Sutter Health

SUTTER CENTER FOR PSYCHIATRY

2025 – 2027 Community Benefit Plan Responding to the 2025 Community Health Needs Assessment

Submitted to the Department of Health Care Access and Information
July 2026

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Table of Contents

Note: This Community Benefit Plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

General Information

Date written plan was adopted by organization's governing body	October 17, 2025
Date written plan was required to be adopted	May 15, 2026
Authorized governing body that adopted the written plan	Sutter Valley Hospitals Board
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body	July 21, 2022

Summary: 2025 Implementation Strategy

The Implementation Strategy (IS) describes how Sutter Center of Psychiatry (SCP), a Sutter Health system not-for-profit hospital, plans to address significant health needs identified in the 2025 Community Health Needs Assessment (CHNA) in calendar (tax) years 2025 through 2027.

The 2025 CHNA and the 2025 - 2027 IS were undertaken by the hospital to understand and address community health needs, in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The hospital reserves the right to amend this IS as circumstances warrant. As outlined in this document, SCP has identified the following significant health needs to be addressed in 2025-2027:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Access to Specialty and Extended Care
6. Active Living and Healthy Eating

SCP welcomes comments from the public on the 2025 CHNA and 2025 - 2027 IS. 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 7700 Folsom Blvd., Sacramento, CA 95826; and
- In-person at the hospital's Information Desk.

Sutter Health's CHNA reports and IS plans are publicly available online at *http://sutterhealth.org/about-us/community-benefit/community-health-needs-assessment*. In addition, the IS will be filed with the Internal Revenue Service using Form 990, Schedule H.

Introduction/Background

About Sutter Health

Sutter Center for Psychiatry (SCP) is affiliated with Sutter Health, a not-for-profit healthcare system dedicated to providing comprehensive, high-quality care throughout California. Committed to closing care gaps and driving innovative healthcare solutions, Sutter is pursuing a bold new plan to reach more people and make excellent healthcare more connected and accessible. Currently serving 3.6 million patients, thanks to our dedicated team of approximately 64,000 employees (including nurses) and 15,000+ affiliated physicians and advanced practice clinicians, with a unified focus on expanding care to serve more patients.

2025 Activities to Address Community Health Needs

As part of Sutter Health's commitment to fulfill its not-for-profit mission, Sutter invests deeply in the communities it serves to help close health care gaps and improve individual and community wellness. Sutter's investments in community benefit programs and services increased to nearly $1.2 billion in 2025, including $101 million in traditional charity care, $830 million in unreimbursed costs of providing care to Medi-Cal patients, $101 million in training, education and development of future health care professionals, as well as investments in programs to address identified community health needs.

In 2025, SCP's investments in community health programs addressed pressing community needs in three main priority areas: access to care, including chronic disease prevention and management; mental health and substance use treatment; and workforce development.

Learn more about how Sutter Health reinvests into communities and works to advance healthy outcomes for all by visiting *sutterhealth.org/community-benefit*.

2025 Community Health Needs Assessment Approach

Community Health Insights (*www.communityhealthinsights.com*) conducted the 2025 CHNA on behalf of SCP. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. [1] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with community health experts, social service providers, and medical personnel. Furthermore, community residents or community service provider organizations participated in focus groups across the service area. Finally, community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization (see Appendix A for CHNA participants)..

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as

[1] Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from *https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods*.

income, educational attainment, and employment. Further, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

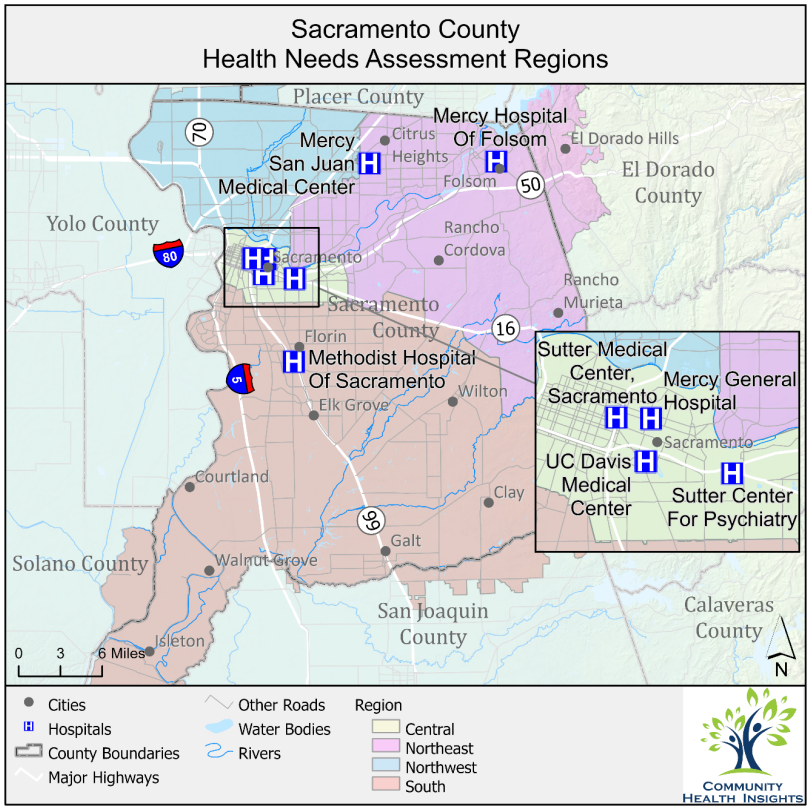
Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize SHNs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs (SHN). These SHN were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

Community Served

The definition of the community served included most portions of Sacramento County and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.6 million residents. The CHNA used this definition of the community served, as this was the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA (Figure 1).

Figure 1: Community served by SCP.



Selected population characteristics for SCP's service area are found in Table 1, below.

Table 1. Population Characteristics: El Dorado and Sacramento Counties		
	El Dorado	*Sacramento*
Total Population	*191,713*	*1,579,211*
Median Age (yrs.)	*46.2*	*36.8*
Median Income	*$*99,246	*$84,010*
% Poverty	*8.6*	*13.1*
% Unemployed	*4.6*	*6.3*
% Uninsured	*4.2*	*5.2*
% Without High School Degree	5.3	*11.6*
% With High Housing Costs	*34.6*	*37.4*
% With Disability	*12.3*	*12.3*
Race/ethnicity		
% White	*74.1*	*41.5*
% Asian	*5.0*	*17.2*
% Hispanic or Latino	*14.2*	*24.0*
% Black or African American	*0.8*	*9.1*
% Multiracial	*4.9*	*6.3*
% Another race/ethnicity	*0.5*	*0.5*
% Native Hawaiian or Pacific Islander	*0.1*	*1.1*
% American Indian or Alaska Native	*0.4*	*0.3*

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Significant Health Needs Identified in the 2025 CHNA

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. The following significant health needs were identified in the 2025 CHNA:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Healthy Equity
5. System Navigation
6. Safe and Violence-Free Environment
7. Increased Community Connections
8. Access to Specialty and Extended Care
9. Access to Functional Needs
10. Healthy Physical Environment
11. Injury and Disease Prevention and Management
12. Active Living and Healthy Eating
13. Access to Dental Care and Preventive Services

Sutter Health's Approach to Implementation Strategies

We are passionate about giving back to the communities that trust us with their health. As a not-for-profit health system, we improve health outcomes beyond the walls of our hospitals and care facilities through community benefit investments and collaborative partnerships. Community-based services, mobile clinics, transportation services, and prevention and wellness programs are among the ways Sutter Health seeks to put its mission into action. Our commitment to healthier lives begins with building stronger communities.

When creating our IS, we focus on innovative and effective strategies, collaborative partnerships and sustainable solutions to address the most pressing community health issues. Using the CHNA as our guide, we tailor our approach in each community to consider the unique needs of those living in the hospital service area. In addition to the CHNA, we also consider:

- Key stakeholder input from community leaders and service providers.
- Data analysis showing gaps in care for Medi-Cal and uninsured individuals.
- Where we can lend our health care expertise to provide valuable tools, perspective or services.
- Existing community capacity to determine where more resources are needed and avoid duplication of efforts.

We have streamlined our IS approach across the Sutter Health system to be more effective in meeting community needs and share best practices across regions. We have identified these three areas as our overarching community health goals:

- **Access to Care, including Chronic Disease Prevention and Management** – increase capacity and reduce barriers for vulnerable patients accessing primary and specialty care, and implement programs to prevent and manage chronic diseases.
- **Mental Health and Substance Use Treatment** – improve access to and quality of mental health and substance use disorder services in clinics, schools, community-based settings, and counties.
- **Workforce Development** – invest in the future generation of healthcare workers to improve the workforce pipeline and access to care.

Health Needs SCP Plans to Address

The health needs the hospital will address in 2025-2027 are:

1. **Access to Basic Needs Such as Housing, Jobs, and Food** – Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[5] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavioral Health and Substance Use Services** – Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Access to Quality Primary Care Health Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

4. **System Navigation** – System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems to receive the necessary benefits and supports to improve health outcomes. Research has shown that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

5. **Access to Specialty and Extended Care** – Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go together, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

6. **Active Living and Healthy Eating**- Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may experience food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals that may be lacking in sufficient nutrition for maintaining health.

SCP Implementation Strategies

To ensure we are meeting the needs outlined in our CHNA, each hospital's IS aligns with the prioritized health needs of the hospital's service area while also supporting our organization's strategic approach.

This IS describes how SCP plans to address significant health needs identified in the 2025 CHNA 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 2025 CHNA.

Below is an outline of the priority health needs SCP plans to by the end of 2027, as well as the goals and strategies we will implement to achieve the listed outcomes.

Priority Health Need	Goal	Strategies	Anticipated Outcomes	Outcomes
Access to Basic Needs Such as Housing, Jobs, and Food	Cultivate a talent pipeline, enhance workforce readiness, and support the broader community.	Invest in a skilled clinical and non-clinical healthcare workforce by supporting post-secondary allied health programs and students through tailored learning experiences, mentorship, tutoring, and other support services.	Program participants will have access to post-secondary allied health programs that provide education or job training and services to support housing and other basic needs.	In 2025, a capital investment was provided in support of technical improvements and capacity building for programs serving people experiencing homelessness.
		Prepare high school students for meaningful employment within the healthcare industry and other fields, through career pathways, mentorship, and social-emotional and academic supports.	High school students in the program gain access to education/job training programs for the skills, mentorship, and social-emotional support necessary to secure meaningful employment in healthcare and other fields.	In 2025, 6,398 youth received services through investments in this strategy, including: • 157 graduated from job training or an internship, • 73 healthcare workers were trained, and • 21,979 tutoring sessions were provided.

		Develop and improve sustainable career pathways in healthcare and other fields through investments in education, job training, technical and soft skill building, leadership development, employment services and supports, and financial coaching, among other programs and services.	Program participants will have access to education or job training and other services to support employment and address basic needs.	In 2025, 108 people were served through investment in this strategy, including 37 who graduated from a job training or internship program and nine who obtained employment.
		Increase employment readiness by investing in programs that foster personal, professional, and leadership development.	Program participants have access to education, job training programs and employment opportunities, and successfully complete these offerings	In 2025, 14 community members received mentorship services through an investment in this strategy.
		Invest in capital projects that expand the capacity of workforce development initiatives in healthcare and other fields to provide education, job training, technical and soft skill building, leadership development, employment services and supports, and financial coaching, among other programs and services.	Educational institutions, collaboratives, and community organizations will make progress towards providing access to education/job training programs and sites for the community.	In 2025, a capital investment was provided to expand the capacity of local healthcare workforce education programs, in anticipation of graduating 170 students per year.

Access to Mental/Behavioral Health and Substance Use Services	Cultivate community mental health by expanding access to inclusive, trauma-informed prevention, intervention, crisis and substance use disorder services through innovative, culturally responsive delivery systems.	Invest in a coordinated network of culturally responsive, trauma-informed, and community-based mental health and/or substance use prevention and intervention strategies—spanning prevention, crisis care and post-stabilization, housing and vocational support, integrated healthcare models, and workforce development—to optimize access, strengthen service capacity, and improve behavioral health outcomes for underserved, uninsured, and high-risk populations across all age groups.	Community members will have access to services addressing behavioral health, primary care and basic needs.	In 2025, 227 community members received services through investments in this strategy, including: • 62 who received behavioral health services, • 61 experienced improved mental health or substance use, and • 45 experienced reduced social isolation.
		Invest in youth mental health prevention through inclusive, trauma-informed programs to expand access, reduce disparities, and strengthen the future mental health workforce, promoting long-term community wellbeing and resilience.	Youth will have access to mental health and life skills education programs.	In 2025, 475 community members received services through investments in this strategy, which supported peer-to-peer and school based mental health training and support.

		Invest in mental health interventions for youth to address emotional and psychological challenges early, optimize access for underserved populations, and support the development of coping skills, resilience, and long-term mental wellbeing.	Youth will have access to services addressing behavioral health, primary care and basic needs.	In 2025, 951 community members, including 849 youth, received services through investments in this strategy. Of those assessed, 251 individuals who experienced improved mental health. Services provided included 32,862 individual or group behavioral health appointments.
Access to Quality Primary Care Health Services	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with Mobile and Street Medicine programs that serve individuals experiencing homelessness and other vulnerable community members by traveling to them, providing healthcare, and facilitating patient connection to housing and other wraparound services.	Community members access healthcare and other services that support health and address basic needs.	In 2025, 224 community members received services through investments in this strategy, including: • 35 who were enrolled in income assistance, • 24 who received primary health services, and • 16 who received specialty care services.
		Support implementation of Electronic Health Records (EHR) within Federally Qualified Health Centers (FQHC) to improve continuity of care for patients and promote integration of EHR systems across primary, specialty and acute care settings.	Federally Qualified Health Centers make annual progress toward implementation and/or successfully complete implementation of new Electronic Health Records.	In 2025, a capital investment was provided to support purchase and implementation of an EHR system, strengthening care coordination at a FQHC.

		Invest in safe and supportive short-term residential care to help community members experiencing housing insecurity heal from an illness or injury and transition to stable housing.	Program participants experience access to healthcare, housing and other community-based services that support health and address basic needs.	In 2025, 795 community members experiencing housing insecurity received respite and recuperative care through investments in this strategy. Of those, 233 individuals received shelter or transitional housing placements.
		Expand the capacity of community clinics to provide high quality primary healthcare services by investing in capital campaigns and programmatic support.	Community clinics make annual progress toward and/or complete capital projects and patients access primary care and other health services.	In 2025, 1,609 community members received services through investments in this strategy, including: • 1,366 accessed primary care services, • 994 accessed behavioral health services, and • 528 received support for managing a chronic condition.

System Navigation	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Support case management in clinical and community settings to ensure patients receive necessary wraparound services that address health related social needs and promote health and wellbeing.	Patients experience increased access to community-based services that address basic needs and healthcare.	In 2025, 4,149 community members received services through an investment in this strategy, including 3,473 who accessed primary care services.
		Invest in Community Health Worker/Promotores/ Navigator initiatives in which trusted community members connect individuals and families with community healthcare providers, clinics, care teams, and resources to address their health, social and/or economic needs.	Patients experience increased access to primary care and other community-based services that support health and address basic needs.	In 2025, 15,438 community members received services through investments in this strategy: • 1,942 who accessed primary care services, • 2,767 who enrolled in health insurance, • Other services provided included 23,395 health education services, 5,581 health care navigation services, and 3,599 screenings.
Access to Specialty and Extended Care	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Expand the capacity of community clinics to provide high quality primary healthcare services by investing in capital campaigns and programmatic support.	Community clinics make annual progress toward and/or complete capital projects and patients access primary care and other health services.	In 2025, 938 community members accessed specialty care through an investment in this strategy.

Active Living and Healthy Eating	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with programs that focus on chronic disease prevention, risk reduction, and management through improved access to screenings and treatment for chronic disease, health behavior and nutrition education, healthy and culturally appropriate foods, and physical activity opportunities for seniors, youth, and other vulnerable community members.	Community members experience access to chronic disease risk reduction education, screenings, and treatment, healthy foods, and physical activity opportunities.	In 2025, through an investment in this strategy, 1,544 community members received services, including over 1,000 meals that were delivered to low-income families and individuals.

Evaluation of Effectiveness

Sutter Health regularly monitors the impact and effectiveness of our community health strategies to ensure programs meet the needs of the communities we serve. We require all community partners who receive funding to report measurable outcomes, including but not limited to the outcomes identified in the table above, to demonstrate the impact of their programs. These reports help track program success, so that we may shift our strategies to more effectively meet the needs in the CHNA if needed.

Health Needs SCP Does Not Plan to Address

While no hospital can address all of the health needs present in its community, many health needs are interrelated. The following were not identified as the primary health needs to be addressed through this IS, though they remain important and are closely connected to our priorities: Healthy Equity, Safe and Violence-Free Environment, Increased Community Connections, Access to Functional Needs, Healthy Physical Environment, Injury and Disease Prevention and Management, and Access to Dental Care and Preventive Services.

SCP is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong community partner so that it can continue to give back to the areas we serve. To leverage our resources and expertise, we are prioritizing the needs we are positioned to most effectively address

Appendix A: 2025 CHNA Participants

Key Informant Interviews

Table A1 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table A1: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Sutter Medical Center Sacramento	03/20/2024	3	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Sacramento County Public Health	03/20/2024	4	Public Health	All residents of Sacramento County
Community Health Works (formerly Sac Covered)	03/21/2024	3	Healthcare outreach and enrollment	All residents of Sacramento County
Methodist Hospital	03/27/2024	4	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Wellspace Health	03/27/2024	1	FQHC: Healthcare services	Low income, medically underserved, racial or ethnic minorities
Mercy Hospital of Folsom	03/27/2024	4	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Sierra Health Foundation	03/27/2024	1	Community health	All residents of Sacramento County
Mercy General Hospital	04/01/2024	1	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Mercy San Juan Medical Center	04/03/2024	2	Acute Care Hospital: Healthcare services	All residents of Sacramento County
UC Davis Medical Center	04/04/2024	4	Acute Care Hospital: Healthcare services	All residents of Sacramento County
La Familia	04/24/2024	1	Behavioral, mental, physical health services; employment and education	Low income; medically underserved, racial or ethnic minorities; immigrants
Valley Vision	04/24/2024	1	Climate and environmental health	All residents of Sacramento County

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Mutual Assistance Center	04/25/2024	2	Community Based Organization; Social and economic infrastructure	Low income, medically underserved, racial or ethnic minorities
National Alliance on Mental Illness (NAMI)	04/25/2024	1	Mental health	All residents of Sacramento County
Sacramento Native American Health Center	05/01/2024	1	Healthcare services	Low income; medically underserved, racial or ethnic minorities
Sacramento Food Bank & Family Services	05/07/2024	1	Community based organization; social services	Low income, food insecure; immigrants and refugees
Roberts Family Development Center	05/13/2024	2	Education, advocacy, enrichment programs	Families in the Greater Sacramento Area
Pro Youth & Family	05/14/2024	1	Youth engagement, leadership development, mental health initiatives	Sacramento area youth
Greater Sacramento Urban League	05/16/2024	1	Economic self-reliance, education, civil rights	Black and other historically marginalized people
Neighborhood Wellness Foundation	05/17/2024	1	Community resources, education and advocacy	Del Paso Heights
CA Endowment Building Healthy Communities	06/05/2024	1	Initiative addressing health inequities	South Sacramento; low income, racial and ethnic minorities
WIND Youth Services	06/11/2024	1	Supportive services and resources	At risked, unhoused youth ages 12 - 24
Opening Doors	06/27/2024	2	Community resources, referrals and education	Immigrants, refugees, sex traffic survivors

Focus Groups

Table A2 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table A2: Focus group list.

Hosting Organization	Date	Number of Participants	Populations Represented
La Familia Counseling Center	06/18/2024	10	Low income and medically underserved; limited English-speaking
Latino Leadership Council	06/20/2024	7	Low income, at risk, limited English speaking
WIND Youth Services	06/26/2024	9	Youth experiencing homelessness; LGBTQ, Hispanic, African American
Neighborhood Wellness	07/02/2024	19	Low income, at risk, African American community members
Sacramento Steps Forward	07/08/2024	7	People experiencing homelessness
Sacramento LGBT Center	07/30/2024	9	LGBTQ community
Health Education Council	07/30/2024	8	At risk, underserved, low income; immigrants and refugees
Greater Sacramento Urban League	07/31/2024	4	Black and other marginalized populations; historically underserved individuals
Helping Hands St. Vincent De Paul Food Bank	07/31/2024	10	Low income, unhoused
Opening Doors	08/05/2024	7	Low income refugees
Asian Resources, Inc.	08/06/2024	8	Low income, immigrant, Asian
Folsom Cordova Partnership	08/08/2024	9	Economically challenged individuals and families

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to community residents of the HSA. Sixty-three respondents completed the survey. Survey respondents were asked if they would like the organizations they represented to be acknowledged in the report. The organizations represented by those respondents who requested acknowledgement are as follows. We thank all respondents for their participation in this process:

The Sacramento Environmental Justice Coalition (Sac-EJC.org), WellSpace Health, Sierra Sacramento Valley Medical Society, Society for the Blind, Turning Point Community Programs, Waking the Village, PRO Youth & Families, The Race and Gender Equity Project, Sacramento Steps Forward, WEAVE Inc., Consumers Self Help Center/Sustainable Wellness Solutions, Citrus Heights HART, World Relief Sacramento, Sacramento Regional Coalition to End Homelessness, Sacramento Area Congregations Together, Law Enforcement Chaplaincy Sacramento, Sacramento Regional Family Justice Center, Stanford Settlement Neighborhood Center, La Familia Counseling Center, Lutheran Social Services of Northern California, Project Lifelong, Wellspring Women's Center, YMCA of Superior California, Mercy Housing, Food Literacy Center, Hmong Youth and Parents United, Sacramento Kindness Campaign, Sacramento ACT, Neighborhood Wellness Foundation, First Step Communities, Greater Sacramento Urban League, Bridging Initiatives International, Community HealthWorks, International Rescue Committee (IRC), Sacramento, Opening Doors, Inc.

Appendix B: 2025 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 expenses are reported based on total cost incurred, offset by any restricted revenue received to determine net community benefit expense. 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 underserved 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 hospitals provide some or all of these community benefit activities.

Sutter Medical Center Sacramento
Total Community Benefits & Unpaid Costs of Medicare
For period from 01/01/2025 through 12/31/2025

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$11,821,259		$11,821,259
Medi-Cal	$118,830,987		$118,830,987
Other Means-Tested Government (Indigent Care)	$28,242,211		$28,242,211
Sum Financial Assistance and Means-Tested Government Program	**$158,894,457**		**$158,894,457**
Other Benefits			
Community Health Improvement Services	$723,660	$0	$723,660
Community Benefit Operations	$0	$464,932	$464,932
Health Professions Education	$0	$1,249,000	$1,249,000
Subsidized Health Services	$0	$1,189,690	$1,189,690
Research	$0	$238,258	$238,258
Cash and in-kind Contributions for Community Benefits	$8,945,767	$99,367	$9,045,134
Other Community Benefits	$0	$0	$0
Total Other Benefits	**$9,669,427**	**$3,241,247**	**$12,910,674**

Community Benefits Spending			
Total Community Benefits	**$168,563,884**	**$3,241,247**	**$171,805,131**
Medicare	$213,627,670		$213,627,670
Total Community Benefits with Medicare	**$382,191,554**	**$3,241,247**	**$385,432,801**