Sutter Health
Memorial Hospital Los Banos

2019 – 2021 Community Benefit Plan
Responding to the 2019 Community Health Needs Assessment
Submitted to the Office of Statewide Health Planning and Development May 2020
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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 Plan describes how Memorial Hospital Los Banos, a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan 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 Plan 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.

Memorial Hospital Los Banos welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital’s address at Memorial Hospital Los Banos, ATTN: Brooke Galas, 520 West I Street, Los Banos, CA 93635; and
- In-person at the hospital’s Information Desk.

About Sutter Health

Sutter Health is nearly 60,000 people strong thanks to its integrated network of clinicians, employees and volunteers. Headquartered in Sacramento, California, Sutter Health provides access to high quality, affordable care for more than 3 million Northern Californians through its network of hospitals, medical foundations, urgent and walk-in care centers, home health and hospice services. Nearly 14,000 doctors and advanced practice clinicians care for Sutter patients.

Recognized as a national leader in quality and access, Sutter’s integrated healthcare system provides access to some of the best medical care in the country that outperforms state and national averages in nearly every quality measure. Through integration, Sutter Health fosters medical innovation and enables care teams to share best practices across the system. This gives patients access to a full range of treatments and services—helping lead to healthier outcomes.

Grounded in its not-for-profit mission, Sutter Health heavily reinvests in its communities, committing hundreds of millions of dollars annually to support programs and organizations that provide healthcare access and services for those in need. From deploying technology that improves the patient experience to supporting strong community partnerships, the strength of Sutter’s integrated system provides a model that can shape the future of healthcare.

Sutter Health’s total investment in community benefit in 2019 was $830 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients, as well as investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.
• As part of Sutter Health’s commitment to fulfill its not-for-profit status and serve the most vulnerable in its communities, Sutter hospitals, affiliated medical foundations and other healthcare providers offer charity care policies to ensure that patients can access needed medical care regardless of their ability to pay. Sutter’s charity care policies, which have been in place for many years, offer financial assistance to uninsured and underinsured patients earning less than 400 percent of the annually adjusted Federal Poverty Level. In 2019, Sutter Health invested $125 million in charity care, compared to $89 million in 2018.

• Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2019, Sutter Health invested $499 million more than the state paid to care for Medi-Cal patients.

• Examples of regional prioritized health needs include access to mental health and addiction care, disease prevention and management, access to basic needs such as housing, jobs and food, as well as increased access to primary care services.

See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

In addition, 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.

Through the 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Substance Abuse
2. Mental Health
3. Nutrition, Physical Activity, and Weight
4. Diabetes
5. Access to Health Services
6. Heart Disease and Stroke
7. Tobacco Use
8. Respiratory Diseases
9. Injury and Violence
10. Infant and Family Planning
11. Cancer
12. Kidney Disease
13. Dementia/Alzheimer’s Disease
14. Potentially Disabling Conditions
The 2019 Community Healthy Needs Assessment conducted by Memorial Hospital Los Banos is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the 2019 assessment on behalf of Memorial Hospital Los Banos in partnership with Mercy Medical Center Merced and Valley Children’s Hospital. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California. Community Health Insights also worked with Professional Research Consultants, Inc. (PRC) to complete the assessment. PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

The Community Health Needs Assessment (CHNA) incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the study sponsors and PRC and is similar to previous surveys used in the region, allowing for data trending.

The full 2019 Community Health Needs Assessment conducted by Memorial Hospital Los Banos is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The study area for the survey effort is defined as each of the residential ZIP Codes comprising Merced County, California. This community definition was determined based on the ZIP Codes of residence of recent patients of Mercy Medical Center Merced, Memorial Hospital Los Banos, and Valley Children’s Hospital. Merced County, the focus of this Community Health Needs Assessment, encompasses 1,935.21 square miles and houses a total population of 265,001 residents, according to latest census estimates. Merced County is predominantly urban, with 85.7% of the population living in areas designated as urban.

In looking at race independent of ethnicity (Hispanic or Latino origin), 58.6% of residents of Merced County are White, 3.4% are Black, 33.6% are some “other” race, and 4.4% are multiple races. Merced County is “younger” than the state and the nation in that the median age is lower. In Merced County, 30.1% of the population are infants, children, or adolescents (age 0-17); another 59.4% are age 18 to 64, while 10.5% are age 65 and older.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

1. **Substance Abuse** – Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes.

2. **Mental Health** – Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and
interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning.

3. **Nutrition, Physical Activity, and Weight** – Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

4. **Diabetes** – Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body’s cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

5. **Access to Health Services** – Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy. Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

6. **Heart Disease and Stroke** – Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

7. **Tobacco Use** – Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General’s report on tobacco was released in 1964.

8. **Respiratory Diseases** – Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

9. **Injury and Violence** – Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

10. **Infant and Family Planning** – Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.
11. **Cancer** – Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

12. **Kidney Disease** – Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

13. **Dementia/Alzheimer’s Disease** – Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person’s daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer’s disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

14. **Potentially Disabling Conditions** – There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the Memorial Hospital Los Banos service area. This included identifying 10 potential health needs (PHNs) in these communities. These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area.

Once identified for the area, the final set of significant health needs (SHN) was prioritized. To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus-group participants were asked to identify the three most significant health needs in their communities. These responses were associated with one or more of the potential health needs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need.

These two measures were next rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second-highest-priority health need, and so on.
2019 – 2021 Implementation Strategy Plan
The implementation strategy plan describes how Memorial Hospital Los Banos plans to address significant health needs identified in the 2019 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 2019 CHNA.

Prioritized Significant Health Needs the Hospital will Address: The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Memorial Hospital Los Banos initiatives that may not be described herein, but which together advance the hospital’s commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Mental Health
2. Nutrition, Physical Activity, and Weight
3. Access to Health Services

Mental Health

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Area Wide Mental Health Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>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. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the MHLB service area.</td>
</tr>
<tr>
<td>Goals</td>
<td>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.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>Number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.</td>
</tr>
</tbody>
</table>

Name of program/activity/initiative

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Telepsychiatry Program</th>
</tr>
</thead>
</table>
**Description**  
MHLB will invest in telepsychiatry technology to expand mental health care access for individuals living in the MHLB service area, providing 24/7 access to providers.

**Goals**  
To ensure patients are evaluated as soon as possible by a licensed psychiatrist.

**Anticipated Outcomes**  
System-wide, the service has completed over 1,283 consults since the initial launch in October.

**Metrics Used to Evaluate the program/activity/initiative**  
Number of consults, number of patients served, and number of services provided.

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### Nutrition, Physical Activity, and Weight

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Health Education and Physical Fitness Program for Youth</th>
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</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>We will invest in a comprehensive children’s wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, will teach students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>To teach children and their families healthy lessons about fitness, physical activity and the importance of nutritious eating.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcome of this program is teaching children and their families how to live a healthier and more active lifestyle, creating lifelong habits.</td>
</tr>
<tr>
<td><strong>Metrics Used to Evaluate the program/activity/initiative</strong></td>
<td>Number of children/families served, active schools, anecdotal stories and other successful program impacts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Movement Videos &amp; Games for Classroom Physical Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>We will invest in a suite of online movement videos and games designed to bring movement and mindfulness into elementary school classrooms and homes. The program improves classroom engagement by helping teachers channel students’ natural energy to improve behavior, focus, and achievement.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Our goals are: to facilitate physical activity, promote classroom engagement, reinforce core subjects and social/emotional learning, and improve academic achievement.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>Increased physical activity in schools resulting in decreased obesity for youth and better health outcomes.</td>
</tr>
<tr>
<td><strong>Metrics Used to Evaluate the program/activity/initiative</strong></td>
<td>Number of students served, number of minutes of physical activity and anecdotal stories.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>After School and Summer Programming for Youth</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Our investments will help startup a new youth recreation program in Los Banos to provide after school and summer programming for youth.</td>
</tr>
<tr>
<td>Goals</td>
<td>To provide youth with educational and physical fitness opportunities to build social and life skills as well as provide a safe place to be while their parents work.</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>We anticipate kids will increase their physical activity levels through this programming.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>Number of kids served, and anecdotal stories.</td>
</tr>
</tbody>
</table>

**Access to Health Services**

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Street Medicine Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>This program will deploy a team of medical professionals who can provide acute medical services and access to education through referrals to individuals who are experiencing homelessness. A Licensed Vocational Nurse (LVN) and a Community Health Worker (CHW) will connect with the homeless population by bringing medical services to them with the use of a Medical Van equipped with medical supplies to perform basic medical services such as wound care, blood pressure checks, and glucose checks.</td>
</tr>
<tr>
<td>Goals</td>
<td>Provide outreach, triage, mobile medicine, transportation, and referrals to the homeless community.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Increased access to primary and specialty care for individuals experiencing homelessness, which will result in decreased emergency room visits because patients will be able to better manage their health.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>Number of people encountered; number of patients treated; patient demographics; services provided; and number of referrals to support services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Respite Care for Individuals Experiencing Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Offered in partnership with a nonprofit homeless shelter, the respite care program is for homeless patients discharged from the hospital. The respite care program wraps people with health and social services, while giving them a place to heal. The program links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the program are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge.</td>
</tr>
<tr>
<td>Goals</td>
<td>The program seeks to connect patients with a medical home, social support and housing.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>The anticipated outcome of the program is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.</td>
</tr>
</tbody>
</table>
Needs Memorial Hospital Los Banos Plans Not to Address
No hospital can address all of the health needs present in its community. Memorial Hospital Los Banos 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 plan does not include specific plans to address the following significant health needs that were identified in the 2019 Community Health Needs Assessment for the following reasons:

1. **Substance Abuse** – Our plan does not address substance abuse directly, however, we anticipate our street medicine and respite care programs will help assist individuals experiencing substance abuse issues and refer them to appropriate resources.

2. **Diabetes** – While we will not invest in this area, our programs in healthy eating and active living will address the upstream social determinants of health which could lead to diabetes later in life.

3. **Heart Disease and Stroke** – While we will not invest in this area, our programs in healthy eating and active living will address the upstream social determinants of health which could lead to heart disease and stroke later in life.

4. **Tobacco Use** – We do not plan to address tobacco abuse directly, however, we anticipate our investments in youth programs will help encourage healthier lifestyle habits for kids that will lead to a decreased likelihood of tobacco use later in life.

5. **Respiratory Diseases** – We do not feel respiratory disease is as pressing as other health needs identified in our assessment for this community, so due to limited time and resources we are choosing not to address this health need directly.

6. **Injury and Violence** – Our implementation plan will not specifically address injury and violence, however our goal is to decrease the likelihood of injury and violence through investments in youth programs that will keep kids safe and in a positive environment.

7. **Infant and Family Planning** – While our community health programs are not focused on infant and family planning, the Memorial Hospital Los Banos Rural Health Clinic does provide Gynecology and Women’s Health services as well as prenatal care to underserved populations.

8. **Cancer** – We do not feel cancer is as pressing as other health needs identified in our assessment for this community, so due to limited time and resources we will not seek to address this health need directly.

9. **Kidney Disease** – We do not feel respiratory disease is as pressing as other health needs identified in this assessment, so due to limited time and resources we are choosing not to address this health need directly.

10. **Dementia/Alzheimer’s Disease** – Given limited time and resources and our focus on other priority needs, we will not be addressing dementia and Alzheimer’s during this implementation cycle. However, we will be increasing our mental health investments which could overlap with those experiencing dementia or Alzheimer’s.

11. **Potentially Disabling Conditions** – Given limited time and resources and our focus on other priority needs, we will not be addressing potentially disabling conditions during this implementation cycle.

Approval by Governing Board
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.
Appendix: 2019 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.

Community benefit programs 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. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.
Memorial Hospital Los Banos
2019 Total Community Benefit
& Unpaid Costs of Medicare

Total 2019 Community Benefit: $9,203,950

- Financial Assistance (Charity Care): $2,783,703
- Government-Sponsored Healthcare (Unpaid Costs of Medi-Cal): $6,008,051
- Other Community Benefits: $18,537
- Cash and In-Kind Donations: $335,280
- Subsidized Health Services: $19,357

There were no unpaid costs of Medicare in 2019