Sierra Nevada Memorial Hospital

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Dignity Health™
Sierra Nevada Memorial Hospital

A message from

Brian Evans, MD, President and CEO of Sierra Nevada Memorial Hospital, and Monty East, Chair of the Dignity Health Sierra Nevada Memorial Hospital Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Sierra Nevada Memorial Hospital (Sierra Nevada Memorial) shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. 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 2021 (FY21), Sierra Nevada Memorial provided $4,505,751 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $36,393,673 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 14, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to us at DignityHealthGSSA_CHNA@dignityhealth.org.

Sincerely,

Brian Evans, MD
President/CEO

Monty East
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Sierra Nevada Memorial Hospital is located in western Nevada County and has 787 employees, more than 100 active medical staff, and offers 104 licensed acute care beds and 21 emergency department beds. The hospital's service area encompasses the communities of Grass Valley, Penn Valley, Rough and Ready, Nevada City, North San Juan and Washington.
Economic Value of Community Benefit	$4,505,751 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $36,393,673 in unreimbursed costs of caring for patients covered by Medicare
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
FY21 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • Crisis Stabilization Unit (CSU): partnership with Nevada County Behavioral Health for patients experiencing acute mental health needs. • 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.
FY22 Planned Programs and Services 	Sierra Nevada Memorial plans to continue to build upon many of previous years' initiatives and explore new partnership opportunities with Nevada County, the different cities, health plans and community organizations. The hospital will continue to serve as a lead in building collaborative efforts to address crucial needs in our community, including social services needs that have been created or exacerbate by the COVID-19 pandemic. In FY22, we will continue to expand the Homeless Recuperative Care program in partnership with Hospitality House to provide recuperative care beds for medically fragile individuals. The hospital will continue to build on the success of the California BRIDGE to provide a Naloxone Distribution program through the emergency department and strengthen the integration of critical substance use navigation and Medication Assisted Treatment (MAT) programs within the community.

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 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 787 employees, more than 100 active medical staff, and offers 104 licensed acute care beds and 21 emergency department beds. Services include: a Family Birth Center, providing family-centered care in private, homelike, comfortable, and safe surroundings; 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. The hospital continues to be the only acute care hospital serving this region and its service area is home to nearly 100,000 residents, with over 28% 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.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

Sierra Nevada Memorial is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application 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 75% of discharges. In FY21, the hospital's service area encompassed four zip codes in the communities of Grass Valley, Penn Valley, and Nevada City (95945, 95946, 95949, and 95959). 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.

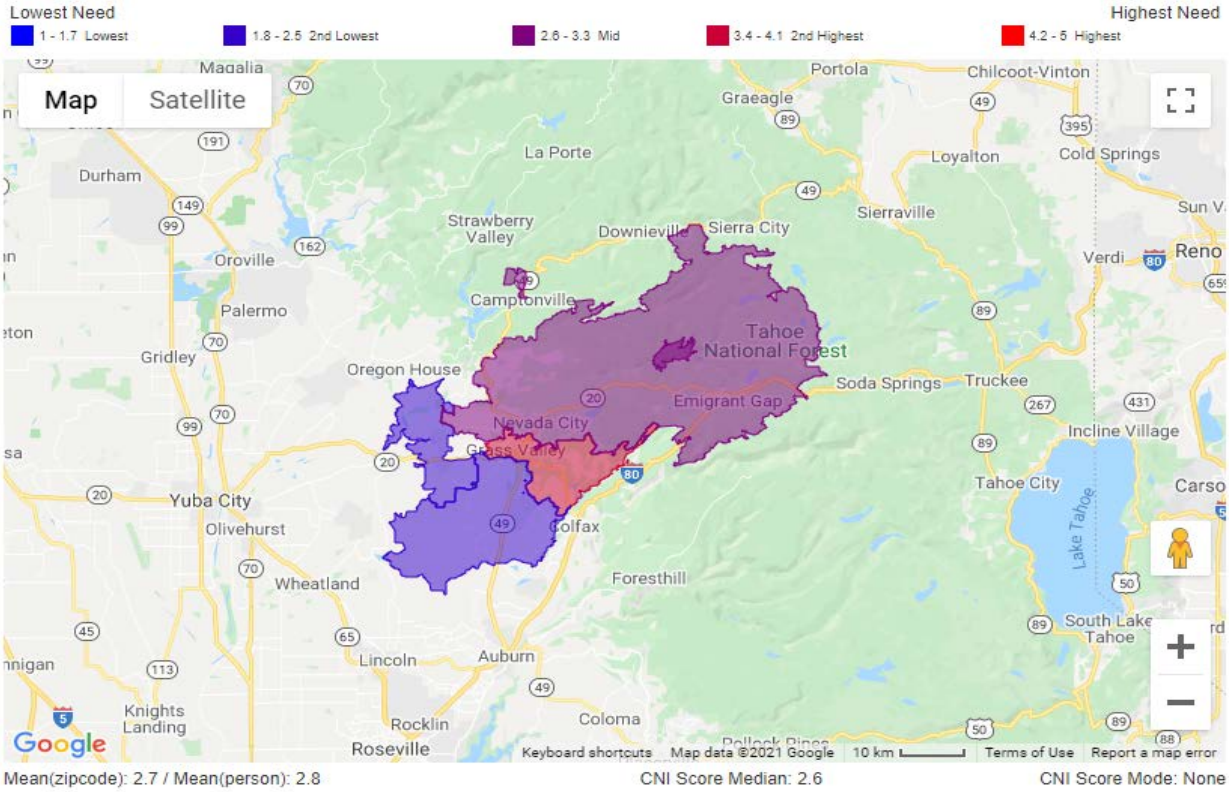
Demographics within Sierra Nevada Memorial's hospital service area are as follows, derived from 2021 estimates provided by Strategy's SG2 Analytics Platform (*Source: Claritas Pop-Facts® 2021)*:

- Total Population: 71,987
- Race/Ethnicity: Hispanic or Latino: 7.7%; White: 86.3%; Black/African American: 0.5%; Asian/Pacific Islander 1.4%; All Other 4.1%
- % Below Poverty: 6.8%
- Unemployment: 3.9%
- No High School Diploma: 4.9%
- Medicaid (household): 6.0%
- Uninsured (household): 4.1%

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): 2.7 / Mean(person): 2.8 CNI Score Median: 2.6 CNI Score Mode: None

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 benefit plan and programs were identified in the most recent CHNA report, which was adopted in 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 https://www.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 health care, 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 or 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, 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.

2021 Report and 2022 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

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 Community Benefit Plan

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

The following outlines the approach taken when planning and developing initiatives to address priority health issues. At the outset, 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 Greater Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

Impact of the Coronavirus Pandemic

The COVID-19 pandemic has globally resulted in millions of confirmed cases and deaths numbering hundreds of thousands. It has caused an unprecedented challenge for our Greater Sacramento Market Hospitals and health care systems worldwide. In particular, the risk to health care; considering most health care workers are unable to work remotely, strategies had to be developed around early deployment of viral testing for asymptomatic and/or frontline health care staff. High health care costs, shortages of protective equipment, and low numbers of ICU beds and ventilators have been major challenges for our hospitals in the delivery of patient care. In communities across our Market, there is concern regarding uninsured individuals, who may work in jobs predisposing them to viral infection which may lead to significant financial consequences in the event of illness.

In response to this pandemic, our Market hospitals have had to implement immediate relief measures and engage in short, medium and longer term planning to re-balance and re-energize our communities in the midst of this crisis. Many of our hospitals have been engaging in collaborative efforts focusing on development of a broad clinical and socioeconomic plans with multi-disciplinary partners from health care, business, social services, government, community based organizations and wider society.

In FY21, Sierra Nevada Memorial took the following actions to respond to the needs created or exacerbated by COVID-19:

- The Community Health team partnered with our grant partners on adapting programs, where needed, to respond to COVID-19 or divert grant funding to support urgent needs arising due to the pandemic.
- Partnered with Nevada County on Project Room Key referring in homeless patients to the designated quarantine motels for shelter and follow-up care.
- Collaborated with the local 211 ensuring they had all materials required to transition to online and virtual healthier living program education.
- Hospitalist team coordinated weekly COVID-19 call for all physicians in the community to collaborate on providing the most up to date education and strategizing for how to best provide care for the community.
- Mobilized employee donations and volunteer time to support Hospitality House, the local homeless shelter. Employees provided cash donations, food, clothing, blankets, toiletries, water and other needed items.
- Sierra Nevada Memorial was also able to use iPads to provide telemedicine for monitoring suspected COVID-19 patients while in the hospital. Furthermore, iPads are used in lieu of in person visitis to facilitate patients staying connected with family and friends. This allowed us to keep our patients, community and staff safe and socially distanced, as well as help in a small way with preserving PPE supplies.
- Sierra Nevada Memorial alongside Nevada County Department of Public Health and other community partners hosted a series of community-based COVID-19 vaccination clinics that ran February – June, 2021. The clinics were part of an effort to provide opportunities for Nevada County residents, with a special focus on those most vulnerable, to receive COVID-19 vaccines at convenient and accessible locations. Together we were able to immunize nearly 8,000 individuals.
- Mobilized market leadership, physicians, and clinical experts within the Dignity Health system through media outlets and social media to answer questions and assuage concerns of our community around COVID-19.

In addition to continuing many of the actions identified above, Sierrra Nevada Memorial plans to take the following actions in FY22 to continue helping alleviate pandemic-induced needs:

- Building stronger partnership with United Way and Interfaith Food Ministries to strategize initiatives to address food insecurity for our school age populations.
- Sierra Nevada Memorial continues to use iPads in lieu of in person visitis to facilitate patients staying connected with family and friends. This allowed us to keep our patients, community and staff safe and socially distanced, as well as help in a small way with preserving PPE supplies.
- Hospitalist team will continue to coordinate weekly COVID-19 call for all physicians in the community to collaborate on providing the most up to date education and strategizing for how to best provide care for the community.
- Continuing to support programing focusing on homelessness, which is a particularly vulnerable population in light of COVID-19, including children and older adults. Specifically in Nevada County this includes Recuperative Care in partnership with Hospitality House.
- The hospital and community physicians are continuing to utilize telemedicine where appropriate, which allows us to keep patients home and safe, especially as we move into flu season.
- Continuing to mobilize Division leadership, physicians, and clinical experts within the Dignity Health system through media and social media to answer questions and assuage concerns of our community around COVID-19.
- Dignity Health is strongly encouraging community members to get their COVID-19 vaccine and flu shot throughout the coming fiscal year and educating patients regarding the importance.

- Continue to advocate with the County proper utilization of federal funding to support ongoing programs exacerbated by the pandemic (e.g., homelessness, food insecurity, behavioral health).
- Alongside County, City, and other providers offering behavioral health services, Sierra Nevada Memorial will continue to convene the monthly Nevada County Behavioral Health Collaboration, to identify gaps in the system of care and devise strategies for behavioral health across the County.

- As a broader community health and community benefit strategy, we will be looking for future opportunities to continue to support programs and initiatives that seek to address issues related to COVID-19

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any 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	Active FY21	Planned FY22
Homeless Recuperative Care Program	In FY18, Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services and Hospitality House, to develop a recuperative care program. Located at Hospitality House, the program provides recuperative care for up to 29 days, housing assistance, and wrap around services, and is a critical safety net for individuals experiencing homelessness who are exiting an in-patient hospital stay.	☒	☒
Resources for Low-Income Patients	The hospital partially or fully subsidizes cost of transportation, prescription medication, medical supplies and equipment, and short term room and board in the community for patients unable to pay for or	☒	☒

	access these resources after being discharged from the hospital.		
Resources for Homeless Patients	The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community resources to homeless patients being discharged from the hospital, with the intent to help prepare them for return to the community.	☒	☒

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	Active FY21	Planned FY22
Nevada County Health Collaborative Integrated Network	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.		
Substance Use Navigation	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.	☒	☒
Care Transition Intervention Program	The collaborative including FREED Center for Independent Living, Granite Wellness Center) and 211Connecting Point 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.	☒	☒
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.	☒	☒
Bright Horizons Health and Wellness Project	Supported through the Community Grants Program, a partnership between Bright Futures for Youth, Sierra Family Therapy and Interfaith Food Ministry, the program provides access to mental and physical health services as well as wellness education and nutrition literacy in order to improve the health status of youth as they progress through adolescence and set them on a path to a healthy and resilient young adulthood.	☒	☒

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	Active FY21	Planned FY22
Patient Navigator Program	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.	☒	☒
Care Transition Intervention Program	The collaborative including FREED Center for Independent Living, Granite Wellness Center, and 211/Connecting Point 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.	☒	☒
Patient Transportation Gas Card Program	Supported through the Community Grants Program, a partnership between Sierra Family Health Center, North San Juan Community Center and Nevada County Behavioral Health Center, this program reduces the barrier of transportation cost to those with little means to get to the Sierra Family Health Center for regular healthcare visits.	☒	☒

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	Active FY21	Planned FY22
Cardiac Rehabilitation	Exercise and education provided to patients during rehabilitation from a cardiac related event or surgery.	☒	☒
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.	☒	☒

Care Transition Intervention Program	The collaborative including FREED Center for Independent Living, Granite Wellness Center, and 211/Connecting Point 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.	☒	☒
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.	☒	☒
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics and community partners to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☒	☒
Bright Horizons Health and Wellness Project	Supported through the Community Grants Program, a partnership between Bright Futures for Youth, Sierra Family Therapy and Interfaith Food Ministry, the program provides access to mental and physical health services as well as wellness education and nutrition literacy in order to improve the health status of youth as	☒	☒

	they progress through adolescence and set them on a path to a healthy and resilient young adulthood.		
Patient Transportation Gas Card Program	Supported through the Community Grants Program, a partnership between Sierra Family Health Center, North San Juan Community Center and Nevada County Behavioral Health Center, this program reduces the barrier of transportation cost to those with little means to get to the Sierra Family Health Center for regular healthcare visits.	☒	☒

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	Active FY21	Planned FY22
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.		

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	Active FY21	Planned FY22
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking 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. • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy	☒	☒

Impact: The initiative to address safe, crime, and violence free communities are anticipated to result in: prevent unsafe environments; improve safety for the patient population served; provide education to all hospital staff on trauma informed care; increase the awareness of services available; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.

Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY21, the hospital awarded the grants below totaling $82,679. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Bright Horizons for Youth	The Friendship Club	$57,679
Sierra Family Health Center	Patient Transportation Gas Card Program	$15,000
Spirit Peers for Independence and Recovery	Coronavirus Pandemic Community Benefit Support Grant	$10,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. 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.

Oncology Nurse Navigator

Significant Health Needs Addressed	❑ Access to basic needs, such as housing, jobs, and food ❑ Access to mental, behavioral and substance use services ❑ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Active living and healthy eating ❑ Safe and violence-free environment
Program Description	The program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The 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 around their diagnosis and treatment options. The program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.

Community Benefit Category	A3-e Health Care Support Services – Information & Referral.
FY 2021 Report	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care. These measures will help to improve patient outcomes and experience.
Measurable Objective(s) with Indicator(s)	Increase the number of underserved patients through outreach and community collaboration. Build awareness of the program among community partners by providing more education within the community setting.
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.
Collaboration	Oncology nurse navigators collaborate with the multidisciplinary medical team and a variety of community partners to find available services for oncology patients in the community.
Performance / Impact	1,662 persons served -- shared by Dignity Health hospitals in Sacramento, Nevada and Yolo Counties.
Hospital's Contribution / Program Expense	$52,044 which is a shared expense by Dignity Health hospitals in Sacramento, Nevada and Yolo Counties.
FY 2022 Plan	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care. These measures will help to improve patient outcomes and experience.
Measurable Objective(s) with Indicator(s)	Continue to build awareness and increase the number of underserved individuals through outreach and community collaboration. Emphasis will be on education and building awareness of the program among community partners.
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	Oncology nurse navigators collaborate with the multidisciplinary medical team and a variety of community partners to find available services for oncology patients in the community.

Substance Use Navigation	
Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ✓ Access to mental/behavioral/substance use services ❑ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Active living and healthy eating ❑ Safe and violence-free environment
Program Description	The Public Health Institute, through its CA Bridge Program, and the CA Department of Health Care Services through the Behavioral Health Pilot Program are working to ensure that people with substance use disorders receive 24/7 high-quality care in every California health system by 2025. By supporting Medication Assisted Treatment training for emergency department physicians, and a Substance Use Navigator, the programs seek to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. A Substance Use Navigator is able to build a trusting relationship with the patient and motivate them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease.
Community Benefit Category	A3-Health Care Support Services
FY 2021 Report	
Program Goal / Anticipated Impact	By providing a 'No Wrong Door' approach to linking treatment for substance use disorder from the emergency department to local MAT clinics.
Measurable Objective(s) with Indicator(s)	Continue to build relationships between community MAT clinics and hospital providers by providing education opportunities, training, and dialogue.
Intervention Actions for Achieving Goal	Meetings with ED physicians, medical staff, nursing staff, social workers, and community MAT providers. Follow up phone calls to patients and providers to ensure warm handoff.
Collaboration	Local MAT agencies include Granite Wellness Center, Aegis, Stallant Health, Western Sierra Medical Clinic, Chapa De, Swope Medical Group and Sound Physicians.
Performance / Impact	Connected with 219 patients admitted through the ED and provided services to connect to care at local MAT agencies.
Hospital's Contribution / Program Expense	This program is funded through a California Department of Health Care Services Behavioral Health Pilot Project grant. Leadership from Emergency Department, Care Coordination and Community Health and Outreach help manage program.

FY 2022 Plan	
Program Goal / Anticipated Impact	Continue work to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease.
Measurable Objective(s) with Indicator(s)	Increase the number of ED providers and hospitalist providers with X-Waiver designation to allow for extended prescription of suboxone (or alternative) upon discharge from the hospital until a patient can be seen in a community MAT program. Engage in conversations and provide education to local OB providers to discuss initiation of Suboxone (or alternate) in the outpatient offices as appropriate.
Intervention Actions for Achieving Goal	Provide education to OB providers on Suboxone initiation in the outpatient setting. Continue two-way communication with ED physicians, medical staff, nursing staff, social workers, and community MAT providers. Follow up phone calls to patients and providers to ensure warm handoff.
Planned Collaboration	Continue work with local MAT agencies to include Granite Wellness Center, Aegis, Stallant Health, Western Sierra Medical Clinic, Chapa De, Swope Medical Group and Sound Physicians.

Bright Horizons Health and Wellness Project

Significant Health Needs Addressed	❑ Access to basic needs, such as housing, jobs, and food ✓ Access to mental/behavioral/substance use services ❑ Access to quality primary care health services ❑ Injury and disease prevention and management ❑ Access to specialty and extended care ✓ Active living and healthy eating ❑ Safe and violence-free environment
Program Description	The project provide access to mental and physical health services as well as wellness education and nutrition literacy in order to improve the health status of youth as they progress through adolescence.
Community Benefit Category	E2- Grants
FY 2021 Report	
Program Goal / Anticipated Impact	Provide youth with access to mental health, healthcare, nutrition education, and navigation to social services to be on the right path to a

	healthy and resilient adulthood and empower them to help their families.
Measurable Objective(s) with Indicator(s)	Numbers served with mental health and health services, number of youth participating in nutrition education classes that will in turn empower youths to choose healthier food choices for their families.
Intervention Actions for Achieving Goal	Continue to collaborate with partnering organizations to provide access to mental health, healthcare and nutrition education to youths and their families.
Collaboration	This project is led by Bright Futures for Youth in collaboration with Sierra Family Therapy and Interfaith Food Ministry.
Performance / Impact	36 case management services including 13 youth referred for mental health services. 115 individuals participated in health, wellness and stress reduction classes. 40 youth received hands on nutrition education classes when number of cohorts were limited to 10 during Covid-19 restrictions.
Hospital's Contribution / Program Expense	$57,679
FY 2022 Plan	
Program Goal / Anticipated Impact	Provide youth with access to mental health, healthcare, nutrition education, and navigation to social services to be on the right path to a healthy and resilient adulthood and empower them to help their families.
Measurable Objective(s) with Indicator(s)	Numbers served with mental health and health services, number of youth participating in nutrition education classes that will in turn empower youths to choose healthier food choices for their families.
Intervention Actions for Achieving Goal	Continue to collaborate with partnering organizations to provide access to mental health, healthcare and nutrition education to youths and their families.
Planned Collaboration	This project is led by Bright Futures for Youth in collaboration with Sierra Family Therapy and Interfaith Food Ministry

Crisis Stabilization Unit

Significant Health Needs Addressed	❑ Access to basic needs, such as housing, jobs, and food ✓ Access to mental/behavioral/substance use services ❑ Access to quality primary care health services ❑ Injury and disease prevention and management ❑ Access to specialty and extended care ❑ Active living and healthy eating ✓ 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. The program accepts self-referrals for anyone experiencing mental conditions and walks into the hospital. Nevada County Behavioral Health contracts with Sierra Mental Wellness to staff and operate the CSU.
Community Benefit Category	E1- Cash Donations
FY 2021 Report	
Program Goal / Anticipated Impact	Reduce the length of time it takes to connect patients in the emergency department experiencing a psychiatric emergency to an appropriate level of psychiatric care. Create a seamless transition from the ED to the CSU. Improve the level of psychiatric care in the community. Reduce readmissions for psychiatric emergencies by providing appropriate and supportive care in our community. Reduce the need for transfers to inpatient psychiatric hospitals.
Measurable Objective(s) with Indicator(s)	Individuals who are experiencing mental health conditions by providing immediate services and resources, including inpatient care. Crisis evaluations completed for individuals served by the program.
Intervention Actions for Achieving Goal	Work 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.
Collaboration	Sierra Nevada Memorial Hospital, Swope Medical Group, Nevada County Behavioral Health, Sierra Mental Wellness, Law Enforcement Agencies.
Performance / Impact	649 CSU admissions and 2,120 crisis evaluations were completed. There were 535 Medicaid patients. There was a 7% increase in admission over previous year.
Hospital's Contribution / Program Expense	$240,000
FY 2022 Plan	
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)	Individuals who are experiencing mental health conditions by providing immediate services and resources, including inpatient care. Crisis evaluations completed for individuals served by the program.
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.

Patient Navigation Program

Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ❑ Access to mental/behavioral/substance use services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Active living and healthy eating ❑ 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, Chapa-De Community Health Centers, Sierra Family Medical Clinic and the hospital.
Community Benefit Category	A3 - Health Care Support Services
FY 2021 Report	
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 Federally Qualified Health Centers 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.

Collaboration	Sierra Nevada Memorial Hospital, the local Federally Qualified Health Centers, and California Health & Wellness.
Performance / Impact	285 referrals and had 169 connects with patients which include appointments scheduled, appointments self-scheduled, PCP reassignments and patient education.
Hospital's Contribution / Program Expense	$9,650 in staff expenses. The patient navigator position is funded by California Health and Wellness. Staff from Community Health and Outreach help manage program.
FY 2022 Plan	
Program Goal / Anticipated Impact	The priority goal for a Patient Navigator is to find healthcare homes for uninsured and underinsured patients presenting to the emergency department for non-emergent health conditions, where they can receive appropriate levels of care with the desired outcome being improved health for designated patient populations. Assess barriers and assisting patients navigate and access community services and social supportive resources including scheduling of appointments and coordinating the referral process between Sierra Nevada Memorial and community health centers/primary care clinics, and social supportive resources. 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 Federally Qualified Health Centers 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 Federally Qualified Health Centers, social services and community based organizations.

Homeless Recuperative Care Program

Significant Health Needs Addressed	✓ Access to basic needs, such as housing, jobs, and food ❑ Access to mental/behavioral/substance use services ✓ Access to quality primary care health services ✓ Injury and disease prevention and management ✓ Access to specialty and extended care ❑ Active living and healthy eating ❑ Safe and violence-free environment

Program Description	Sierra Nevada Memorial partnered with Nevada County Health and Human Services to develop a 4-bed homeless recuperative care program located at Hospitality House.
Community Benefit Category	E1- Cash Donations
FY 2021 Report	
Program Goal / Anticipated Impact	This program provides a safe discharge plan, and a clean, dry, supportive place to recover from a recent hospitalization for patients who are homeless. Improves 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)	Contract drafted, signed, and ready to present to the Board of Supervisors for approval.
Intervention Actions for Achieving Goal	Regular meetings with a recuperative care team to develop a program that meets the needs of the community and makes the most of available resources. Identify key metrics to track. Create partnerships.
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, Community Recovery Resources, Grass Valley Police Department, Sierra Nevada Gastroenterology, AMI Housing.
Performance / Impact	The program is located at Hospitality House, and provides recuperative care for up to 29 days, housing assistance, and wrap around services. 23 individuals received services through the program and average length of stay was 15 days.
Hospital's Contribution / Program Expense	$90,000
FY 2022 Plan	
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	Continue 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, Community Recovery Resources, Grass Valley Police Department, Sierra Nevada Gastroenterology, AMI Housing.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services 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.

- Community Vision (formerly Northern California Community Loan Fund)
  Dignity Health has partnered with Community Vision since 1992, and was one of Dignity Health's first community investment. This CDFI has invested more than $254 million in projects throughout Northern and Central California, promoting economic justice and alleviating poverty by increasing the financial resilience and sustainability of community-based nonprofits and enterprises. In 2016 and 2017 Dignity Health approved two 7-year $1,000,000 loans respectively—the first as lending capital for NCCLF's many projects, and the second as lending capital in a "FreshWorks" Fund supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts").

- Rural Community Assistance Corporation (RCAC)
  In June 2017 Dignity Health approved a 7-year $500,000 loan to RCAC for projects in rural California, Nevada and Arizona. RCAC assists rural communities in building social capital, environmental infrastructure, and affordable housing. It also provides nonprofit organizations with access to financing. RCAC financing creates employment opportunities, affordable housing, safe and reliable environmental infrastructure, and much-needed community facilities and services. RCAC operates in rural California, Nevada and Arizona, and several other states west of the Rockies.

- 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.

- 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.

- Transitional Housing and Lodging - When there are no available alternatives, Sierra Nevada Memorial 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, Hospitality House, Nevada County Economic Resource Council,

BriarPatch Community Market and Hospice of the Foothill. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them, Granite Wellness Center, Nevada County Arts Council, Nevada City Chamber of Commerce, American Heart Association, and others.

Economic Value of Community Benefit

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**4,286**	**2,441,334**	**0**	**2,441,334**	**1.3%**
Medicaid*	**16,703**	**34,879,524**	**35,336,236**	**0**	**0.0%**
Means-Tested Programs	**12**	**58,512**	**32,678**	**25,834**	**0.0%**
Community Services					
A - Community Health Improvement Services	777	961,895	0	961,895	0.5%
C - Subsidized Health Services	231	103,880	0	103,880	0.1%
E - Cash and In-Kind Contributions	317	529,025	419,595	109,430	0.1%
Totals for Community Services	0	177,452	0	177,452	0.1%
Totals for Community Services	**1,325**	**1,772,252**	**419,595**	**1,352,657**	**0.7%**
Totals for Poor	**22,326**	**39,151,622**	**35,788,509**	**3,363,113**	**1.8%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,990	161,352	0	161,352	0.1%
B - Health Professions Education	132	834,536	0	834,536	0.5%
C - Subsidized Health Services	125	146,750	0	146,750	0.1%
Totals for Community Services	**2,247**	**1,142,638**	**0**	**1,142,638**	**0.6%**
Totals for Broader Community	**2,247**	**1,142,638**	**0**	**1,142,638**	**0.6%**
Totals - Community Benefit	**24,573**	**40,294,260**	**35,788,509**	**4,505,751**	**2.5%**
Medicare	**42,056**	**105,452,939**	**69,059,266**	**36,393,673**	**19.9%**
Totals with Medicare	**66,629**	**145,747,199**	**104,847,775**	**40,899,424**	**22.4%**

**Consistent with IRS instructions and CHA guidance, Medicaid net benefit is reported at $0 due to Medicaid Provider Fee revenue received exceeding expense in FY21. Without the Provider Fee, Medicaid net benefit for services delivered would have been $9,596,472. Net gain for Medicaid is still included in all "Totals" calculations, however.*

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

Monty East, Chair Retired Utilities District Manager Current Real Estate Agent	Alex Klistoff, MD, Vice Chair Retired Physician
Stephanie Ortiz, Secretary Executive Dean, Sierra College Nevada County Campus	Dan Castles Retired Technology Industry CEO
Jason Fouyer President, Cranmer Engineering	Michael Korpiel President, Dignity Health Mercy San Juan Hospital
Alison Lehman County Executive Officer	Andrew Chang, MD Gastroenterologist Past Chief of Staff
Bob Long Retired Healthcare Administrator	Vivian Tipton Executive Director Hospice of the Foothills
Brian Evans, MD President and CEO Sierra Nevada Memorial Hospital	