

## **Sutter Health**

### **Sutter Delta Medical Center**

#### **2014 Community Benefit Plan Update**

Based on the 2013 – 2015 Community Benefit Plan

Responding to the 2013 Community Health Needs Assessment

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

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

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

## Introduction

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

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

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

## About Sutter Health

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

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

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

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

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

For more facts and information about Sutter Delta Medical Center, please visit [www.sutterdelta.org](http://www.sutterdelta.org).

## 2013 Community Health Needs Assessment Summary

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

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

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

Primary data collection for the assessment included input from 89 members of the hospital service area, expert interviews with 18 key informants, and focus group interviews with 71 community members. In addition, a community health assessment collected data on more than 68 assets in the greater East Bay area. Secondary data included health outcome data, socio-demographic data, and behavioral and environmental data at the ZIP code or census tract level. Health outcome data included emergency department (ED) visits, hospitalization, and mortality rates. Socio-demographic data included data on race and ethnicity, poverty (female-headed households, families with children, people over 65 years of age), educational attainment, health insurance status, and housing arrangement (own or rent). Behavioral and environmental data helped describe general living conditions of the service area such as crime rates, pollution, access to parks, and availability of healthy food.

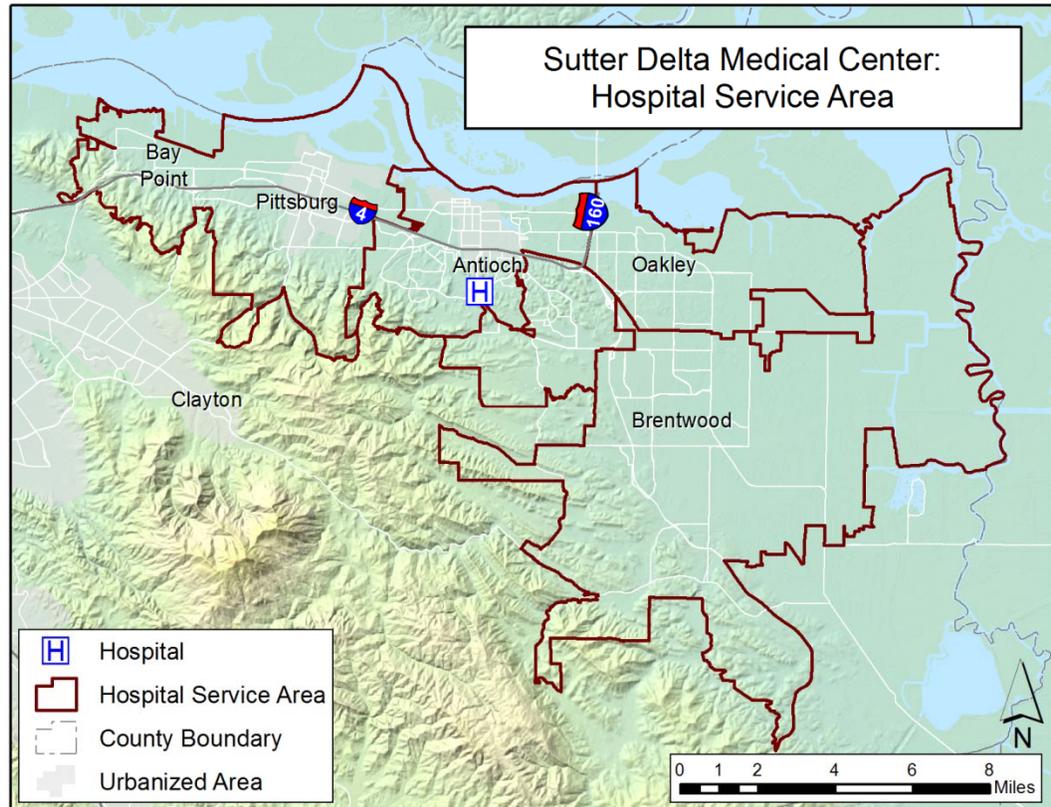
The health needs identified through analysis of both quantitative and qualitative data are as follows:

1. Lack of access to behavioral health services
2. Lack of access to primary care health services
3. Lack of access to affordable, healthy food
4. Safety as a health issue-mental health, crime, violence
5. Lack of access to dental care and preventative services
6. Pollution as a health issue
7. Lack of access to basic needs such as food, housing, jobs

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

**Definition of Community Served by the Hospital**

The Sutter Delta Medical Center primary service area is home to more than 278,000 community residents. The area consists of six Contra Costa County ZIP codes with a majority of community members living in the cities of Antioch, Pittsburg, Brentwood, and Oakley. These communities are situated along the Interstate 4 and 160 corridors and many reside on the bay.



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

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

**Significant Health Needs Identified**

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

Significant Community Health Need	Intends to Address
<p><b>Lack of access to behavioral health services</b>            Area experts and community members consistently reported the immense struggle service area residents had in maintaining positive mental health and in accessing treatment for mental illness. Mental health issues were the most commonly reported health issue by both key informants and community members. These included severe mental health issues as well as issues that arose from stress and anxiety brought on by living in a state of scarce resources and living in unsafe physical environments due to crime.</p>	No
<p><b>Lack of access to primary care health services</b>            Lack of access to health care was mentioned consistently by key informants and community members as a major barrier to healthy living. Specifically, lack of primary care providers, long wait times, cost of care, under or uninsured status, and lack of transportation to/from providers were stressed. Community members emphasized the difficulties they had with gaining access to care in a timely fashion, indicating that most of the time spent accessing care for health problems is reactive and not preventative, largely due to affordability and ease of access.</p>	Yes
<p><b>Lack of access to affordable, healthy food</b>            Healthy eating was the most commonly mentioned topic by key informants and community members as a major contributor to negative health outcomes for the community. The main concerns regarding healthy eating for the service area focused on access to affordable, quality healthy foods and on issues of food insecurity as evidenced by many liquor stores and convenience stores but few accessible grocery stores in the community.</p>	No
<p><b>Safety as a health issue-mental health, crime, violence</b>            Local experts and community members stressed the impact of safety on the health of residents. Five ZIP codes exceeded the state benchmark for emergency room visits due to assault, and three of the six exceeded the state benchmark for hospitalizations due to assault. The qualitative findings focused on the impact of violence, lack of safe places to live and exercise, being trapped in unsafe neighborhoods, and poor relationships between law enforcement and low income neighborhood residents.</p>	No
<p><b>Lack of access to dental care and preventive services</b>            Dental issues were a consistent finding from primary data collection and analysis. Dental and related issues were the fourth most frequently mentioned health issue by key informants and focus group participants. Issues included the lack of access to dental care, the high cost of dental care, and the detriment to health and wellbeing brought on by poor oral health.</p>	No

<p><b>Pollution as a health issue</b>  Both key informants and community members mentioned area pollution and air quality as a major contributor to poor health. The areas of Bay Point, Pittsburgh, and Central Antioch have higher pollution burden scores than the rest of the service area ZIP codes and are located on the largest portion of the bay. Environmental factors that produce this pollution burden include ozone and PM2.5 concentrations, diesel PM emissions, pesticide use, toxic emissions from facilities, traffic density, cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities.</p>	<p>No</p>
<p><b>Lack of access to basic needs: food, housing, jobs</b>  Many key informants noted that those who are poor and impoverished in the service area tend to struggle the most with health issues. Generational poverty, lack of jobs, poor nutrition, and housing challenges significantly influence the health status of the community.</p>	<p>No</p>

## 2013 – 2015 Implementation Strategy

On December 12, 2013, Sutter East Bay Hospital's Board of Directors passed resolution #13-12004 approving this Community Benefit IRS Implementation Strategy designed to respond to community health needs, defined as health drivers and health outcomes. Different than past community health needs assessments, the 2013 assessment focused on identifying specific vulnerable ZIP codes as communities most in need of support. In addition to the many community benefit programs and services provided throughout Sutter Health East Bay Region, this 2013-2015 implementation strategy is focused on responding to specific health needs of specific zip codes, including, but not limited to, those most vulnerable ZIP codes of Pittsburgh and Antioch.

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

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

This implementation strategy describes how Sutter Delta Medical Center plans to address significant health needs identified in its 2013 Community Health Needs Assessment and consistent with its charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations.

## Lack of Access to Primary Care Health Services

<b>Name of Program, Initiative or Activity</b>	<b>Emergency Department Utilization and Care Transitions with Federally Qualified Health Centers – La Clinica</b>
<b>Description</b>	The purpose of this initiative is to establish a stronger working relationship with La Clinica that will 1) improve care transitions for targeted patients between Sutter Delta Medical Center and La Clinica; 2) decrease non-urgent (Level 1 and Level 2) emergency department visits; 3) decrease readmissions of La Clinica patients to Delta; and 4) provide access for uninsured and underinsured patients.
<b>Anticipated Impact and Plan to Evaluate</b>	A strategic plan will be developed by <b>July 31, 2014</b> that will identify a cohort of targeted patients and establish specific objectives to ensure: 1) all targeted patients are connected to a medical home; 2) all targeted patients are connected, as appropriate, to community resources; and 3) there will be a 10% reduction in non-urgent emergency department utilization by La Clinica patients.
<b>2014 Impact</b>	The Care Transition Registered Nurse program was launched in December of 2014, and placed an RN Case Manager at the La Clinica de la Raza Monument site. Unfortunately the new hire was unable to continue in the position and left in January, delaying actual implementation. In February, the new RN was hired. The Care Transitions Nurse coordinates care for established La Clinica patients, Contra Costa Health Plan Members, regardless of assignment, and patients with MediCal with no established medical home (including those with presumptive MediCal), when they are discharged from the emergency department and inpatient settings. Uninsured patients without a health home were also linked to La Clinica as appropriate. Since the program began in March of 2015, 179 patients have been transitioned from the hospital to La Clinica. Of those, 107 (60%) kept follow up appointments with a primary care physician. Twelve patient slots are made available each week for patients referred from Sutter Delta.
<b>Mechanism(s) Used to Measure Impact</b>	Tracking system is in place that captures all inpatient and ED patients referred by Sutter Delta to La Clinica as well as the number of appointments made and kept. All patient encounters are noted in La Clinica's electronic health record. Community Health Center Network is also tracking patients in order to complete an annual evaluation.
<b>Community Benefit Contribution/Expense</b>	\$141,000
<b>Program, Initiative, or Activity Refinement</b>	Delta Community Benefit contributed funds to expand capacity at the La Clinica Monument Site. The clinic is now open an additional two evenings per week to further expand to four evenings in June of 2015.

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This increased capacity allows for same day appointments.

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**Name of Program, Initiative or Activity**      **Expansion of Sutter Delta Community Clinic**

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**Description**      Sutter Delta Community Clinic, a Community Benefit program of Sutter Delta Medical Center, provides drop-in care for uninsured East County residents six evenings each week. In 2012, more than 4,500 patients received care through the clinic. Currently, the Community Clinic is open 24 evening hours each week. The goal is to expand those hours from four hours daily to eight hours, six days each week.

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**Anticipated Impact and Plan to Evaluate**

- The Community clinic will expand its hours from four hours, six days each week to eight hours, six days each week by **June 30, 2014**.
- The clinic expects to increase the number of patients seen from 4,500 to 6,000 annually.

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**2014 Impact**      The Delta Community Clinic allows uninsured patients, who may otherwise have limited access to health care due to documentation status, access to urgent care. Instead of going to the ED for urgent care, these patients can get care at the community clinic on a sliding fee scale. A total of 3,490 patients were seen in 2014. This is a decrease from 2015, due in large part to the Affordable Care Act and increased eligibility for many of our vulnerable community members. Program hours were not expanded in 2014. However, that goal will be carried on through 2015. We anticipate expanding hours from 24 hours, 6 days each week to 32 hours, 4 days each week.

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**Mechanism(s) Used to Measure Impact**      Patients sign in when they arrive and their care is charted in the Electronic Health Record.

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**Community Benefit Contribution/Expense**      \$30,000

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**Program, Initiative, or Activity Refinement**      Expand opportunities for offerings such as increasing “point of care” testing to provide more information to providers. We anticipate reaching a goal of 10% decrease in readmissions among patients with congestive heart failure, heart attack, or pneumonia.

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**Name of Program, Initiative or Activity**      **Congestive Heart Failure Program**

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<b>Description</b>	In 2014, Sutter Delta Medical Center will implement a new Congestive Heart Failure Program designed to prevent patients' avoidable readmission after a diagnosis of congestive heart failure. After being discharged from the medical center, patients can be seen by a clinician at the Community Clinic and will receive an evaluation of their diet, medications, weight, and other risk factors in order to prevent hospital readmission.
<b>Anticipated Impact and Plan to Evaluate</b>	There will be a 10% decrease in readmission for patients discharged from the medical center with congestive heart failure.
<b>2014 Impact</b>	A new Congestive Heart Failure program, called Healthy Heart Program, was launched in July 2014. During the last 6 months of 2014, 63 patients were contacted within seven days of discharge. Fifty-three patients had telephone consultations and ten patients had face-to-face appointments. During those consultations, that lasted between 1-2 hours, both the patient and family/caregivers received extensive education centered on lifestyle modification critical to avoid readmission. This included sessions on healthy eating, weight, medication reconciliation, and any other lifestyle changes dealing with their primary diagnosis concerns. Of the 63 patients, fewer than 15% were readmitted within a 30 day time period. The program is staffed by a Nurse Practitioner (NP) and is open to patients 20 hours each week.
<b>Mechanism(s) Used to Measure Impact</b>	Patients sign in for each encounter with a Nurse Practitioner. All education provided and any monitoring of weight and blood pressure are documented in the Electronic Health Record. The NP also reviews lab results from the most recent visit. Readmission tools are in place and readmission audits are completed to determine readmission rates.
<b>Community Benefit Contribution/Expense</b>	\$6,000/month for NP salary, with a total of \$36,000 for the six months.
<b>Program, Initiative, or Activity Refinement</b>	The CHF program has now expanded to include acute myocardial infarctions and pneumonia and is now called the Healthy Heart Program for Chronic Conditions.
<b>Name of Program, Initiative or Activity</b>	<b>Diabetes Education Services</b>
<b>Description</b>	Sutter Delta Medical Center in collaboration with the Diabetes Center of Alta Bates Summit Medical Center will provide a recurring series of four classes a month serving approximately 100-200 Sutter Delta patients and Bay Point and Pittsburg residents. The education will include: 1)

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understanding the diabetes disease process and treatment options; 2) incorporating nutritional management and physical activity into their lifestyles; 3) using medications safely and for maximum therapeutic effectiveness; 4) monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making; 5) preventing, detecting, and treating acute and chronic complications; and 6) developing personal strategies that address psychosocial issues and concerns and promote health and behavior change.

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**Anticipated Impact and Plan to Evaluate**

At least 80% of participants will succeed in reaching personal action goals set in the first class. The goal is to support individuals with diabetes to improve the management of their disease and to avoid unnecessary emergency department visits or hospitalizations.

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**2014 Impact**

Four, 2-hour classes were offered monthly at Sutter Delta with a total of 206 patient visits.

90% of participants answered “very good” to questions regarding overall satisfaction and usefulness of class information.

95% of participants answered “very confident” or “confident” to the assessment of their ability to manage their diabetes following the class series.

80% of participants succeeded in reaching their self-care behavior or action plan goal by the fourth class.

Preliminary data is showing a 25% reduction in emergency department visits following diabetes education classes.

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

Tracking mechanisms include excel spreadsheet and emergency department use via EPIC records, # of patient encounters documented via sign-in sheets, patient action plans, and program evaluations.

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**Community Benefit Contribution/Expense**

\$25,000

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**Program, Initiative, or Activity Refinement**

Increased patient contact and data collection to assess reasons for referred patients not attending classes and reasons for patients not completing classes. Continued data analysis of emergency department use and re-hospitalization for one year post program completion.

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**Name of Program, Initiative or Activity**

**Asthma Resource Center (ARC)**

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<b>Description</b>	Reduce ED utilization and admissions of patients with asthma presenting at the Sutter Delta Emergency Department who may be more appropriately cared for in another setting, by developing an Asthma Resource Center modeled after the ABSMC Alta Bates Campus. The Asthma Resource Center (ARC) provides education, tools for asthma management, and medications, as appropriate, when ordered by a physician with a focus on uninsured and underinsured individuals.
<b>Anticipated Impact and Plan to Evaluate</b>	Support individuals with asthma to improve the management of their disease and to avoid unnecessary emergency department visits or hospitalizations.
<b>2014 Impact</b>	The ARC newly opened in October and served 15 people in 2014.
<b>Mechanism(s) Used to Measure Impact</b>	Tracking mechanisms include # of patients contacted, # of patients scheduled for in-person education, pre and post Asthma Control Test (ACT), and clinic follow up.
<b>Community Benefit Contribution/Expense</b>	\$25,000
<b>Program, Initiative, or Activity Refinement</b>	For 2015, we will build and utilize EPIC to track and manage patient data. In addition, we will establish a partnership with La Clinica to provide warm handoffs and on-site asthma education.
<b>Name of Program, Initiative or Activity</b>	<b>Save a Life Sister</b>
<b>Description</b>	Save a Life Sister provides breast cancer screening and diagnostic services for all adult residents of East Contra Costa County, who, due to low income and/or lack of health coverage do not have access to these services. If cancer is detected, a nurse navigator links women to treatment services. Education and support services are offered as well.
<b>Anticipated Impact and Plan to Evaluate</b>	Save a Life Sister will provide breast cancer screening and diagnostic services to 200 individuals annually, through clinical breast exams and, as indicated, screening and diagnostic services.
<b>2014 Impact</b>	Early screening allows a woman the best chance for successful treatment if breast cancer is found.

<b>Mechanism(s) Used to Measure Impact</b>	SALS utilize the same screening model of Every Woman Counts (EWC), a state and federal sponsored program, to ensure quality screening. Every individual is monitored annually or as needed via Electronic Health Record and with direct telephone contact.
<b>Community Benefit Contribution/Expense</b>	\$15,757
<b>Program, Initiative, or Activity Refinement</b>	Minor revision to ensure that patients are not getting a billing in error remains a challenge to resolve due to unreported and/or late discovery.
<b>Name of Program, Initiative or Activity</b>	<b>Access to Homeless Shelter in East Contra Costa County</b>
<b>Description</b>	Sutter Delta will reconnect and strengthen relationships with the Philip Dorn Center Respite Care Program and explore developing an Interim Care Program in East Contra Costa County in collaboration with Contra Costa County, John Muir, and Kaiser.
<b>Anticipated Impact and Plan to Evaluate</b>	<ul style="list-style-type: none"> <li>• Connection to homeless patients being discharged from Sutter Delta to a medical home</li> <li>• Connection of homeless patients to community resources</li> <li>• Reduction in ALOS for homeless patients</li> </ul>
<b>2014 Impact</b>	Sutter Delta reconnected and strengthened its relationship with the Phillip Dorn Center Respite Care Program. However, due to lack of funding and access to appropriate facility in East Contra Costa County, there was little interest among Kaiser or John Muir to collectively develop an Interim Care Program in East County. This project was not further pursued. However, the effort will be extended to 2015.
<b>Mechanism(s) Used to Measure Impact</b>	No mechanisms were used because the program was not implemented in 2014.
<b>Community Benefit Contribution/Expense</b>	Not Applicable
<b>Program, Initiative, or Activity Refinement</b>	Determine interest among other partners and continue efforts through 2015.

## Needs Sutter Delta Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Delta Medical Center is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. This implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2013 Community Health Needs Assessment:

1. Lack of access to behavioral health services
2. Lack of access to affordable, healthy food
3. Safety as a health issue-mental health, crime, violence
4. Lack of access to dental care and preventive services
5. Pollution as a health issue
6. Lack of access to basic needs such as food, housing, jobs

Sutter Delta Medical Center provides substantial financial assistance to uninsured and underinsured residents of East Contra Costa County. The primary need in this community is access to care. Thus the described enhancement of the onsite community clinic, improved access to primary care through enhanced relationships with local FQHC's, and targeted prevention initiatives will be the focus for 2013-2015.

## Approval by Governing Board

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

## Appendix: 2014 Community Benefit Financials

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

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

Services for the poor and underserved include traditional charity care which covers health care services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Services for the poor and underserved also include the cost of other services provided to persons who cannot afford health care because of inadequate resources and are uninsured or underinsured, and cash donations on behalf of the poor and needy.

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

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

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

**2014 Community Benefit Financials**  
**Sutter East Bay Hospitals**

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

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