Sierra Nevada Memorial Hospital

2019 Community Health Implementation Strategy

Adopted October 2019

Dignity Health.
Sierra Nevada Memorial Hospital

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At-a-Glance Summary

Community Served

Sierra Nevada Memorial Hospital is located in western Nevada County and continues to be the only acute care hospital serving this region. The hospital's service area is home to nearly 75,000 residents, with over 27% of the population age 65 years of age and older. While a number of health resources are available within its more populated communities, Nevada County's rural environment contributes to barriers in accessing health care and health-related services for individuals and families living in the country. Therefore, the community is heavily dependent on the hospital to often serve all its health needs.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

1. Access to Basic Needs, Such as Housing, Jobs, and Food
2. Access to Mental, Behavioral, and Substance Abuse Services
3. Access to Quality Primary Care Health Services
4. Injury and Disease Prevention and Management
5. Access to Specialty and Extended Care
6. Safe and Violence-Free Environment

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

- Crisis Stabilization Unit (CSU): partnership with Nevada County Behavioral Health for patients experiencing acute mental health needs.
- Angel Bed Pilot Program: provide direct access to residential treatment beds for individuals experiencing addiction issues which have led to frequent interactions with law enforcement.
- Care Transitions: partnership with FREED to provide navigation and increase access to healthcare services for vulnerable populations.
- Emergency Department navigation program: connect patients with primary care services and assistance with scheduling follow-up appointments to decrease unnecessary return visits to the emergency department.
- Oncology nurse navigator: information and resource for low-income patients who otherwise may not have access to care.
- Alzheimer's Outreach Program: education and support to those caring for persons with Alzheimer's disease and other forms of dementia.
- Homeless Recuperative Care program: collaborative partnership with Nevada County Health and Human Services to provide shelter for those experiencing homelessness to receive housing assistance and wrap around services at Hospitality House.

Anticipated Impact 	The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Health and Outreach staff, hospital executive leadership, Board of Directors, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.
Planned Collaboration 	• Nevada County Public Health • Sierra Care Physicians • Nevada County Behavioral Health • Connecting Point • Granite Wellness Centers • Nevada County School District • Nevada County Sherriff • Aegis • Grass Valley • Turning Point • Western Sierra Medical Clinic • Sierra Mental Wellness • Chapa De Indian Health • Nevada County Superior Court • Common Goals • SPIRIT Peer Empowerment • Sierra Family Medical Clinic • FREED • Hospitality House • Communities Beyond Violence • National Alliance on Mental Illness (NAMI) • Wayne Brown Correctional Facility • Nevada County Sheriff Office • Nevada City Police Department • Falls Prevention Coalition • Sound Physicians • Swope Medical Group • AMI Housing • Dignity Health Tele-network • Sierra Care Physicians • Dignity Health Medical Group • California Forensic Medical Group

This document is publicly available online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

Written comments on this report can be submitted to the Sierra Nevada Memorial Community Health and Outreach Department at 3400 Data Drive, Rancho Cordova, CA 95670 or by e-mail to DignityHealthGSSA_CHNA@dignityhealth.org.

Our Hospital and the Community Served

About Sierra Nevada Memorial Hospital

Sierra Nevada Memorial Hospital (Sierra Nevada Memorial) is a member of Dignity Community Care, which is a part of CommonSpirit Health.

Sierra Nevada Memorial is situated in Nevada County, located at 155 Glasson Way in Grass Valley, CA. The service area for the hospital occupies the majority of the western portion of Nevada County, California. The hospital has expanded in numerous ways since opening in 1958 to meet the growing needs of the community. Today, the hospital has 850 employees and offers 104 licensed acute care beds and 18 emergency department beds. Additions have included an Ambulatory Treatment Center, a Community Cancer Center that is nationally accredited by the Commission on Cancer of the American College of Surgeons, state-of-the-art Diagnostic Imaging Center and Women's Imaging Center and Wound Care Healing & Hyperbaric Medicine Center. The hospital is a certified Primary Stroke Center by The Joint Commission and has earned the Gold Plus Achievement Award for Stroke from the American Heart Association and American Stroke Association.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Financial Assistance for Medically Necessary Care

Sierra Nevada Memorial delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

Sierra Nevada Memorial Hospital's community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives its top 80% of discharges. The hospital's service area encompasses seven zip codes in the communities of Grass Valley, Penn Valley, Rough and Ready, Nevada City, North San Juan and Washington (95945, 95946, 95949, 95959, 95960, 95975, and 95986). A summary description of the community is below. Additional details can be found in the CHNA report online.

Northwest of Lake Tahoe in the woodlands and forests of the Sierra Nevada Mountains, Nevada County is in the heart of California's historic Gold Country and includes the small cities of Grass Valley, Nevada City and Truckee, and nine other unincorporated cities. Since the Gold Rush of 1849, the region experienced a dramatic transformation of its landscape, with open-range cattle grazing, orchards, timber production and deep, hard-rock gold mining becoming economic mainstays. By the mid-1950s, however, the last major commercial mines closed and the traditional natural resource-based economy went into decline. By 1998, employment in agriculture, forestry and mining (together) in Nevada County dwindled to about 2% of all local jobs. Today, employment by sector paints a picture of economic health by industry in the County overall. The Service-Providing sector leads in the number of people employed (64.8%), followed by Government (20.7%), and Goods Producing (13.2%) sectors. Average weekly wages range from $473 in Leisure and Hospitality to $1,488 in Federal Government. This year, the number of jobs in the County increased from 31,380 to 32,840. There was a rise of a little over two percent in average weekly pay in the last year for Nevada County. This is in contrast to the one percent drop in average annual pay in California during the same time period. Nevada County's vibrant community, abundant natural beauty, location and natural resources provide a competitive advantage for employee attraction. Nevada County's top businesses include technology, health care, recreation, lodgings, grocery stores, schools, and other service providers.

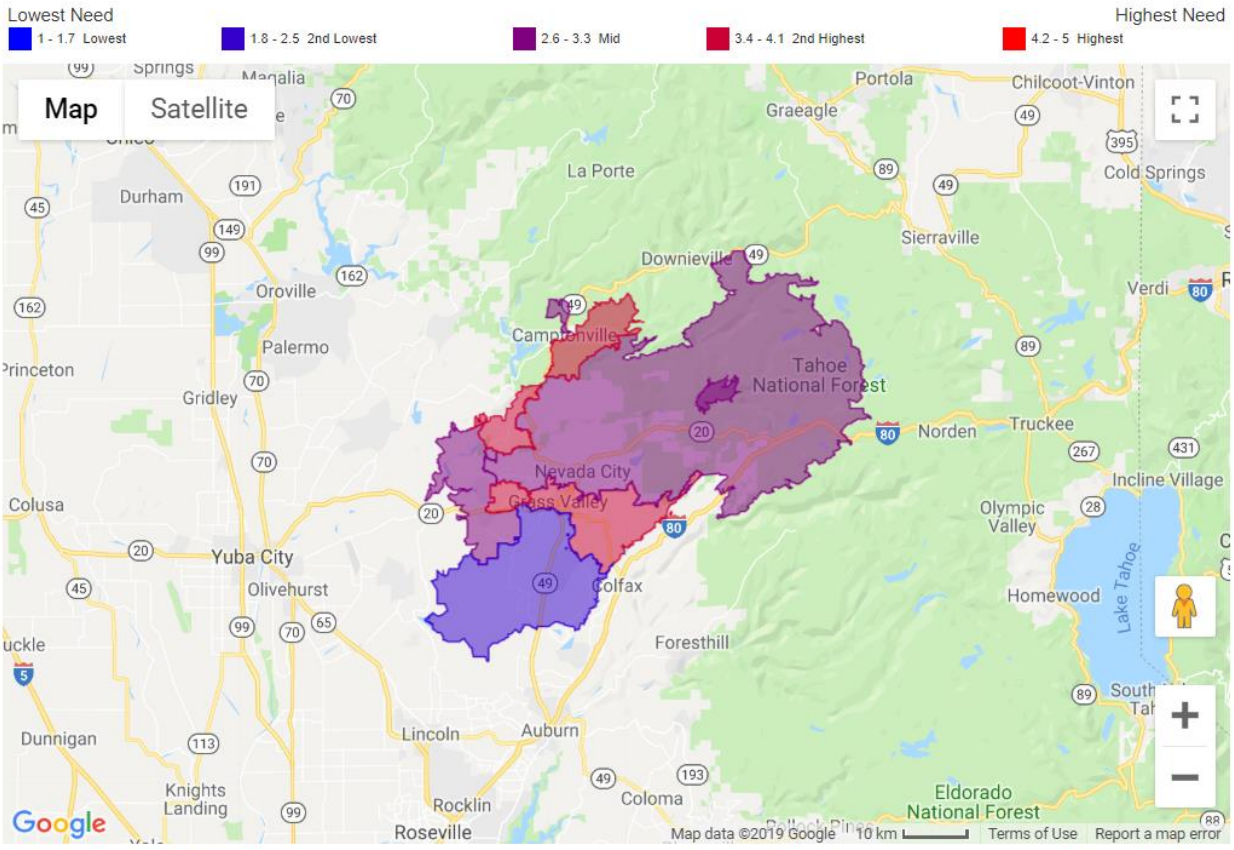
Demographics within Sierra Nevada Memorial's hospital service area are as follows, derived from 2018 estimates provided by Truven Health Analytics data:

- Total Population: 74,169
- Hispanic or Latino: 7.3%
- Race: 86.7% White, 0.6% Black/African American, 1.5% Asian/Pacific Islander, 3.9% All Other.
- Median Income: $54,284
- Uninsured: 8.9%
- Unemployment: 4.0%
- No HS Diploma: 6.3%
- CNI Score: 3.1
- Medicaid Population: 25.5%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 3.1 / Mean(person): 2.9 CNI Score Median: 3.1 CNI Score Mode: 2.8

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted June 2019. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment or upon request at the hospital's Community Health office.

Significant Health Needs

The community health needs assessment identified the following significant community health needs:

1. **Access to Basic Needs, Such as Housing, Jobs, and Food**: Includes economic security, food security/insecurity, housing, education and homelessness.
2. **Access to Mental, Behavioral, and Substance Abuse Services**: Includes access to prevention and treatment services.
3. **Access to Quality Primary Care Health Services**: Encompasses access to primary care resources which include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar.
4. **Injury and Disease Prevention and Management**: Contains health outcomes that require disease prevention and/or management and treatment including: cancer, cardiovascular disease/stroke, HIV/AIDS/STDs and asthma.
5. **Access to Specialty and Extended Care**: Encompasses access to specialty care and extended services including skilled nursing facilities, hospice care, in-home healthcare, etc.
6. **Access and Functional Needs – Transportation and Physical Disability**: Includes the need for transportation options, transportation to health services and options for person with disabilities.
7. **Active Living and Healthy Eating**: Encompasses all components of active living and healthy eating including health behaviors, associated health outcomes and aspects of physical environment/living conditions.
8. **Access to Dental Care and Prevention**: Encompasses lack of providers and access, especially in rural areas.
9. **Pollution-Free Living Environment**: Contains measures of pollution such as air and water pollution levels.
10. **Safe and Violence-Free Environment**: Consists of safety from violence and crime including violent crime, property crimes and domestic violence.

Significant Needs the Hospital Does Not Intend to Address

Sierra Nevada Memorial, as a rural community hospital, does not have the capacity or resources to address all priority health issues identified in Nevada County. The hospital is not directly addressing the

affordable and accessible transportation and active living and health eating priorities although programs are in place to assist community residents in limited capacity. In addition, the hospital will continue to seek collaborative opportunities that address needs that have not been selected as priorities. The hospital is not addressing access and functional needs – transportation and physical disability, pollution-free living environment and access to dental care and prevention, as these priorities are beyond the capacity and expertise of Sierra Nevada Memorial. However, the hospital will look for opportunities to coordinate and collaborate with other entities that offer programs that address these needs.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

Sierra Nevada Memorial is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners. The Community Board and Community Health Advisory Committee are composed of community members who provide stewardship and direction for the hospital as a community resource. These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity

- Demonstrate Collaboration

A general approach is taken when planning and developing initiatives to address priority health issues. At the onset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the Woodland Memorial leadership team, and Dignity Health leaders at the regional and local levels from Mission Integration, IT, Legal, Administration, and Finance. These core teams help shape initiatives, provide internal perspective on issues (i.e. utilization trends relative to the issue, gaps experienced in available follow-up or wraparound care for patients, etc.) and help define appropriate processes, procedures and methodologies for measuring outcomes.

The planning and development of each initiative also involves research on best practices to identify existing evidence-based programs and interventions, and relationship strengthening with community-based providers that serve target populations for intended initiatives. Once identified, community-based partners become part of the hospital's core project team. Core project teams for all initiatives meet quarterly, or as needed, to evaluate program progress and outcomes, and to make program changes and/or improvements. When target populations and priority health issues are shared by other Dignity Health hospitals in the Greater Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Access to Basic Needs, Such as Housing, Jobs, and Food

Strategy or Program Name	Summary Description
Homeless Recuperative Care Program	In FY18, Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services, to develop a 4-bed homeless recuperative care program. This program was approved by the County Board of Supervisors in August of 2018, and will begin services in October of 2018. The program will located at Hospitality House, and will

	provide recuperative care for up to 29 days, housing assistance, and wrap around services.

Anticipated Impact: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option.

Health Need: Access to Mental, Behavioral, and Substance Abuse Services

Strategy or Program Name	Summary Description
Nevada County Health Collaborative Integrated Network	Sierra Nevada Memorial was awarded Rural Health Network Development Program through Health Resources and Services Administration (HRSA). The program strengthens the collaborative network to increase access, integration, and coordination of rural health services including primary care, behavioral health, and telemedicine. In addition to addressing access to behavioral health services, this program also responds to access to high quality health care and services and disease prevention, management, and treatment.
Crisis Stabilization Unit	The Crisis Stabilization Unit (CSU), operated by Nevada County, is a 23-hour 4-bed mental health urgent care and crisis unit on the hospital campus. The CSU is an innovative partnership between the Sierra Nevada Memorial and Nevada County Behavioral Health in which the hospital leases the land at no fee and funds 3 dedicated psychiatric beds in the unit. The CSU allows patients in acute psychiatric crisis to receive rapid access to appropriate care for their psychiatric emergency.
Mental Health Crisis Support Partnership	Nevada County contracted mental health crisis workers assist patients in the hospital's emergency department, providing support, identifying placement, and creating safe discharge plans. The program addresses the urgent need for mental health services and the steady increase emergency department crisis evaluations.
Tele-Psychiatry	Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care. Access is available to both the ED and inpatient setting. In 2018 Sierra Nevada Memorial provided funding through the HRSA grant to Western Sierra Medical Clinic (WSMC) to purchase tele-health equipment for their clinic. In FY19, additional community based clinic will receive funding for the implementation of tele-psychiatry services through the HRSA grant.
Addiction Treatment Navigation Program	Through a partnership with Granite Wellness Centers, the program provides a dedicated Chemical and Alcohol Dependency Counselor who works regular hours in the hospital emergency department, and on the inpatient floors to connect with patients struggling with addiction issues, and identify treatment services and funding that meets each patient's

	individual needs. In FY19, Nevada County Behavioral Health will add a mobile access worker who will come to the hospital to expedite the access to Drug Medi-Cal funds for these patients.
Angel Bed Pilot Program	Sierra Nevada Memorial's Community Grants program funded a collaboration between Grass Valley Police Department, Granite Wellness Centers and Western Sierra Medical Clinic. This program allows for "bridge bed funding" for patients with high law enforcement involvement due to their addiction to access immediate residential addiction treatment services.
Data 2000 Waiver Training and Medication Assisted Treatment Policy	Supported physicians in obtaining the Data 2000 DEA waiver, and developed a nursing Buprenorphine Induction policy and procedure, and trained nurses on the new policy. This new induction program allows patients to begin treatment while hospitalized, and then through navigation program, these patients experience a seamless transition to community based Medication Assisted Treatment programs.
Screening Brief Intervention and Referral to Treatment Training	Training provided by UCLA to clinicians in the hospital on Screening Brief Intervention and Referral to Treatment training, and motivational interviewing techniques to improve the opportunities to link patients to new addiction treatment resources.
Integrated Care Coordination to Family Wellness Program Expansion	Through the Community Grants, the collaborative including FREED Center for Independent Living, Granite Wellness Centers and Western Sierra Medical Clinic (WSMC) focuses on care transition and patient navigation between organizations and services and develops a "no wrong door" system of referral. This collaborative addresses all three priority health needs by increasing access to primary, mental health, substance use, and preventative health care for vulnerable populations.

Anticipated Impact: These programs and services are intended to grow and strengthen the services and resources available in the community. These efforts aim to improve the ease of access to quality services, remove barriers, expand capacity, and create a coordinated continuum system of care thereby improving behavioral health outcomes and reducing the negative health and social impacts of behavioral health conditions on individuals and the community.

Health Need: Access to Quality Primary Care Health Services

Strategy or Program Name	Summary Description
Emergency Department Based Primary Care Navigation	The Patient Navigator program focuses on assisting patients who rely on emergency departments for non-urgent needs. The navigators connect patients to a medical home and assist them with scheduling a follow up appointment along with identifying any barriers that may create obstacles with accessing ongoing care. The Patient Navigator Program represents a unique collaboration between California Health and Wellness, a Medi-Cal insurance plan, and the hospital.

Western Sierra Medical Center Navigation Program	With funding from the HRSA grant, this program provides education on accessing primary care, assists patients in scheduling appointments, provides reminder and follow up calls, and assesses the patient's barriers to care. This program also targets high ED utilizers and patients with frequent readmissions, and those needing ongoing community case management.
Financial assistance for uninsured/underinsured and low income residents	The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy.
Dignity Health Community Grants Program	Conducted annually by the hospital, the Dignity Health Community Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to care, and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.

Anticipated Impact: The hospital's initiatives to address access to high quality primary care health and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; and improve collaborative efforts between all health care providers.

Health Need: Injury and Disease Prevention and Management

Strategy or Program Name	Summary Description
Cardiac Rehabilitation	Exercise and education provided to patients during rehabilitation from a cardiac related event or surgery.
Care Transition Intervention Program	The Care Transition Intervention Program is an evidenced based program offered in partnership with FREED. This is a model that utilizes coaching methods to assist patients with high risk of readmission, or highly complex health and social needs post hospitalization in managing their own health condition successfully. Patients are followed for 30 days post discharge, including a home visit.
Complex Discharge Management Assistance	Care Coordination provides a number of services to patients at discharge with challenges accessing resources necessary to healing including transportation, clothing, medication and transitional housing.
Support Groups	Hospital-sponsored support groups for cancer, brain injury, pulmonary issues, and stroke provide an opportunity for patients and family members to share their concerns while learning to manage their condition
Alzheimer's Outreach Program	The hospital's Home Care Department, in collaboration with Sierra Nevada Memorial Hospital Foundation, and Nevada County Health and Human Services offers an Alzheimer's Outreach Program that serves as a unique community education, resource and support center. A licensed social worker is dedicated to the program who provides education and

	caregiver support via home visits and personal consultations, and links those that need specialized care to important resources, including assisted living/care centers.
Falls Prevention Program	The program, offered in partnership with the hospital, Sierra Nevada Memorial Hospital Foundation, and the Falls Prevention Coalition, provides education to the community about fall risk factors and prevention strategies for older adults and caregivers. Participants also learn appropriate exercises for enhanced balance and strength.
Diabetes Empowerment Education Program (DEEP™)	The Diabetes Empowerment Education Program™ (DEEP™) is an evidence-based diabetes education program for people with diabetes or prediabetes. DEEP encourages lifestyle changes while learning about diabetes and how it can impact the quality of life. The hospital has partnered with Nevada County Public Health and Connecting Point with HRSA grant funding to offer workshops in the community at no cost, including targeted outreach to diabetic and pre-diabetic clients utilizing community food bank services.
Chronic Disease Self-Management Program (CDSMP)	The Chronic Disease Self-Management program (CDSMP) is an evidenced based chronic disease workshop. In FY18, with HRSA grant funding support, the hospital again partnered with Connecting Point to provide these programs at no cost to the community.
Social Determinants of Health Assessment Program	In FY18 the hospital developed a Social Determinants of Health Assessment form to help to more broadly identify patients who may benefit from community services and resources. Through a HRSA grant funded partnership with Connecting Point, patients will be contacted to receive assistance in accessing resources.
Anticipated Impact: The initiatives in place to address this health need are anticipated to result in: a reduction of hospital admissions related to poor chronic disease management; prevent chronic disease; improve the health and quality of life for those with a chronic illness; enable participants to manage their disease by creating a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.	

Health Need: Access to Specialty and Extended Care

Strategy or Program Name	Summary Description
Congestive Heart Active Management Program (CHAMP®)	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits.
Oncology Nurse Navigator	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis

	onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Hepatitis C Eradication Program	The building of the collaboration for this program began in 2018 and is a partnership between Sierra Nevada Memorial Hospital, Sierra Nevada Gastroenterology, Nevada County Public Health, and FREED. This program targets low income, uninsured, underinsured, and homeless individuals who have received a positive Hepatitis C diagnosis, and assist in navigating through the health system to access the new medications available with the potential to cure this disease. FREED will utilize the Care Transitions Intervention coaching model and assist patients in obtaining insurance and a primary care provider as necessary, and will remain in contact with the patient throughout the length of their HCV treatment at Sierra Nevada Gastroenterology.
Tele-Endocrinology	Sierra Nevada Memorial Hospital plans to expand its tele-health specialty care access in the ED and inpatient setting with the addition of Tele-Endocrinology services.

Anticipated Impact: The hospital's initiatives to address access to specialty and extended care services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; and improve collaborative efforts between all health care providers.

Health Need: Safe and Violence-Free Environment

Strategy or Program Name	Summary Description
Human Trafficking Community Response Program	The Human Trafficking Community Response Program initiative focuses on: Educating staff to identify and respond to victims within the hospital; Provide victim-centered, trauma-informed care; Collaborate with community agencies to improve quality of care; Access critical resources for victims; and Provide and support innovative programs for recovery and reintegration.

Anticipated Impact: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Crisis Stabilization Unit	
Significant Health Needs Addressed	❑ Access to basic needs, such as housing, jobs, and food ✓ Access to mental/behavioral/substance abuse services ❑ Access to quality primary care health services ❑ Injury and disease prevention and management ❑ Access to specialty and extended care ❑ Access and functional needs ❑ Active living and health eating ❑ Access to dental care and preventive services ❑ Pollution-free living environment ✓ Safe and violence-free environment
Program Description	The Crisis Stabilization Unit (CSU) is a 4 bed, 23 hour mental health facility on the hospital campus. It opened in partnership with Nevada County Behavioral Health serving primarily Medi-Cal patients experiencing an acute mental health condition. Nevada County Behavioral Health contracts with Sierra Mental Wellness to staff and operate the CSU.
Community Benefit Category	E1-a Cash Donations - General contributions to nonprofit organizations
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Continued strengthening partnerships to link more individuals to care in the CSU resulting in a further reduction of ED boarded length of stay and ultimately improving the quality of care for the patient. Reduce time to CSU transfer.
Measurable Objective(s) with Indicator(s)	Length of psychiatric boarding time in ED, number of inpatient placements. Number of tele-psych consults
Intervention Actions for Achieving Goal	Continue working collaboratively with partners to create a seamless transition of care including monthly interactions and meetings with CSU staff to monitor and evaluate program success and challenges and develop monthly reports on data that can be shared between partners
Planned Collaboration	Sierra Nevada Memorial Hospital, Swope Medical Group, Nevada County Behavioral Health, Sierra Mental Wellness, Law Enforcement Agencies

Emergency Department Navigation Program	
Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ❑ Access to mental/behavioral/substance abuse services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ✓ Access and functional needs ❑ Active living and health eating ❑ Access to dental care and preventive services ❑ Pollution-free living environment ❑ Safe and violence-free environment
Program Description	The Patient Navigator program focuses on assisting patients who rely on emergency departments for non-urgent needs. The navigators connect patients to a medical home and assist them with scheduling a follow up appointment along with identifying any barriers that may create obstacles with accessing ongoing care. The Patient Navigator Program represents a unique collaboration between California Health and Wellness, a Medi-Cal insurance plan, Western Sierra Medical Clinic, and the hospital.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Contact 100% of California Health and Wellness patients presenting to the emergency department for non-emergent health conditions. Assess barriers, connect patients to medical home, and assist in scheduling a follow up appointment as needed. Support patient in attending follow up care with their primary care provider to improve primary care access and reduce inappropriate ED utilization and recidivism.
Measurable Objective(s) with Indicator(s)	Number of patients served, services provided, and follow up appointments scheduled. Identify primary barriers to care and directly identify and assist high utilizers.
Intervention Actions for Achieving Goal	Meet with FQHC's to facilitate expedited access to follow up appointments. Communicate regularly with navigators and health plan regarding trends, resources needed and challenges connecting patients to care.
Planned Collaboration	Sierra Nevada Memorial Hospital, the local FQHC's, and California Health & Wellness.

Oncology Nurse Navigator	
Significant Health Needs Addressed	❑ Access to basic needs, such as housing, jobs, and food ❑ Access to mental/behavioral/substance abuse services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Active living and health eating ❑ Access to dental care and preventive services ❑ Pollution-free living environment ❑ Safe and violence-free environment
Program Description	The Oncology Nurse Navigator is designed to help patients navigate the maze of options related to cancer and to complement and enhance services provided by physicians. Nurse navigators provide information, resources and referrals for follow-up biopsies and other treatments that low-income patients otherwise would not be able to access. In addition, through this program patients are linked to survivor peer support partners.
Community Benefit Category	A3-g Health Care Support Services - Case management post-discharge
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Continue to improve access to low cost and no-cost treatments and the continuity of care by navigating patients through the process of obtaining appropriate resources and referrals in a timely manner and serve as an educational resource for patients and their families.
Measurable Objective(s) with Indicator(s)	Increase outreach to FQHC's and Community Clinics on low cost or no cost mammography. Increase the number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners. Continue to provide education within the community setting.
Intervention Actions for Achieving Goal	Continue to promote services in the community and work with hospital and community partners to increase awareness of services and resources. This includes working with our patient navigators in the ED and community clinics who serve the underserved.
Planned Collaboration	Cancer nurse navigators continue to work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance. Current partnerships include peer support, Sierra Family, Western Sierra Medical Center (WSMC) and Chapa-De.

Angel Bed Pilot Program	
Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ✓ Access to mental/behavioral/substance abuse services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Active living and health eating ❑ Access to dental care and preventive services ❑ Pollution-free living environment ✓ Safe and violence-free environment
Program Description	This is an innovative partnership funded by the hospital's community grants program and brings together Granite Wellness Centers, Grass Valley Police Department (GVPD), and Western Sierra Medical Clinic (WSMC) to provide direct access to residential treatment beds for individuals whose addictions issues have led to frequent interactions with law enforcement. This program hopes to reduce the negative long term impact of addiction by offering an alternate to incarceration through addiction treatment.
Community Benefit Category	E2-a Grants - Program grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Remove barriers to immediate residential treatment access and leverage the moment of potential increased motivation to enter treatment due to interaction with law enforcement. Impact includes increased willingness to enter treatment, improved access to treatment, successful participation in treatment, and reduced future interactions with law enforcement. Through financial support from Nevada County, direct bed capacity has been expanded and they dedicated one mobile access worker to expedite access Drug Medi-Cal funding.
Measurable Objective(s) with Indicator(s)	Numbers served, connected to treatment resources and successfully engaged in treatment on an ongoing basis. Reduction in law enforcement encounters.
Intervention Actions for Achieving Goal	Meetings with ED physicians, care coordination, social work, Nevada County Behavioral Health to facilitate expedited placement and sustainable funding to expand capacity.
Planned Collaboration	Swope Medical Group, WSMC, Hospitality House, Wayne Brown Correctional Facility, GVPD, CoRR, Nevada County Behavioral Health.

Homeless Recuperative Care Program	
Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ❑ Access to mental/behavioral/substance abuse services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Active living and health eating ❑ Access to dental care and preventive services ❑ Pollution-free living environment ✓ Safe and violence-free environment
Program Description	In FY18, Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services, to develop a 4-bed homeless recuperative care program located at Hospitality House.
Community Benefit Category	E2-a Grants - Program grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Implementation of the program. Provide a safe discharge plan, and a clean, dry, supportive place to recover from a recent hospitalization for patients who are homeless. Improve access to ongoing health care through a medical home, provide wrap-around services and assist in accessing housing services available.
Measurable Objective(s) with Indicator(s)	Number of: patients served; linkages to wrap-around services provided; individuals connected to follow up appointments; and patients who access housing. Reduction in hospital readmissions.
Intervention Actions for Achieving Goal	Regular meetings with a recuperative care team to discuss individual placement successes and challenges. Connect Hospitality House staff to navigation resources to assist in supporting individuals in accessing services such as CTI services, Hepatitis C navigation, substance use navigation, direct entry bed, primary care navigation.
Planned Collaboration	Sierra Nevada Memorial Hospital, Nevada County Health and Human Services, Nevada County Behavioral Health, Hospitality House, Western Sierra Medical Clinic, Chapa De Indian Health, FREED, Granite Wellness Centers, Grass Valley Police Department, Sierra Nevada Gastroenterology, AMI Housing.

Hospital Board and Committee Rosters

Monty East, Chair Retired Utilities District Manager Current Real Estate Agent	Alex Klistoff, MD, Vice Chair Retired Physician
Nancy Guerland, Secretary Retired Home Health Executive	Dan Castles Retired Technology Industry CEO
Dale Creighton President, SCO Planning and Engineering	Michael Korpiel President, Dignity Health Mercy San Juan Hospital
Stacy Fore, DDS Local General Dentist	Alison Lehman County Executive Officer
Scott Robertson CEO, Emerald Cove Marina at Bullard's Bar	Andrew Chang, MD Gastroenterologist Past Chief of Staff
Brian Evans, MD President and CEO Sierra Nevada Memorial Hospital