Sierra Nevada Memorial Hospital

Community Benefit 2015 Report and 2016 Plan
A message from:

Katherine Medeiros, president and CEO of Sierra Nevada Memorial Hospital, and Edward Sylvester, Chair of the Sierra Nevada Memorial Hospital Board of Directors

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited by and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. Dignity Health’s comprehensive approach to community health improvement includes multi-pronged initiatives directed at significant health needs, partnering with others in the community working to improve health, and investing in efforts that address social determinants of health.

Sierra Nevada Memorial Hospital (Sierra Nevada Memorial) shares a commitment to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2015 Report and 2016 Plan describes much of this work. This report meets requirements of not-for-profit hospitals in the Patient Protection and Affordable Care Act to adopt a community health Implementation Strategy at least every three years, and in California state law (Senate Bill 697) to produce an annual community benefit report and plan. Dignity Health complies with both mandates in all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2015 (FY 2015), Sierra Nevada Memorial provided $3,646,728 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital’s total community benefit expense was $27,206,565.

Sierra Nevada Memorial’s Board of Directors reviewed, approved and adopted the Community Benefit 2015 Report and 2016 Plan at its October 8, 2015 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 916-851-2731.
# Table of Contents

**Executive Summary** 3

**Mission, Vision, and Values** 5

**Our Hospital and Our Commitment** 6

**Description of the Community Served** 7

**Community Benefit Planning Process**
- Community Health Needs Assessment Process 9
- CHNA Significant Health Needs 9
- Community Benefit Plan Development Process 11
- Planning for the Uninsured/Underinsured Patient Population 11

**2015 Report and 2016 Plan**
- Summary, Anticipated Impact, and Planned Collaboration 13
- Program Digests 17

**Economic Value of Community Benefit** 23

**Appendices**
- Appendix A: Board of Directors Roster 24
- Appendix B: Other Programs and Non-Quantifiable Benefits 25
EXECUTIVE SUMMARY

Sierra Nevada Memorial is located in the western part of Nevada County and continues to be the only acute care hospital serving this region. The hospital’s service area is home to 73,834 residents with a growing number who are Medi-Cal insured. Historically lacking safety net providers to serve this population, the community is heavily dependent on the hospital to often serve all its health needs. The hospital must continuously balance its responsibility caring for the acutely ill with the role it serves as a safety net provider for the poor and vulnerable in a region where public and community capacity is limited.

The hospital has expanded in numerous ways since opening in 1958 to meet the growing needs of the community. Today, the hospital has 875 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, Wound Care Healing & Hyperbaric Medicine Center, and Wellness Center. The hospital has also earned the Gold Seal of Approval from the Joint Commission as a Primary Stroke Center.

The significant community health needs that form the basis of this report and plan were identified in the hospital’s most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/cm/media/documents/Sierra-Nevada-Memorial-Hospital.pdf. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The significant community health needs identified are:

1. Lack of access to primary care and preventive services
2. Lack of integration of behavioral health and primary care
3. Transportation issues and limitations
4. Limited access to healthy foods, food security
5. Lack of access to specialty care
6. Lack of dental care
7. Lack of access to mental health services
8. Eligibility requirements for Medi-Cal and other social services
9. Lack of access to outdoor and recreational activities
10. Lack of access to physical therapy

In FY 2015, Sierra Nevada Memorial took numerous actions to help address identified needs. These included:

- Mental Health Crisis Support Partnership
- Integrated Care Coordination for Family Wellness
- Cancer Nurse Navigator
- Heart Failure Program
- Diabetes: Take Control!
- Alzheimer’s Outreach Program
- Penn Valley Satellite Lab and X-Ray Clinic
- Tele-Psychiatric Care
- Better Breather, Pulmonary Rehabilitation, and Smoking Cessation Classes
- Cardiac Rehabilitation
- Support Groups
- Falls Prevention Program
In FY 2016, the hospital plans to collaboratively build upon a number of these initiatives, and complete implementation for several new initiatives responding to priorities with emphasis on access to primary and mental health care. Working in partnership with Nevada County and other community partners, an initiative to provide mental health crisis support will continue to move into the second phase with the establishment of a four-bed crisis stabilization unit on the hospital campus. The hospital is expanding its Integrated Care Coordination for Family Wellness program in collaboration with FREED Center for Independent Living, Community Recovery Resources and Western Sierra Medical Clinic. This will better serve patients utilizing the emergency department for needs that could be more appropriately addressed in a community care setting. In FY 2016, this partnership will also increase emphasis on serving patients with substance abuse in the hospital setting. As part of Dignity Health system-wide initiative, the hospital is also gearing up to implement a clinical and community strategy to end human trafficking, which will include training and process improvement for clinical staff and the engagement of community partners.

One component of the community benefit that Sierra Nevada Memorial delivers is providing care to Medi-Cal enrolled patients for substantially less than the cost to deliver that care. To help offset low Medi-Cal reimbursements, all hospitals in California pay fees to the state called the “Provider Fee” (see http://www.calhospital.org/hospital-fee-program) that are used to obtain federal matching funds to supplement Medi-Cal payments. This helps the hospital to provide care to vulnerable patients within the service area.

For the year ending June 30, 2015, Sierra Nevada Memorial’s net Medi-Cal community benefit expense was lower than historical norms. This is due to the timing of the federal government’s approval of Provider Fee payments to hospitals, which in FY 2015 included not only all of FY 2015, but also six months of services delivered in FY 2014. Sierra Nevada Memorial maintains its strong, mission-based commitment to caring for Medi-Cal enrollees and all members of the community. The hospital served 33,082 Medi-Cal patients in FY 2015, compared to 25,404 in FY 2014; a 30 percent increase.

The economic value of community benefit provided by Sierra Nevada Memorial in FY 2015 was $3,646,728, excluding unpaid costs of Medicare in the amount of $23,559,837.

This report and plan is publicly available at www.dignityhealth.org by navigating to “Community Health” and “Community Benefit Reports.” It will be distributed to hospital leadership, members of the Community Board and Community Health Committee and widely to management and employees of the hospital as it serves as a valuable tool for ongoing community benefit awareness and training. The document will also be broadly distributed externally to Community Health Needs Assessment partners, community leaders, government and public health officials, program partners and other agencies and businesses throughout the region.
MISSION, VISION AND VALUES

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.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we’ve learned that modern medicine is more effective when it’s delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word “care” is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.
OUR HOSPITAL AND OUR COMMITMENT

Sierra Nevada Memorial’s roots in western Nevada County date back to the 1930s, when mining engineer Errol MacBoyle and local doctor Carl Jones led an effort to build a new community hospital with funds and land donated by MacBoyle’s Idaho-Maryland Mine. World War II interrupted construction of the hospital and by the mid-1950s both MacBoyle and Jones had passed away. Several years later the unfinished hospital building was sold to businessman Charles Litton. With proceeds from the sale and community fundraising efforts, a new community hospital became a reality when Sierra Nevada Memorial opened its doors in 1958.

Located at 155 Glasson Way in Grass Valley, CA, Sierra Nevada Memorial has expanded in numerous ways since its early days to meet the growing needs of the community. Today, the hospital has 804 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, Wound Care Healing & Hyperbaric Medicine Center, and Wellness Center. The hospital has also earned the Gold Seal of Approval from the Joint Commission as a Primary Stroke Center.

Rooted in Dignity Health’s mission, vision and values, Sierra Nevada Memorial is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Health Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

The development of community health improvement strategies to address priority health issues is a collaborative effort engaging members of a dedicated Community Health and Outreach Department who work directly with the hospital president, management and clinical staff, as well as community partners. The department is responsible for implementing, managing and evaluating initiatives, and oversees community benefit reporting and the development of the hospital’s Community Health Needs Assessment (CHNA). The department director reports quarterly to the Sierra Nevada Memorial Board of Directors, which has oversight for ensuring hospital initiatives and services are aligned with priority health issues identified in the CHNA, represents the needs of the community and monitors the progress of initiatives. The Board of Directors reviews and approves the CHNA and the Community Benefit plan (see Appendix A for a roster of the Sierra Nevada Memorial Board of Directors).

Sierra Nevada Memorial’s community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, community health improvement services and health professions education. Our community benefit also includes monetary grants provided to not-for-profit organizations that are working together to address significant health needs identified in the CHNA. Many of these programs and initiatives are described in this report.

In addition, we are investing in community capacity to improve health – including addressing the social determinants of health – through Dignity Health’s Community Investment Program. Dignity Health investments support nonprofit organizations that deliver an array of services to low-income communities in the Sacramento region. CPCA Ventures, for example, in partnership with NCB Capital Impact, manages a loan program that provides financing opportunities to California’s community clinics and health centers that might not be able to access traditional financing sources. Dignity Health’s funds were used to support this program. Over the past two decades, CPCA Ventures has helped California’s community clinics and health centers double both in numbers of sites and in numbers of patients being served.
DESCRIPTION OF THE COMMUNITY SERVED

Sierra Nevada Memorial’s community, or primary service area, in Nevada County, is defined as the geographic area which it serves and determined by analyzing patient discharge data. The hospital’s primary service area encompasses five zip codes in the communities of Grass Valley, Penn Valley, Rough and Ready and Nevada City (95949, 95945, 95959, 95975, and 95946). Grass Valley (95945), and Nevada City (95959) are designated Medically Underserved Areas by the Health Resources and Services Administration. The Administration has also designated these two communities, and Penn Valley (95946) and Rough and Ready (95975) as Health Professional Shortage Areas.

Located 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, a large portion of the county's economy is based on income from non-wage-related sources such as dividends and pensions from a large retirement community, and local service-sector employment and businesses.

With almost 179,000 acres of national forest and over 15,000 acres of state park land, Nevada County is known for its open space, rural atmosphere and small-town style of life. 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.

Demographics within Sierra Nevada Memorial’s primary service area are as follows, derived from estimates provided by The Nielsen Company and Truven Health Analytics, Inc. for 2015:

- Total Population: 73,834
- Hispanic or Latino: 7.2%
- Race: 87.3% White, 0.5% Black/African American, 1.4% Asian & Native Hawaiian or Other Pacific Islander, 0.8% American Indian/Alaska Native, 0.1% Other, 2.7% Two or More Races
- Median Income: $55,666
- Uninsured: 6.3%
- Unemployment: 6.0%
- No HS Diploma: 5.9%
- CNI Score: 2.4
- Medicaid Population: 17.1%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes

Sierra Nevada Memorial Community Needs Index (CNI) Data

The hospital’s CNI Score of 2.4 falls in the second highest range. The CNI highlights by zip code the areas of greatest risk for preventable hospitalizations (see CNI map below). The data is derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).
Sierra Nevada Memorial Community Needs Index (CNI) Map: Median CNI Score: 2.4
COMMUNITY BENEFIT PLANNING PROCESS

Sierra Nevada Memorial engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment (CHNA) with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Board of Directors and other stakeholders in the development and annual updating of the community benefit plan.

CHNA Process
The most recent CHNA was completed and adopted by Sierra Nevada Memorial in June 2013. The CHNA was conducted through a collaborative process that included Sierra Nevada Memorial, other Dignity Health hospitals in Sacramento and Yolo County, Kaiser Permanente, Sutter Health and UC Davis Health System. These health systems all serve the same or portions of the same communities. Nonprofit research consultant, Valley Vision, Inc., was retained to lead the assessment process, based on its local presence and understanding of the greater Sacramento region and experience in conducting multiple CHNAs across an array of communities for nearly a decade.

The CHNA was guided by an objective that focused on identifying communities and specific groups within these communities experiencing health disparities. Another objective was to identify contributing factors that create both barriers and opportunities for specific populations to live healthier lives. The assessment study area included the hospital’s primary service area. Zip code boundaries served as the unit-of-analysis for most indicators to allow for closer examination of health outcomes at the community level, which are often hidden when viewed at the county level. A mixed methods research approach was applied. Primary qualitative data was obtained from interviews with hospital clinical and community benefit staff members and key informants, including Nevada and surrounding county public health and community experts and nonprofit agencies. A focus group consisting of 12 community members was conducted with area residents, and phone interviews and website analyses were conducted to assess community health assets. Secondary quantitative data was collected on health, demographic, behavioral, and environmental factors. County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity of health issues.

An important component of the assessment included the identification of community and hospital resources that might be available to address priority needs. This resource mapping process provided insight on community capacity and potential opportunities for collaborating with partners. There were 25 community resources identified by zip code and evaluated1. The hospital is currently working with a number of the resources identified and several others are being targeted for future partnership initiatives.

Sierra Nevada Memorial’s CHNA was broadly distributed externally to community leaders, government and public health officials, program partners and other agencies and businesses throughout the region, and made available internally to hospital leadership and employees.

CHNA Significant Health Needs
Significant health needs were evaluated and prioritized in collaboration with Valley Vision workgroup partners and other community stakeholders, using the following criteria:

- Magnitude/scale of the problem
- Severity of the problem
- Problem linked to high utilization rates

1 Details on community resources can be found under Appendix H in Sierra Nevada Memorial Hospital’s CHNA
Ten significant health needs emerged from the assessment across the hospital’s primary service area:

1. Lack of access to primary care and preventive services
2. Lack of integration of behavioral health and primary care
3. Transportation issues and limitations
4. Limited access to healthy foods, food security
5. Lack of access to specialty care
6. Lack of dental care
7. Lack of access to mental health services
8. Eligibility requirements for Medi-Cal and other social services
9. Lack of access to outdoor and recreational activities
10. Lack of access to physical therapy

Other needs were also uncovered through assessment, including lack of access to mental health care and needs of an aging population. These concerns also came to light in a study by the Nevada County Health and Human Service Agency.

Health needs appeared in greater magnitude within two communities of concern, including Grass Valley (95945) and Rough and Ready (95975). These two areas of concern are home to more than 27,000 residents who are highly diverse, have high rates of poverty, low educational attainment, high levels of unemployment, and rent versus own their homes. In Rough and Ready (95975), there are more families in poverty with children and elderly residents 65 years of age or older living in poverty than the national average.

While the 2013 Community Health Needs Assessment reflects a substantial list of priority health issues in Nevada County, the hospital is focused specifically on priority health issues that include access to primary care; access to mental health treatment; access to specialty care; access to preventative health services and education and; access to health care and social support services for the elderly. Initiatives that address these priorities largely target vulnerable and at-risk populations, with emphasis on identified communities of concern and collaboration with community partners to maximize efforts and have a greater region-wide impact. Initiatives also utilize methodologies to measure and demonstrate health improvement outcomes. Sierra Nevada Memorial will continue to work with its partners to refine goals and strategies over time to ensure they effectively address the needs identified.

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 lack of county-wide transportation. The Transit Services Division of the Nevada County Department of Public works provides public transit and paratransit services in western Nevada County. The hospital does, however, ensure patients without the means for travel receive transportation. Although not directly addressing the need for access to healthy foods, the hospital participates in the BriarPatch Community Market Cooperative, which is focused on developing healthy food strategies. The City of Grass Valley and Nevada City also provides weekly farmers markets that offer fresh foods at affordable costs. The hospital does not have the resources or expertise to address the need for dental care, although dental emergencies by patients admitting to the emergency department receive treatment. Chapa-De provides dental services to the underserved population in Nevada County. The hospital will continue to seek collaborative opportunities that address needs that have not been selected where it can appropriately contribute to addressing needs.
Community Benefit Plan Development Process
As a matter of Dignity Health policy, the hospital’s community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- **Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

At the onset of planning and developing initiatives, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the Sierra Nevada 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 Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

Many initiatives involve coalition building to better understand priority health or social issues from a broader perspective. The Mental Health Crisis Support Coalition, for example, brought County government administrators and elected officials, law enforcement, emergency medical services, community providers and consumers together for a common goal to improve the way in which mental health care is accessed and delivered. The collective engagement of these stakeholders is leading to significant improvements and expansions in mental health services based on best and emerging new practice models across the state.

**Planning for the Uninsured/Underinsured Patient Population**
In keeping with its mission, the hospital offers patient financial assistance (also called charity care) to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay. The hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. The amount of financial assistance provided in FY 2015 is listed in the Economic Value of Community Benefit section of this report.

To ensure all patients and families are aware of the policy, the hospital distributes and displays financial assistance information in a number of ways. Notices in several languages spoken by the populations the hospital serves are posted in the emergency department, in admitting and registration areas, and in the business and financial services office. Notices are also placed in all patient bills and include a toll-free contact number.
Continued education to stay current on the Financial Assistance Policy is required for hospital leadership and employees at all levels of the organization. Employees working in Admitting and Patient Financial Services are versed in the policy and dedicated to assisting patients that are in need of support. Any employee or member of the medical staff can refer patients for financial assistance. Family members, friends or associates of a patient may also make a request for financial assistance.
2015 REPORT AND 2016 PLAN

This section presents programs and initiatives the hospital is delivering, funding, or on which it is collaborating with others, to address significant community health needs. It includes both a report on activities for FY 2015 and planned programs with measurable objectives for FY 2016.

SUMMARY

Below are community benefit and community health programs and initiatives operated or substantially supported by the hospital FY 2015, and those planned to be delivered in FY 2016. New programs planned by the hospital, or programs the hospital intends to expand in 2016, are denoted by *:

1: Access to Primary, Mental, and Specialty Health Care

- Western Sierra Medical Clinic Collaboration* - The hospital works closely with the region’s Federally Qualified Health Center, Western Sierra Medical Clinic, to increase access to care. The clinic is able to operate a second site by utilizing hospital-owned facilities in the community of Grass Valley at a significantly reduced cost. The positive impact of this relationship was highlighted by participants in the 2013 Community Health Needs Assessment who noted they received follow-up primary care appointments at the clinic within 72 hours of being released from the hospital or emergency department.

- Penn Valley Satellite Lab and X-Ray Clinic* - Nearly 200 Medi-Cal-insured and indigent residents received services in FY 2015 at the hospital's Satellite Lab and X-Ray Clinic located in the underserved area of Penn Valley/Rough and Ready. FY 2015 was the second year of operation for this outpatient facility, which fills a major gap in services in this part of the region.

- Mental Health Crisis Support Partnership* - A unique and innovative partnership continues to evolve between the hospital and Nevada County to address the urgent need for mental health services and the steady increase in residents admitting to the emergency department in crisis. A County psychotherapist is stationed in the hospital’s emergency department to support patients in crisis. Specially trained on-call peer counselors are available to support patient needs around the clock. These services are resulting in more timely quality care for patients with acute psychiatric issues; 95 patients on average each month receive treatment. The second phase of the program will be implemented in FY 2016 when a four-bed crisis stabilization unit is established on the hospital campus.

- Tele-Psychiatric Care – The hospital has implemented the use of tele-psychiatry in its emergency department to allow patients to access psychiatric services during a crisis day or night. Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care.

- Cancer Nurse Navigator - Nurse Navigators at the hospital are effectively supporting the need for specialized care for individuals with breast and lung cancer, and victims of stroke. The navigation program has continued to expand to meet a growing demand for services. Patients receive education on treatment options, as well as referrals for follow-up care and education. Navigation services target underserved populations that otherwise would not have access to care.

- Integrated Care Coordination for Family Wellness* - The hospital continues to work in partnership with the FREED Center for Independent Living, Community Recovery Resources and Western Sierra Medical Clinic to increase access to primary, mental and preventative health care and to integrate and coordinate these services for vulnerable populations. Partners have undergone cross-training to understand each other’s services and developed a process for seamless referrals. Western Sierra Medical Clinic has established a clinic co-located at Community Recovery Resources. A FREED navigator is currently stationed on the hospital campus to work directly with hospital case managers. In FY 2016, partners will expand their services to increase their focus on emergency
department utilization and develop a seamless process for referrals or add on-call services that could respond to patients who need immediate follow-up care to community resources.

- **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.

### 2: Access to Preventative Health Services and Education

- **Heart Failure Program** - A best practice heart disease intervention model at the hospital provides assistance and support to individuals suffering from heart disease. Heart disease is among the top causes of death in Nevada County, and a major cause for hospitalization. The program offers ongoing educational and clinical support to residents with heart failure, and provides medication monitoring.

- **Cardiac Rehabilitation** - Complementary to the Heart Failure Program, the hospital offers cardiac rehabilitation programs and classes specifically focused on underserved individuals who lack access to such services.

- **Diabetes: Take Control!** - The active and growing Diabetes: Take Control! program provides education and nutrition counseling to enable residents to better manage diabetes, maintain good health and avoid hospitalization for uncontrolled symptoms. Program workshops follow the evidence-based Stanford University Diabetes Self-Management Program curriculum. The hospital has over 12 facilitators trained to lead workshops, and has trained new program leaders at Western Sierra Medical Clinic to extend the reach of the program.

- **Better Breather, Pulmonary Rehabilitation, and Smoking Cessation Classes** - In response to the high prevalence of Chronic Obstructive Pulmonary Disease and asthma in Nevada County, the hospital offers ongoing Better Breather, Pulmonary Rehabilitation, and Smoking Cessation classes, which are open to all at a reduced cost.

- **Support Groups** - Hospital-sponsored support groups for cancer, brain injury, stroke and asthma provide complementary resources for medical treatment, and are an opportunity for patients and family members to share their concerns while learning methods for handling difficult situations. Groups are conducted by a trained hospital staff member, and bring people together facing similar issues to share experiences and advice. Benefits include reduced stress, anxiety, loneliness and isolation, improved coping skills and an enhanced understanding of conditions and treatment options.

### 3: Access to Health Care and Social Support Services for the Elderly

- **Alzheimer’s Outreach Program** - The hospital’s Home Care Department 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, which offers services, including a “Yes I Can” course that teaches caregivers and families how to provide quality care for those with Alzheimer’s who are still living at home and a Caregiver Support Group. The program also 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** - Sierra Nevada Memorial Hospital is fulfilling an important need in the community through its Falls Prevention Program. The program is offered at the hospital and in the community to capture a larger number of participants, and consists of education about fall risk factors and prevention strategies for older adults and caregivers. Participants also learn appropriate exercises for enhanced balance and strength.

### Anticipated Impact

The anticipated impacts of specific 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 Department, hospital executive leadership, Board of Directors, and Dignity Health receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its community benefit program by conducting Community Health Needs Assessments every three years.

**Planned Collaboration**

**Human Trafficking**

The initial phase of this initiative launched in late FY 2015 with the roll-out of education and training to hospital clinical staff to increase awareness and improve quality of care for human trafficking victims. In early 2016 community agencies serving human trafficking victims were convened to share information on their organizations and begin to outline the community strategy component for this initiative. Partners include:

- A Community for Peace
- My Sister’s House
- Opening Doors
- Bridget’s Dream

Sierra Nevada Memorial will continue to develop relationships with community partners, law enforcement, and the District Attorney’s Office to help identify victims and connect them to available resources.

**Mental Health Crisis Support Partnership**

Collective efforts by Sierra Nevada Memorial, Nevada County, and community partners on the Mental Health Crisis Support Partnership are addressing the urgent need for mental health services and the steady increase in residents admitting to the emergency department in crisis. The first phase of the program was completed in FY 2015, with the placement of a County licensed psychotherapist in the hospital’s emergency department to support patients in crisis. Specially trained on-call peer counselors are also available at the hospital to support patient needs around the clock. The second phase of the program will be implemented in FY 2016 with the establishment of a four-bed crisis stabilization unit on the hospital campus. The partnership continues to add community resources to address the need for out-patient services and improve the continuum of care between emergency department discharge and follow-up appointments in the community setting.

In addition to Sierra Nevada Memorial, core partners to date include:

- Nevada County Health and Human Services
- Grass Valley Police Department
- Nevada County Police Department
- Nevada County Sheriff
- Community Recovery Resources
- Western Sierra Medical Clinic
- SPIRIT Peer Empowerment Center
- Hospitality House
- Sierra Family Medical Clinic
- National Alliance on Mental Illness (NAMI)

**Integrated Care Coordination for Family Wellness**

Developed through the Community Grants program, the Integrated Care Coordination for Family Wellness is a collaborative initiative with FREED Center for Independent Living, Community Recovery Resources and Western Sierra Medical Clinic. The partnership responds to priority health issues surrounding access to primary, mental and preventative health care and the need to integrate and coordinate these services for
vulnerable populations. The hospital continues to work in partnership with all three community organizations as emergency department utilization grows by residents who cannot find care elsewhere. In FY 2016, all three partners will expand their services to increase their focus on emergency department utilization and develop a seamless process for referrals and on-call services that could better respond to patients who need immediate follow-up care to community resources.

This community benefit plan specifies significant community health needs that the hospital plans to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in other community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

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.
### HEART FAILURE PROGRAM

**Significant Health Needs Addressed**
- Access to Primary, Mental and Specialty Health Care
- Access to Preventative Health Services and Education
- Access to Health Care and Support Services for the Elderly

**Program Emphasis**
- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

**Program Description**
The program is open to all residents with a diagnosis of congestive heart failure at no cost. The program improves the health status of heart failure patients by providing a vital link to the medical world through regular phone interaction and educational discussion. The program monitors patient symptoms or complications, and provides recommendations on diet changes, medicine modifications, daily weights and physician visits. The hospital also provides a Cardiac Rehabilitation program to complement the Heart Failure Program where participants receive appropriate exercise therapy.

**Planned Collaboration**
The Heart Failure program will work to develop relationships with community clinics, and other community service providers to improve collaboration.

**Community Benefit Category**
A3-g Health Care Support Services - Case management post-discharge

### FY 2015 Report

**Program Goal / Anticipated Impact**
Improve the health and quality of life of those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.

**Measurable Objective(s) with Indicator(s)**
Avoid hospital or emergency department admissions amount 60% of participants; enhance outreach to individuals living in underserved parts of the region.

**Baseline / Needs Summary**
Heart failure is a priority health issue for Nevada County, identified in past and current Community Health Needs Assessments. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.

**Intervention Actions for Achieving Goal**
Conduct regular meetings with the program team and expand outreach to increase enrollment.

**Program Performance / Outcome**
671 participants enrolled in the program and only 7% were readmitted to the hospital 3 months post intervention.

**Hospital's Contribution / Program Expense**
$82,892

### FY 2016 Plan

**Program Goal / Anticipated Impact**
Improve the health and quality of life for those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.

**Measurable Objective(s) with Indicator(s)**
Continue to increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Strengthen collaboration between program and community service providers. Provide ongoing education to community clinics about available services.

**Baseline / Needs Summary**
Heart failure is a priority health issue for Nevada County, identified in past and current Community Health Needs Assessments. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.

**Intervention Actions for Achieving Goal**
Conduct regular meetings with the program team and expand outreach to increase enrollment. Continue to focus on improvements in program outcome evaluation.
## CANCER NURSE NAVIGATOR

### Significant Health Needs Addressed
- ✔ Access to Primary, Mental and Specialty Health Care
- ✔ Access to Preventative Health Services and Education
- ❐ Access to Health Care and Support Services for the Elderly

### Program Emphasis
- ✔ Disproportionate Unmet Health-Related Needs
- ✔ Primary Prevention
- ✔ Seamless Continuum of Care
- ✔ Build Community Capacity
- ✔ Collaborative Governance

### Program Description
The Cancer 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. The hospital provides similar navigator services for stroke victims.

### Planned Collaboration
Cancer nurse navigators work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance.

### Community Benefit Category
A3-g Health Care Support Services - Case management post-discharge

### FY 2015 Report

#### Program Goal / Anticipated Impact
Improve access to treatments and 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 number of underserved individuals assisted through outreach and community collaboration and build awareness of the program among community partners.

#### Baseline / Needs Summary
Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers resources that would otherwise not be accessible for Medi-Cal and uninsured populations.

#### Intervention Actions for Achieving Goal
Promote services into community and work with hospital and community partners to increase awareness of services and resources.

#### Program Performance / Outcome
1,294 persons served

#### Hospital's Contribution / Program Expense
$156,321

### FY 2016 Plan

#### Program Goal / Anticipated Impact
Continue to improve access to treatments and 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)
Continue to increase 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.

#### Baseline / Needs Summary
Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers necessary resources that would otherwise not be accessible for Medi-Cal and uninsured populations.

#### Intervention Actions for Achieving Goal
Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with community clinics who serve the underserved.
## DIABETES – TAKE CONTROL!

| Significant Health Needs Addressed | Access to Primary, Mental and Specialty Health Care | Access to Preventative Health Services and Education
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Access to Health Care and Support Services for the Elderly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Emphasis</th>
<th>Disproportionate Unmet Health-Related Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Prevention</td>
</tr>
<tr>
<td></td>
<td>Seamless Continuum of Care</td>
</tr>
<tr>
<td></td>
<td>Build Community Capacity</td>
</tr>
<tr>
<td></td>
<td>Collaborative Governance</td>
</tr>
</tbody>
</table>

| Program Description | The program offers diabetes education and nutritional counseling to help residents better manage this chronic condition, avoid uncontrolled symptoms and hospitalization, and lead healthier, more productive lives. The program focuses on diabetes facts and nutrition and self-management tools and skills, and also offers nutrition consultations. |

| Planned Collaboration | Develop stronger relationships with community partners, specifically community clinics, to bring awareness of the program and services offered and develop a seamless referral process. |

| Community Benefit Category | A1-e Community Health Education - Self-help |

### FY 2015 Report

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Improve the health and quality of life for individuals suffering from diabetes by enabling them to manage the symptoms of this chronic illness, providing needed education, and reducing their need to be admitted or readmitted to the hospital.</th>
</tr>
</thead>
</table>

| Measurable Objective(s) with Indicator(s) | Increase awareness of the program in the community and expand the number of lay leaders necessary to increase workshop offerings to reach a greater number of participants. Specifically, achieve and/or exceed target metric goal – 70% of all participants avoid hospital admission three months post intervention. |

| Baseline / Needs Summary | Diabetes is an identified health issue within the hospital’s community. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease. |

| Intervention Actions for Achieving Goal | Regularly evaluate the program for effectiveness, including feedback from participants, and increase outreach to the community and with partners to reach underserved populations. |

| Program Performance / Outcome | 122 participants were served in FY15 and less than 1% was readmitted to the hospital when measured at three month post-intervention. |

| Hospital’s Contribution / Program Expense | $13,905 |

### FY 2016 Plan

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Improve the health and quality of life for individuals suffering from diabetes by enabling them to manage the symptoms of this chronic illness, providing needed education, and reducing their need to be admitted or readmitted to the hospital. Build a network for the participants to stay connected and provide support to each other.</th>
</tr>
</thead>
</table>

| Measurable Objective(s) with Indicator(s) | Increase awareness of the program in the community to enhance enrollment numbers coming from community partners and expand the number of lay leaders necessary to increase workshop offerings to reach a greater number of participants. Specifically achieve and/or exceed target metric goal – 70% of all participants avoid hospital admission three months post intervention. |

| Baseline / Needs Summary | Diabetes is an identified health issue within the hospital’s community. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease. |

| Intervention Actions for Achieving Goal | Continue to evaluate the program for effectiveness, including feedback from participants, and increase outreach to the community, specifically community clinics, and with partners to reach underserved populations. |
| Significant Health Needs Addressed | ✓ Access to Primary, Mental and Specialty Health Care  
  ✓ Access to Preventative Health Services and Education  
  ✓ Access to Health Care and Support Services for the Elderly |
|-----------------------------------|----------------------------------------------------------|
| Program Emphasis                  | ✓ Disproportionate Unmet Health-Related Needs  
  ✓ Primary Prevention  
  ✓ Seamless Continuum of Care  
  ✓ Build Community Capacity  
  ✓ Collaborative Governance |
| Program Description               | Offered by the hospital’s Home Care group, the Alzheimer’s Outreach Program offers a series of classes and support groups designed to assist and empower caregivers with knowledge and skills to help them prevent the mental and physical challenges involved in caring for those with Alzheimer’s and other forms of dementia. The program teaches caregivers and family members how to provide quality care for Alzheimer’s patients still living at home. Home visits, telephone consultations and a resource website are important components of the program. |
| Planned Collaboration             | Develop linkages between hospital program and community programs that serve the same population to improve collaboration. |
| Community Benefit Category        | A1-a Community Health Education - Lectures/Workshops |

**FY 2015 Report**

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Improve the quality of care and quality of life for those with Alzheimer’s and other forms of dementia, and support the special needs of caregivers and family members by providing assistance, education, training and resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>Evaluate the program to align with the needs of the community, and enhance outreach and collaboration in the community to create awareness of this available service.</td>
</tr>
<tr>
<td>Baseline / Needs Summary</td>
<td>The Alzheimer’s Outreach program provides a much needed specialty service that is not available elsewhere in the community. Alzheimer’s is among the leading causes of death in Nevada County, particularly for females.</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>Continued outreach to the community to create awareness of available services.</td>
</tr>
<tr>
<td>Program Performance / Outcome</td>
<td>558 participants served</td>
</tr>
<tr>
<td>Hospital’s Contribution / Program Expense</td>
<td>$1,141</td>
</tr>
</tbody>
</table>

**FY 2016 Plan**

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Continue to improve the quality of care and quality of life for those with Alzheimer’s and other forms of dementia, and support the special needs of caregivers and family members by providing assistance, education, training and linkages to additional resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>Continue to evaluate the program to align with the needs of the community, and enhance outreach and collaboration in the community to create awareness of this available service including a seamless referral process.</td>
</tr>
<tr>
<td>Baseline / Needs Summary</td>
<td>The Alzheimer’s Outreach program provides this much needed specialty service that is not available elsewhere in the community. Alzheimer’s is among the leading causes of death in Nevada County, particularly for females.</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>Continued outreach to the community to create awareness of available services and improve relationships with community partners to increase enrollment and link community resources.</td>
</tr>
</tbody>
</table>
**FALLS PREVENTION**

| Significant Health Needs Addressed | ✓ Access to Primary, Mental and Specialty Health Care  
|✓ Access to Preventative Health Services and Education  
|✓ Access to Health Care and Support Services for the Elderly |

| Program Emphasis | ✓ Disproportionate Unmet Health-Related Needs  
|✓ Primary Prevention  
|☐ Seamless Continuum of Care  
|☐ Build Community Capacity  
|☐ Collaborative Governance |

| Program Description | The Falls Prevention Program is offered at the hospital and in the community and consists of education about fall risk factors and prevention strategies for older adults and their caregivers. Participants also learn appropriate exercises for enhanced balance and strength. |

| Planned Collaboration | Sierra Nevada Memorial Hospital is an active participant in the Falls Prevention Coalition of Nevada County. |

| Community Benefit Category | A1-a Community Health Education - Lectures/Workshops |

### FY 2015 Report

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Reduce the risk of injury by falls through education and prevention strategies for older adults and their caregivers.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
<th>Increase awareness about the program through outreach to the community and to health care providers. Through work with the Falls Prevention Coalition, engage additional community partners.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Baseline / Needs Summary</th>
<th>Injury and death due to falls, primarily among the elderly population, is a growing concern in Nevada County.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Build awareness about the program through outreach to the community to increase participation.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Program Performance / Outcome</th>
<th>267 persons served</th>
</tr>
</thead>
</table>

| Hospital’s Contribution / Program Expense | $2,791 |

### FY 2016 Plan

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Reduce the risk of injury by falls through education and prevention strategies for older adults and their caregivers.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
<th>Continue to increase awareness about the program through outreach to the community and to health care providers. Through work with the Falls Prevention Coalition, engage additional community partners.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Baseline / Needs Summary</th>
<th>Injury and death due to falls, primarily among the elderly population, continues to be a growing concern in Nevada County.</th>
</tr>
</thead>
</table>

| Intervention Actions for Achieving Goal | Continue to build awareness about the program through outreach to the community to increase participation and engage more community partners to participate in the Falls Prevention Coalition. |
### INTEGRATED CARE COORDINATION FOR FAMILY WELLNESS

| Significant Health Needs Addressed | ✔ Access to Primary, Mental and Specialty Health Care  
|                                     | ☐ Access to Preventative Health Services and Education  
|                                     | ☐ Access to Health Care and Support Services for the Elderly |

| Program Emphasis | ✔ Disproportionate Unmet Health-Related Needs  
|                  | ✔ Primary Prevention  
|                  | ✔ Seamless Continuum of Care  
|                  | ✔ Build Community Capacity  
|                  | ✔ Collaborative Governance |

| Program Description | This program focuses on Care Transition Coaching and Patient Navigation between organizations and services and develops a "no wrong door" system of referral and care across organizations. Program includes patient navigation to community partners and CTI Coaching services for individuals referred from the hospital who are at-risk of readmission. |

| Planned Collaboration | This is a collaborative program involving FREED Center for Independent Living, Community Recovery Resources (CoRR), Western Sierra Medical Clinic (WSMC), and Sierra Nevada Memorial Hospital. |

| Community Benefit Category | E2-a Grants - Program grants |

#### FY 2015 Report

| Program Goal / Anticipated Impact | Improved access to primary care, substance abuse, behavioral health, and preventative services with particular focus on individuals who have been hospitalized and are at risk of readmission, and/or individuals who utilize the hospital Emergency Room for care related to substance abuse or conditions that could be managed more efficiently in a primary care or substance use treatment environment. |

| Measurable Objective(s) with Indicator(s) | Improve patient care and health outcomes while reducing costs to the health system in avoidable hospital readmissions and ED visits by addressing social determinates of health and by streamline access to preventative and treatment services. Increase numbers of vulnerable patients receiving multiple safety-net services and decrease emergency department visits and hospital readmissions. |

| Baseline / Needs Summary | Coordinated access to primary, specialty, and mental health care including substance abused remains a priority need in the CHNA. Collaborative programs that focus on the integration of behavioral health and primary care for vulnerable populations living in rural communities help to address the gaps in services. |

| Intervention Actions for Achieving Goal | Increase numbers of vulnerable patients receiving multiple safety-net services and decrease emergency department visits and hospital readmissions while expanding substance abuse and a primary care screening process across organizations. |

| Program Performance / Outcome | During the second half of FY15, 162 unduplicated patients were served by the partnership and were linked to a variety of services including enrollment into the Care Transition Intervention Program, primary care and substance abuse services, and other community resources. |

| Hospital's Contribution / Program Expense | $64,000 |

#### FY 2016 Plan

| Program Goal / Anticipated Impact | Continue to improve access to primary care, substance abuse, behavioral health, and preventative services for individuals with particular focus on individuals who have been hospitalized and are at risk of readmission, and/or individuals who utilize the hospital Emergency Room for care related to substance abuse or conditions that could be managed more efficiently in a primary care or substance use treatment environment. |

| Measurable Objective(s) with Indicator(s) | Improve patient care and health outcomes while reducing costs to the health system in avoidable hospital readmissions and ED visits by addressing social determinates of health and by streamline access to preventative and treatment services. Increase numbers of vulnerable patients receiving multiple safety-net services and decrease emergency department visits and hospital readmissions. |

| Baseline / Needs Summary | Coordinated access to primary, specialty, and mental health care including substance abused continues a priority need in the CHNA. Collaborative programs that focus on the integration of behavioral health and primary care for vulnerable populations living in rural communities help to address the gaps in services. |

| Intervention Actions for Achieving Goal | Increase numbers of vulnerable patients receiving multiple safety-net services and decrease emergency department visits and hospital readmissions while expanding substance abuse and a primary care screening process across organizations. |
ECONOMIC VALUE OF COMMUNITY BENEFIT

The following FY 2015 (for period from 7/1/2014 through 6/30/2015) Classified Summary of Unsponsored Community Benefit Expense for Sierra Nevada Memorial was calculated using a cost accounting methodology.

<table>
<thead>
<tr>
<th>Benefits for Living in Poverty</th>
<th>Persons Served</th>
<th>Total Expenses</th>
<th>Offsetting Revenue</th>
<th>Net Benefit</th>
<th>% of Organization Expenses</th>
<th>% of Organization Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td>5,281</td>
<td>2,213,911</td>
<td>0</td>
<td>2,213,911</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Medicaid</td>
<td>33,081</td>
<td>33,619,742</td>
<td>34,020,664</td>
<td>(400,922)</td>
<td>(0.3)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Means-Tested Programs</td>
<td>28</td>
<td>85,834</td>
<td>35,734</td>
<td>50,100</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Community Services

| A - Community Health Improvement Services | 4,690 | 316,632 | 0 | 316,632 | 0.2 | 0.2 |
| E - Financial and In-Kind Contributions | 6 | 641,651 | 0 | 641,651 | 0.4 | 0.4 |
| F - Community Building Activities | 0 | 2,772 | 0 | 2,772 | 0.0 | 0.0 |

G - Community Benefit Operations

| Totals for Community Services | 4,696 | 1,021,731 | 0 | 1,021,731 | 0.7 | 0.7 |

Totals for Living in Poverty | 43,086 | 36,941,218 | 34,056,398 | 2,884,820 | 1.9 | 1.9 |

<table>
<thead>
<tr>
<th>Benefits for Broader Community</th>
<th>Persons Served</th>
<th>Total Expenses</th>
<th>Offsetting Revenue</th>
<th>Net Benefit</th>
<th>% of Organization Expenses</th>
<th>% of Organization Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Community Health Improvement Services</td>
<td>7,393</td>
<td>48,869</td>
<td>720</td>
<td>48,149</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>B - Health Professions Education</td>
<td>26</td>
<td>49,951</td>
<td>0</td>
<td>49,951</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>E - Financial and In-Kind Contributions</td>
<td>657</td>
<td>609,657</td>
<td>0</td>
<td>609,657</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>F - Community Building Activities</td>
<td>25</td>
<td>54,151</td>
<td>0</td>
<td>54,151</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

G - Community Benefit Operations

| Totals for Community Services | 8,101 | 762,628 | 720 | 761,908 | 0.5 | 0.5 |

Totals for Broader Community | 8,101 | 762,628 | 720 | 761,908 | 0.5 | 0.5 |

| Totals - Community Benefit | 51,187 | 37,703,846 | 34,057,118 | 3,646,728 | 2.4 | 2.4 |
| Medicare                   | 86,037 | 74,904,268 | 51,344,431 | 23,559,837 | 15.5 | 15.7 |

Totals Including Medicare | 137,224 | 112,608,114 | 85,401,549 | 27,206,565 | 17.9 | 18.2 |

For the year ending June 30, 2015, Sierra Nevada Memorial’s net Medi-Cal community benefit expense was lower than historical norms. This is due to the timing of the federal government’s approval of Provider Fee payments to hospitals, which in FY 2015 included not only all of FY 2015 but also six months of services delivered in FY 2014. Please see the Executive Summary of this report for additional details.
## Appendix A: Board of Directors Roster

Sierra Nevada Memorial Hospital Board of Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ed Sylvester</td>
<td>Retired CEO Engineering Community Representative</td>
</tr>
<tr>
<td>Kathy Rappath</td>
<td>Community Representative</td>
</tr>
<tr>
<td>Michele White</td>
<td>Retired Human Resources Management Community</td>
</tr>
<tr>
<td>Dale Creighton</td>
<td>President, SCO Planning and Engineering Community</td>
</tr>
<tr>
<td>Stacy Fore, DDS</td>
<td></td>
</tr>
<tr>
<td>Alex Klistoff, MD</td>
<td></td>
</tr>
<tr>
<td>Scott Robertson</td>
<td>Community Representative</td>
</tr>
<tr>
<td>Kevin Vaziri</td>
<td>President and CEO Woodland Healthcare</td>
</tr>
<tr>
<td>Alan Wong, MD</td>
<td>Katherine A. Medeiros President and CEO Sierra</td>
</tr>
<tr>
<td></td>
<td>Nevada Memorial Hospital</td>
</tr>
</tbody>
</table>
APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital’s mission and its commitment to improving community health and well-being.

- **Health Professions Education** - The hospital regularly sponsors seminars and training for medical students, physicians, nurses, and other students in the health care field. Hundreds of hours each year are committed to providing internships for nurses, paramedics, therapists, and clinical laboratory technicians.

- **Enrollment Assistance** – Hospital and Nevada County employees provide enrollment assistance at the hospital to low income patients, in an effort to get coverage in Medi-Cal and other government assistance programs.

- **Transitional Housing and Lodging** - Where there are no available alternatives, Sierra Nevada Memorial Hospital subsidizes payments for room and board in the community for patients unable to pay when they are discharged from the hospital.

Additionally, members of the hospital’s leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies, such as the Western Sierra Medical Clinic and Hospice of the Foothills. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them, the Allied Health Scholarship Award, KARE Crisis Nursery, Hospitality House, and Domestic Violence and Sexual Assault Coalition.