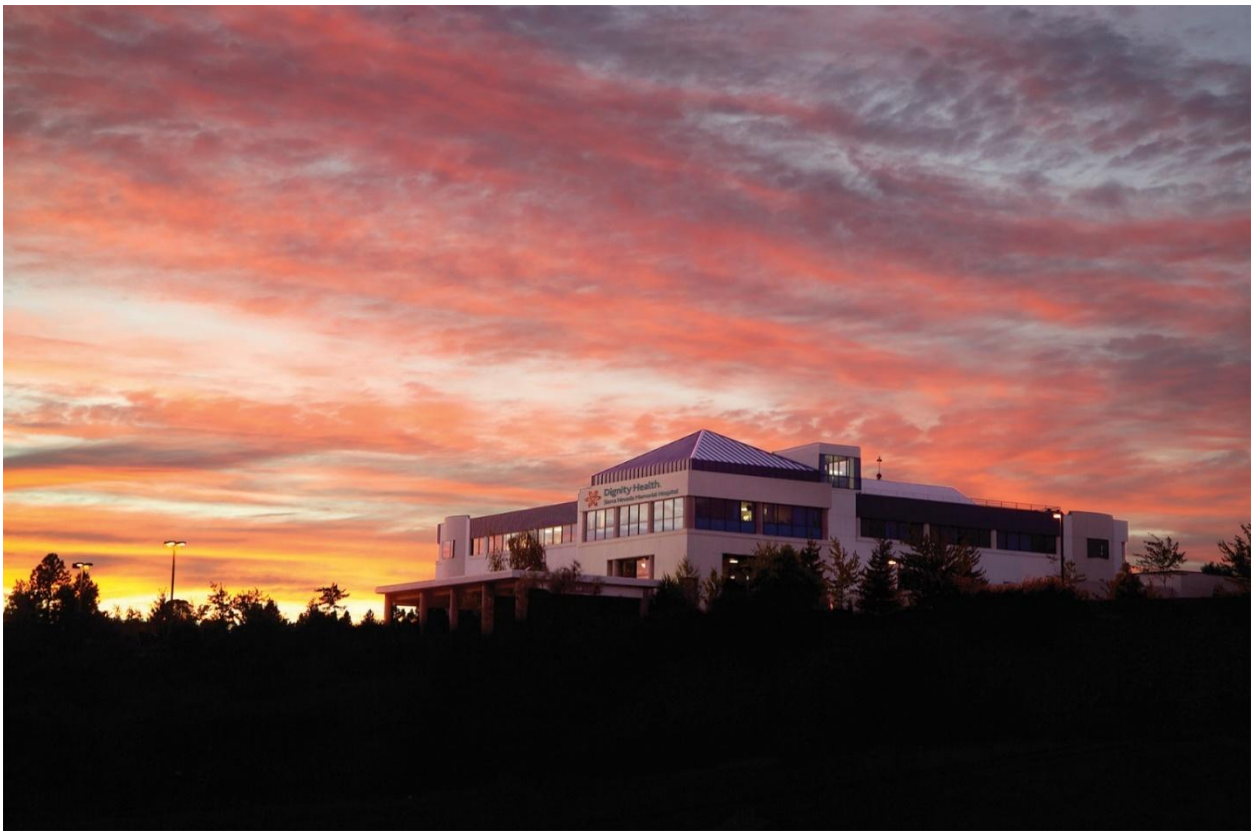
# Sierra Nevada Memorial Hospital

## Community Benefit 2023 Report and 2024 Plan

**Adopted November 2023**



Dignity Health
Sierra Nevada Memorial Hospital

# A message from

Scott Neeley, MD, President and CEO of Sierra Nevada Memorial Hospital, and Stephanie Ortiz, 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 2023 Report and 2024 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 2023 (FY23), Sierra Nevada Memorial provided $5,982,706 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $22,745,065 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2023 Report and 2024 Plan at its November 2, 2023 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 out to DignityHealthGSSA_CHNA@dignityhealth.org.

Sincerely,

Scott Neeley, MD
President/CEO

Stephanie Ortiz
Chairperson, Board of Directors

# Table of Contents

# At-a-Glance Summary

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| **Community Served** | Sierra Nevada Memorial Hospital is located in western Nevada County and has 807 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. Nevada County is home to just over 100,000 residents, with an estimated over one-third of the residents living in unincorporated communities. 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. |
| **Economic Value of Community Benefit** | $5,982,706 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits<br><br>$22,745,065 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:<br><br>1. Access to Basic Needs Such as Housing, Jobs, and Food<br>2. Access to Mental/Behavioral Health and Substance Use Services<br>3. Access to Quality Primary Care Health Services<br>4. Access to Specialty and Extended Care<br>5. System Navigation<br>6. Increased Community Connections<br>7. Injury and Disease Prevention and Management<br>8. Safe and Violence-Free Environment |
| **FY23 Programs and Services** | The hospital delivered several programs and services to help address identified significant community health needs. These included:<br><br>● Crisis Stabilization Unit (CSU): partnership with Nevada County Behavioral Health for patients experiencing acute mental health needs.<br>● Care Transitions: partnership with FREED to provide navigation and increase access to healthcare services for vulnerable populations.<br>● Patient Navigator Program: connect patients with primary care services and assistance with scheduling follow-up appointments to decrease unnecessary return visits to the emergency department. |

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| | • Oncology Nurse Navigator: information and resource for low-income patients who otherwise may not have access to care.<br>• Alzheimer's Outreach Program: education and support to those caring for persons with Alzheimer's disease and other forms of dementia.<br>• Medical Respite/Recuperative Care program: collaborative partnership with Foothill House of Hospitality and Medi-Cal Managed Care Plans to provide a respite care shelter for those experiencing homelessness to receive housing assistance and wrap around services. |
| **FY24 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, with specific focus on improving the linkages to primary care, mental health services, social services and community resources.<br><br>Sierra Nevada Memorial will continue to play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including: the Homeless Recuperative Care Program in partnership with Hospitality House; and active engagement with CalAIM Enhanced Care Management and Community Supports. Furthermore, 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, and continually implements and upgrades its technology and recruits employees who understand the vital importance of kindness and compassion in the healing process. The hospital has 807 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. Sierra Nevada Memorial was recognized in the Human Rights Campaign Foundation's 2022 Healthcare Equality Index (HEI) for its equitable treatment and inclusion of LGBTQ+ patients, visitors and employees. The hospital continues to be the only acute care hospital serving this region. 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

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

## Description of the Community Served


Sierra Nevada Memorial Hospital's community or hospital service area (HSA) is the geographic area (by ZIP code) outlined in the hospital's Community Health Needs Assessment (CHNA). 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. 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. Today, the Service-Providing sector leads in the number of people employed, followed by Government, and Goods Producing sectors. Nevada County is home to just over 100,000 residents, with an estimated one-third of the residents living in unincorporated communities, and a high proportion of adults over the age of 65 (29.5%). 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 county. Nevada County is comprised of two major cities: Grass Valley and Nevada City; one town: Truckee; and eleven unincorporated communities: Alta Sierra, Lake Wildwood, Lake of the Pines, Penn Valley, Rough and Ready, North San Juan, Washington, Kingvale, Soda Springs, Floriston and Graniteville. 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 2023 estimates provided by SG2's Analytics Platform (*Source: Claritas Pop-Facts® 2023; SG2 Market Demographic Module)*:

- Total Population: 81,109
- Race/Ethnicity: Hispanic or Latino: 8.9%; White: 80.2%; Black/African American: 0.5%; Asian/Pacific Islander 1.3%; All Other 9.0%
- % Below Poverty: 5.4%
- Unemployment: 2.7%
- No High School Diploma: 4.9%
- Medicaid: 22.2%
- Uninsured: 4.7%

# 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 April 2022.

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 CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| 1. Access to Basic Needs Such as Housing, Jobs, and Food | Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care. | ✓ |
| 2. Access to Mental/Behavioral Health and Substance Use Services | Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic | ✓ |

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| | challenges occur. Access to mental, behavioral, and substance-use services is an essential ingredient for a healthy community where residents can obtain additional support when needed. | |
| 3. Access to Quality Primary Care Health Services | Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners and physician assistants, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community. | ✓ |
| 4. Access to Specialty and Extended Care | Extended care services, which include specialty care, are services provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare. | ✓ |
| 5. System Navigation | System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities. Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency. | ✓ |
| 6. Increased Community Connections | As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to | ✓ |

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| | promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care. | |
| 7. Access to Functional Needs | Functional needs include indicators related to transportation and disability. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life. | |
| 8. Injury and Disease Prevention and Management | Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement. | ✓ |
| 9. Active Living and Healthy Eating | Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold. They are often challenged with food insecurity, lacking the means to consistently secure food for themselves or their families. When families rely on food pantries and | |

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| | school meals alone, these may not always provide sufficient nutrition for maintaining health. | |
| 10. Safe and Violence-Free Environment | Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) physical safety is essential. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior. | ✓ |

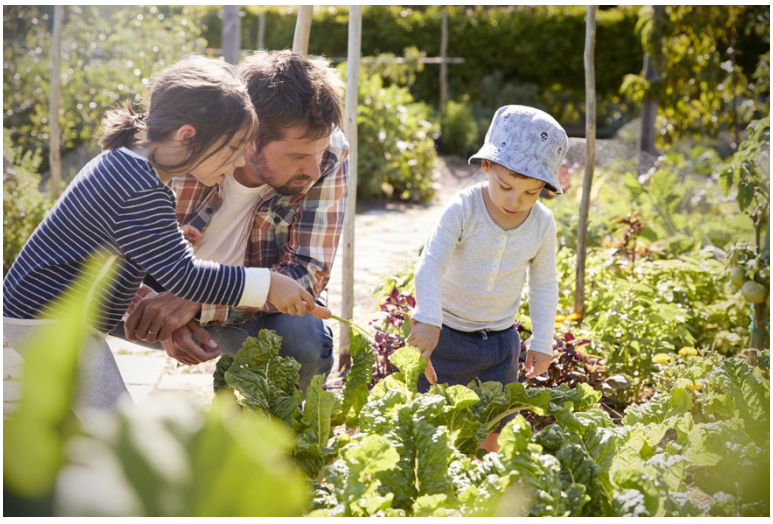
### Significant Needs the Hospital Does Not Intend to Address

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; although, the hospital will continue to seek collaborative opportunities that address needs that have not been selected as priorities. The hospital is not addressing access to functional needs and active living and healthy eating, 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.

## 2023 Report and 2024 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 FY23 and planned activities for FY24, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.



### 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 hospital 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.

## Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.


Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.


Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.


Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.


Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

## 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** | **Summary Description** | **Active FY23** | **Planned FY24** |
| Medical Respite/Recuperative Care Program | A collaborative partnership with Foothill House of Hospitality, Sierra Nevada Memorial and Medi-Cal Managed Care Plan to provide a respite care shelter for those experiencing homelessness to receive housing assistance and wrap around services 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 upon discharge from the hospital. | ☑ | ☑ |
| 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 Patients Experiencing Homelessness | The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community | ☑ | ☑ |

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| | resources to patients experiencing homelessness being discharged from the hospital, with the intent to help prepare them for return to the community. | | |
| Connecting Youth to Positive Social Determinants of Health | Supported through the Community Grants Program, a partnership between Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, and Granite Wellness. The project improves access to basic needs, health care, mental health supports, substance use prevention and intervention services, and mitigates factors that contribute to poor health outcomes. | ☑ | ☑ |
| **Goal and 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. | | | |
| **Collaborators:** The hospital will partner with Nevada County Health and Human Services, Hospitality House, Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, and Granite Wellness, and local community based organizations to deliver this access to increase basic needs such as housing, jobs and food. | | | |

| | **Health Need: Access to Mental/ Behavioral Health and Substance-Use Services** | | |
|---|---|---|---|
| **Strategy or Program** | **Summary Description** | **Active FY23** | **Planned FY24** |
| 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 crises to receive rapid access to appropriate care for their psychiatric emergency. | ☑ | ☑ |
| Mental Health Crisis Support Partnership | Nevada County contracted mental health crisis workers to assist patients in the hospital's emergency department, providing support, identifying placement, and creating safe discharge plans. The program addresses the urgent | ☑ | ☑ |

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| | need for mental health services and the steady increase of emergency department crisis evaluations. | | |
| 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 grants. | ☑ | ☑ |
| 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. | ☑ | ☑ |
| Tele-Psychiatry | Psychiatrists are available via remote technology to provide early evaluation and psychiatric intervention for patients, improving access to timely quality care. Access is available to both the ED and inpatient setting. | ☑ | ☑ |
| Connecting Youth to Positive Social Determinants of Health | Supported through the Community Grants Program, a partnership between Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, and Granite Wellness. The project improves access to basic needs, health care, mental health supports, substance use prevention and intervention services, and mitigates factors that contribute to poor health outcomes. | ☑ | ☑ |
| **Goal and Impact:** The hospital's initiative to address access to behavioral health services are anticipated to result in: improve patient linkages to outpatient behavioral health services; provide a seamless transition of care; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services. | | | |
| **Collaborators:** The hospital will partner with Nevada County Behavioral Health, FREED Center for Independent Living (Granite Wellness Center), 211 Connecting Point, Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, Granite Wellness, and local community based organizations to deliver this access to increase mental, behavioral health and substance use services. | | | |

| | Health Need: Access to Quality Primary Care Health Services | | |
|---|---|---|---|
| **Strategy or Program** | **Summary Description** | **Active FY23** | **Planned FY24** |
| 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. | ☑ | ☑ |
| Health Professions Education - Other | Provides a clinical setting for trainings and internships for students in the greater Sacramento region pursuing health professions other than physicians and nurses. This includes, but is not limited to: EMT, Paramedics, Pharmacy, Respiratory Therapy, Physical Therapy, Radiology Technologist and Surgical Technologist. | ☑ | ☑ |
| Health Professions Education - Nursing | Provides clinical setting for nursing students enrolled in education with an outside local college or university for additional training and education. This includes, but is not limited to: Undergraduate Nursing, Undergraduate Nursing-Preceptorship, Nursing BSN and Nursing ADN. | ☑ | ☑ |
| 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. | ☑ | ☑ |
| **Goal and Impact:** The hospital's initiatives to address access to high quality health care and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the healthcare system; increased primary care "medical homes" among those reached by navigators; reduce barriers to care; and improve collaborative efforts between all health care providers. | | | |
| **Collaborators:** The hospital will partner with California Health and Wellness, FREED Center for Independent Living, Granite Wellness Center, 211 Connecting Point, local medical clinics and local community based organizations to deliver this access to quality primary care health services. | | | |

| | Health Need: Access to Specialty and Extended Care |
|---|---|

| Strategy or Program | Summary Description | Active FY23 | Planned FY24 |
|---|---|---|---|
| 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 around their diagnosis and treatment options. The Navigation program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region. | ☑ | ☑ |
| Health Professions Education - Other | Provides a clinical setting for trainings and internships for students in the greater Sacramento region pursuing health professions other than physicians and nurses. This includes, but is not limited to: EMT, Paramedics, Pharmacy, Respiratory Therapy, Physical Therapy, Radiology Technologist and Surgical Technologist. | ☑ | ☑ |
| Health Professions Education - Nursing | Provides clinical setting for nursing students enrolled in education with an outside local college or university for additional training and education. This includes, but is not limited to: Undergraduate Nursing, Undergraduate Nursing-Preceptorship, Nursing BSN and Nursing ADN. | ☑ | ☑ |

**Goal and Impact:** The hospital's initiatives to address access to specialty and extended care and services are anticipated to result in: increased timely access and services, and increased knowledge about how to access and navigate the healthcare system for specialty and extended care, specifically to those that are uninsured or underinsured.

**Collaborators:** The hospital will partner with local medical clinics, and local community based organizations to deliver this access to specialty and extended care.

## Health Need: System Navigation

| Strategy or Program | Summary Description | Active FY23 | Planned FY24 |
|---|---|---|---|
| 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. | ☑ | ☑ |
| Domestic Violence and Sexual Assault Mobile Response Team | Supported through the Community Grants Program, a partnership between Community Beyond Violence, Grass Valley Police Department, Nevada County Sheriff's Office, and Nevada City Police Department A formal collaboration between CBV and GVPD creating a mobile response team for domestic violence and sexual assault. The LEO will be responsible for making arrests and ensuring the safety of all involved, the DV/SA advocate will provide crisis intervention and trauma informed counseling and advocacy with the criminal justice system, medical system and refer appropriate parties for ongoing supportive services. | ☑ | ☑ |

**Goal and Impact:** The hospital's initiatives to address system navigation is to continue to assist underserved patients admitted to the emergency department (ED) for primary care in finding primary care medical homes or reconnecting them with their assigned provider and other social support services to reduce their reliance on the ED, improve their health and lower costs..

**Collaborators:** The hospital will partner with local medical clinics, Nevada County Behavioral Health, FREED Center for Independent Living, Granite Wellness Center, 211 Connecting Point, Community Beyond Violence, Grass Valley Police Department, Nevada County Sheriff's Office, Nevada City Police Department and local community based organizations to deliver this access to system navigation.

## Health Need: Increased Community Connections

| Strategy or Program | Summary Description | Active FY23 | Planned FY24 |
|---|---|---|---|
| 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, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish. | | |
| Support Groups | 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. | ☑ | ☑ |
| **Goal and Impact:** The initiative to address increased community connections by the hospital is anticipated to result in: individuals with a sense of security, belonging, and trust in their community have better health. Community members with opportunities to connect with each other through programs, and services are important in fostering a healthy community. Healthcare and community support services are more effective when they are delivered in a coordinated fashion and in collaboration to build a network of care. | | | |
| **Collaborators:** The hospital will partner with local medical clinics, Sierra Nevada Memorial Hospital Foundation, Nevada County Health and Human Services, and local community based organizations to deliver this access to increase community connections. | | | |

| | **Health Need: Injury and Disease Prevention and Management** | | |
|---|---|---|---|
| **Strategy or Program** | **Summary Description** | **Active FY23** | **Planned FY24** |
| 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, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish. | ☑ | ☑ |
| 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. | ☑ | ☑ |
| 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 around their diagnosis and treatment options. The Navigation program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region. | ☑ | ☑ |
| 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 grants. | ☑ | ☑ |
| 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. | ☑ | ☑ |
| 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. | | |

**Goal and Impact:** The initiative to address this health need by the hospital is anticipated to result in: reduction of hospital admissions for chronic disease related; improve the health and quality of life for those who suffer from chronic illness; enable participants to better manage their disease; and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.

**Collaborators:** The hospital will partner with local medical clinics, Sierra Nevada Memorial Hospital Foundation, Nevada County Health and Human Services, and local community based organizations to deliver this access to injury and disease prevention and management.

| | **Health Need: Safe and Violence-Free Environment** | | |
|---|---|---|---|
| **Strategy or Program** | **Summary Description** | **Active FY23** | **Planned FY24** |
| Community Based Violence Prevention | The Community Based Violence Prevention Program initiative focuses on:<br>• Educating staff to identify and respond to victims of violence and human trafficking within the hospital;<br>• Provide victim-centered, trauma-informed care;<br>• Collaborate with community agencies to improve quality of care;<br>• Access critical resources for victims; and<br>• Provide and support innovative programs for recovery and reintegration.<br>• Public policy initiatives<br>• Community-based programs<br>• Research on best practices<br>• Resources for education and awareness<br>• Partnerships with national, state and local organizations<br>• Socially responsible investing and shareholder advocacy | ☑ | ☑ |
| Domestic Violence and Sexual Assault Mobile Response Team | Supported through the Community Grants Program, a partnership between Community Beyond Violence, Grass Valley Police Department, Nevada County Sheriff's Office, and Nevada City Police Department A formal collaboration between CBV and GVPD creating a mobile response team for domestic violence and sexual assault. The LEO will be responsible for making arrests and ensuring the safety of all involved, the DV/SA advocate will provide crisis intervention and trauma informed counseling and advocacy with the criminal justice system, medical system and refer appropriate parties for ongoing supportive services. | ☑ | ☑ |

**Goal and 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.

**Collaborators:** The hospital will partner with local shareholder advocacy groups, Community Beyond Violence, Grass Valley Police Department, Nevada County Sheriff's Office, Nevada City Police Department and local community based organizations to deliver this access to increase safe and violence-free environment.

## Community Health Improvement 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 related to CHNA priorities.

In FY23, Sierra Nevada Memorial Hospital awarded grants totaling $86,845. Some projects also may be described elsewhere in this report.

| Grant Recipient | Project Name | Amount |
|---|---|---|
| Bright Futures for Youth | Connecting Youth to Positive Social Determinants of Health | $43,045 |
| Community Beyond Violence | Domestic Violence and Sexual Assault Mobile Response Team | $43,800 |

## Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

| | Oncology Nurse Navigator |
|---|---|
| Significant Health Needs Addressed | ☐ Access to Basic Needs Such as Housing, Jobs, and Food<br>☐ Access to Mental/Behavioral Health and Substance Use Services<br>☐ Access to Quality Primary Care Health Services<br>✓ Access to Specialty and Extended Care<br>✓ System Navigation<br>☐ Increased Community Connections<br>✓ Injury and Disease Prevention and Management<br>☐ Active Living and Healthy Eating<br>☐ 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 |

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| | 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. |
| Population Served | The primary beneficiaries are individuals diagnosed with cancer. |
| 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. |
| **FY 2023 Report** | |
| Activities Summary | • Provide nurturing support with guidance and support throughout the cancer treatment process.<br>• Act as a liaison among caregivers and physicians<br>• Help navigation additionally support services for their patient<br>• Coordinate appointments and treatments.<br>• Educate the community on cancer prevention and treatment. |
| Performance / Impact | 2,006 persons served |
| Hospital's Contribution / Program Expense | $71,088 |
| **FY 2024 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. |
| Planned Activities | 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. |

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| | **Substance Use Navigation** |
| Significant Health Needs Addressed | □ Access to Basic Needs Such as Housing, Jobs, and Food<br>✓ Access to Mental/Behavioral Health and Substance Use Services<br>□ Access to Quality Primary Care Health Services<br>✓ Access to Specialty and Extended Care<br>✓ System Navigation |

| | |
|---|---|
| | ☐ Increased Community Connections<br>☐ Injury and Disease Prevention and Management<br>☐ Active Living and Healthy Eating<br>☐ 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 (MAT) 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 |
| Population Served | The primary beneficiaries of this program are individuals not currently engaging in substance use treatment and services. |
| 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. |
| **FY 2023 Report** | |
| Activities Summary | • Provided navigation with a warm hand off and scheduled appointments with MAT agencies for patients with opiate use disorder (OUD) and substance use disorder (SUD), i.e. alcohol, stimulants, and benzos.<br>• Provided free Naloxone, and facilitated doses of buprenorphine, and suboxone Bridge prescriptions to patients.<br>• Enrolled and assisted patients with health insurance such as Medi-Cal.<br>• Connected patients to primary care with MAT programs and community resource education. |
| Performance / Impact | 511 patients were connected with or offered services on substance use disorders, treatment resources, harm reduction education, sobriety support and information. |
| Hospital's Contribution / Program Expense | This program is funded through a California Department of Health Care Services Behavioral Health Pilot Project grant. Leadership from ED, Care Coordination and Community Health and Outreach help manage this program. |
| **FY 2024 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. |

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| Planned Activities | 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. |

| Connecting Youth to Positive Social Determinants of Health | |
|---|---|
| Significant Health Needs Addressed | ✓ Access to Basic Needs Such as Housing, Jobs, and Food<br>✓ Access to Mental/Behavioral Health and Substance Use Services<br>☐ Access to Quality Primary Care Health Services<br>☐ Access to Specialty and Extended Care<br>☐ System Navigation<br>☐ Increased Community Connections<br>☐ Injury and Disease Prevention and Management<br>☐ Active Living and Healthy Eating<br>☐ Safe and Violence-Free Environment |
| Program Description | This program is supported through the Community Grants Program, a partnership between Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, and Granite Wellness. The project improves access to basic needs, health care, mental health supports, substance use prevention and intervention services, and mitigates factors that contribute to poor health outcomes. |
| Population Served | The primary beneficiaries of this program are youth and young adults ages 12-26 in Nevada County. |
| Program Goal / Anticipated Impact | Ensure that youth and their families have access to basic needs, health care, mental health supports, substance use prevention and intervention services for better overall health outcomes. |
| **FY 2023 Report** | |
| Activities Summary | ● Provide case management with access to basic needs and social service support.<br>● Provide awareness of alternatives to substance use through prevention and early intervention.<br>● Provide access to mental health and physical services by connecting participants to counseling services and health providers.<br>● Provide access to health care job opportunities through awareness of career pathways. |
| Performance / Impact | From January to June 2023, this program provided early intervention services to 118 youth. 75 youths received case management support, 44 received referrals to mental and behavioral health care services, and 10 teens were provided information regarding career pathways and job opportunities within Nevada County. |

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| Hospital's Contribution / Program Expense | $43,045 |
| **FY 2024 Plan** | |
| Program Goal / Anticipated Impact | Continue to ensure that youth and their families have access to basic needs, health care, mental health supports, substance use prevention and intervention services for better overall health outcomes. |
| Planned Activities | Continue to collaborate with partnering organizations to provide access to basic needs and health and social services resources with case management for youths. |

|  | **Alzheimer's Outreach Program** |
|---|---|
| Significant Health Needs Addressed | □ Access to Basic Needs Such as Housing, Jobs, and Food<br>✓ Access to Mental/Behavioral Health and Substance Use Services<br>□ Access to Quality Primary Care Health Services<br>□ Access to Specialty and Extended Care<br>□ System Navigation<br>✓ Increased Community Connections<br>✓ Injury and Disease Prevention and Management<br>□ Active Living and Healthy Eating<br>□ Safe and Violence-Free Environment |
| Program Description | 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. |
| Population Served | Individuals in the community suffering from memory impairment or adjusting to a new diagnosis and caregivers in need of guidance and support. |
| Program Goal / Anticipated Impact | This program helps support any individual or caregiver suffering from a memory impairment through two primary components: educational and clinical. |
| **FY 2023 Report** | |
| Activities Summary | This program provides one-on-one crisis care and case management support for families, caregiver education, community education and outreach, and respite care funds for families in need. |

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| Performance / Impact | 285 individuals received services through the program. |
| Hospital's Contribution / Program Expense | $62,092 |
| **FY 2024 Plan** | |
| Program Goal / Anticipated Impact | Continuing to provide support to any individual or caregiver suffering from a memory impairment through educational and clinical components. |
| Planned Activities | Continue to provide one-on-one crisis care and case management support for families, caregiver education, community education and outreach, and respite care funds for families in need at no cost to the participants. |

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| | **Patient Navigator Program** |
| Significant Health Needs Addressed | ✓ Access to Basic Needs Such as Housing, Jobs, and Food<br>☐ Access to Mental/Behavioral Health and Substance Use Services<br>✓ Access to Quality Primary Care Health Services<br>✓ Access to Specialty and Extended Care<br>☐ System Navigation<br>☐ Increased Community Connections<br>✓ Injury and Disease Prevention and Management<br>☐ Active Living and Healthy Eating<br>☐ 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. |
| Population Served | The primary beneficiaries of this program are individuals on Medi-Cal or uninsured not connected to primary care services or need immediate assistance to schedule with their primary care. |
| Program Goal / Anticipated Impact | Assist underserved patients admitted to the emergency department (ED) for primary care in finding primary care medical homes or reconnecting them with their assigned provider and other social support services to reduce their reliance on the ED, improve their health and lower costs. Support patients in |

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| | attending follow up care with their primary care provider to improve primary care access and reduce inappropriate ED utilization and recidivism. |
| **FY 2023 Report** | |
| Activities Summary | Patient Navigators scheduled follow-up primary care appointments for individuals in the emergency department (ED). Also, they provided assistance with social services resources, health insurance eligibility and linkages to other community health care services. |
| Performance / Impact | 572 connected with scheduled appointments, appointments self-scheduled, PCP reassignments and patient education. |
| Hospital's Contribution / Program Expense | The patient navigator position is funded by California Health and Wellness. |
| **FY 2024 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 assist patients with navigating and accessing 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 patients in attending follow up care with their primary care provider to improve primary care access and reduce inappropriate ED utilization and recidivism. |
| Planned Activities | Meet with Federally Qualified Health Centers to facilitate expedited access to follow up appointments. Communicate regularly with navigators and health plans regarding trends, resources needed and challenges connecting patients to care. |

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| | **Medical Respite/Recuperative Care Program** |
| Significant Health Needs Addressed | ✓ Access to Basic Needs Such as Housing, Jobs, and Food<br>✓ Access to Mental/Behavioral Health and Substance Use Services<br>✓ Access to Quality Primary Care Health Services<br>✓ Access to Specialty and Extended Care<br>□ System Navigation<br>□ Increased Community Connections<br>✓ Injury and Disease Prevention and Management<br>□ Active Living and Healthy Eating |

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|---|---|
| | □ Safe and Violence-Free Environment |
| Program Description | A collaborative partnership with Foothill House of Hospitality, Sierra Nevada Memorial and Medi-Cal Managed Care Plan to provide a respite care shelter for those experiencing homelessness to receive housing assistance and wrap around services 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 upon discharge from the hospital. |
| Population Served | The primary beneficiaries of this program are individuals experiencing homelessness in need of a safe environment to fully recover when discharged from the hospital. |
| Program Goal / Anticipated Impact | Increase access to a continuum of care and social support services to meet the special needs of individuals experiencing homelessness necessary to improve their health status, and reduce their need to admit/readmit to the hospital. |
| **FY 2023 Report** | |
| Activities Summary | • Provide patients with meals, bed rest, self-care and in-house physical therapy as needed.<br>• Assist patients with accessing medical home, social services and community housing supports. |
| Performance / Impact | 33 individuals received services through the program with a total of 426 bed nights. |
| Hospital's Contribution / Program Expense | $108,334 |
| **FY 2024 Plan** | |
| Program Goal / Anticipated Impact | Continue to increase access to a continuum of care and social support services to meet the special needs of individuals experiencing homelessness necessary to improve their health status, and reduce their need to admit/readmit to the hospital. |
| Planned Activities | Continue to work with partners to improve the number of successful referrals. Emphasis will be focused on improving communication between hospital and Hospitality House staff to discuss individual placement successes and challenges, as well as accessing services such as CTI services, Hepatitis C navigation, substance use navigation, direct entry bed, primary care navigation. Emphasis will be placed on coordinating referrals with other CalAIM benefits including Enhanced Care Management and Community Supports Housing Navigation. |

## 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.

- California FarmLink - In June 2020, CommonSpirit approved a $500,000 loan to California FarmLink used to support the organization's loan program, which in turn provides affordable financing for small-scale farmers, beginning farmers, and farmers of color. California FarmLink is a nonprofit public benefit corporation formed in 1999 with a mission to invest in the prosperity of farmers and ranchers through lending, education, and access to land throughout farming communities in Central Coast, Sacramento, San Joaquin, and North Coast, California.

- 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 investments. 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.

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 | Offsetting Revenue | Net Benefit | % of Expenses |
|---|---|---|---|---|---|
| **Benefits for Poor** | | | | | |
| **Financial Assistance** | **5,072** | **$2,573,602** | **$0** | **$2,573,602** | **1.4%** |
| **Medicaid** | **16,642** | **$50,211,131** | **$53,638,846** | **$0** | **0.0%** |
| **Community Services** | | | | | |
| A - Community Health Improvement Services | 466 | $1,852,851 | $0 | $1,852,851 | **1.0%** |
| C - Subsidized Health Services | 208 | $106,985 | $0 | $106,985 | **0.1%** |
| E - Cash and In-Kind Contributions | 166 | $401,235 | $0 | $401,235 | **0.2%** |
| F - Community Building Activities | Unknown | $5,537 | $0 | $5,537 | **0.0%** |
| G - Community Benefit Operations | 1 | $84,983 | $0 | $84,983 | **0.0%** |
| **Totals for Community Services** | **841** | **$2,451,591** | **$0** | **$2,451,591** | **1.3%** |
| **Totals for Benefits for Poor** | **22,555** | **$55,236,324** | **$53,638,846** | **$5,025,193** | **2.7%** |
| **Benefits for Broader Community** | | | | | |
| **Community Services** | | | | | |
| A - Community Health Improvement Services | 3,961 | $307,523 | $45,278 | $262,245 | **0.1%** |
| B - Health Professions Education | 121 | $553,214 | $0 | $553,214 | **0.3%** |
| C - Subsidized Health Services | 128 | $142,054 | $0 | $142,054 | **0.1%** |
| **Totals for Community Services** | **4,210** | **$1,002,791** | **$45,278** | **$957,513** | **0.5%** |
| **Totals for Broader Community** | **4,210** | **$1,002,791** | **$45,278** | **$957,513** | **0.5%** |
| **Totals - Community Benefit** | **26,765** | **$56,239,115** | **$53,684,124** | **$5,982,706** | **3.2%** |
| **Medicare** | **34,715** | **$84,464,777** | **$61,719,712** | **$22,745,065** | **12.0%** |
| **Totals Including Medicare** | **61,480** | **$140,703,89** | **$115,403,83** | **$28,727,771** | **15.2%** |

**Consistent with IRS instructions and CHA guidance, Medicaid is reported at $0 net benefit because offsetting revenue was greater than expense in FY23. 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

### Sierra Nevada Memorial Hospital Board of Directors

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|---|---|
| Stephanie Ortiz, Chair<br>Executive Dean, Sierra College Nevada County Campus | Bob Long, Vice Chair<br>Retired Healthcare Administrator |
| Vivian Tipton, Secretary<br>Executive Director<br>Hospice of the Foothills | Monty East<br>Retired Utilities District Manager<br>Current Real Estate Agent |
| Jason Fouyer<br>President, Cranmer Engineering | Dr. Thomas Boyle<br>General Surgery, Past Chief of Staff |
| Alison Lehman<br>County Executive Officer | Anne Guerra<br>Retired, Community Resource Business Advocate |
| Daryl Grigsby<br>Retired Public Works Director | Michael Korpiel<br>President, Dignity Health Greater Sacramento Market & President/CEO, Dignity Health Mercy San Juan Hospital |
| Scott Neeley, MD<br>President/CEO<br>Sierra Nevada Memorial Hospital | |