care and building the capacity we so desperately need in Yolo County and the greater Sacramento Region.

**Safe places to be active:** This is primarily a law enforcement and city/county planning issue and not something that SDH has the expertise to effectively address.

## Approval by Governing Board

This implementation strategy was approved by the Governing Board of Sutter Davis Hospital on November 11, 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 Health Sacramento Sierra Region 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 Health Sacramento Sierra Region
<b>Services for the Poor and Underserved</b>	\$172,994,189
<b>Benefits for the Broader Community</b>	\$7,016,259
<b>Total Quantifiable Community Benefit</b>	\$180,010,448

*This reflects the community benefit values for Sutter Health Sacramento Sierra Region (SHSSR), the legal entity that includes Sutter Davis Hospital, Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Medical Center, Sacramento, Sutter Roseville Medical Center and Sutter Solano Medical Center. For details regarding the community benefit values specifically for SDH, please contact Kelly Brenk at (916) 541-0519 or BrenkKM@sutterhealth.org.*

**2014 Community Benefit Financials**  
**Sutter Health Sacramento Sierra Region**

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<b>Services for the Poor and Underserved</b>	
Traditional charity care	\$35,785,331
Unpaid costs of public programs:	
Medi-Cal	\$127,853,320
Other public programs	\$4,368,320
Other benefits	\$4,987,218
<b>Total services for the poor and underserved</b>	<b>\$172,994,189</b>

<b>Benefits for the Broader Community</b>	
Education and research	\$2,850,696
Cash and in-kind donations	\$3,793,322
Other community benefits	\$372,241
<b>Total benefits for the broader community</b>	<b>\$7,016,259</b>

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