Sierra Nevada Memorial Hospital

Hospital HCAI ID:106291023

Community Benefit 2025 Report and 2026 Plan

Adopted October 2025

Dignity Health®
Sierra Nevada Memorial Hospital

A member of CommonSpirit

A message from

Scott Neeley, MD, President, and Bob Long, 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 drivers of health.

Sierra Nevada Memorial Hospital shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2025 Report and 2026 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. 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 2025 (FY25), Sierra Nevada Memorial Hospital provided $2,579,571 in patient financial assistance, and $2,654,697 in community health improvement services, community grants and other community benefits. The net benefit of Medicaid is reported as $0 due to Medicaid Provider Fee revenue making revenues greater than expenses. The hospital also incurred $23,972,574 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 23, 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

Scott Neeley, MD
President

Bob Long
Chairperson, Board of Directors

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At-a-Glance Summary

Hospital HCAI ID: 106291023

Report Period Start Date: July 1, 2024 **Report Period End Date**: June 30, 2025

Community Served	Sierra Nevada Memorial Hospital, located in Grass Valley, California, serves over 80,000 western Nevada County residents. The community served by Sierra Nevada Memorial Hospital primarily resides in the unincorporated areas of western Nevada County and the communities of North San Juan, Pike, Washington, Graniteville, Alta Sierra, Grass Valley, Nevada City, Lake Wildwood, Penn Valley, and Smartsville. The community served by Sierra Nevada Memorial Hospital resides in one of the following zip codes: 95945, 94946, 95949, 95959, 95960, 95975, 95977, and 95986.
Economic Value of Community Benefit	$2,579,571 in patient financial assistance, and $2,654,697 in community health improvement services, community grants and other community benefits. The net benefit of Medicaid is reported as $0 due to Medicaid Provider Fee revenue making revenues greater than expenses. $23,972,574 in unreimbursed costs of caring for patients covered by Medicare fee-for-service. Community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
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: • Access to behavioral healthcare, including substance use disorder treatment and navigation of services • Access to primary care and dental care • Community belonging • Unmet vital conditions, including transportation, finances, housing (including the unhoused population), and education
FY25 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: The hospital delivered several programs and services to help address identified significant community health needs. These included: • Oncology Nurse Navigator

	• Alzheimer's Outreach Program • Medical Respite/Recuperative Care Program • Substance Use Navigation • Patient Navigator Program • Connecting Youth to Positive Social Determinants of Health • HealthSpan
FY26 Planned Programs and Services	Existing FY25 programs for Sierra Nevada Memorial Hospital will continue into FY26 and the hospital will continue to seek opportunities with collaborative partners to further the health of the community.

This document is publicly available online at:
https://www.dignityhealth.org/sacramento/locations/sierra-nevada-memorial-hospital/community-health-and-community-benefit

Written comments on this report can be submitted to the Sierra Nevada Integration and Community Health Office, 155 Glasson Way, Grass Valley, CA 95945 or by e-mail to brian.stoltey@commonspirit.org.

Our Hospital and the Community Served

About Sierra Nevada Memorial Hospital

Sierra Nevada Memorial Hospital is a Dignity Health hospital. Dignity Health is a member of CommonSpirit Health.

Dignity Health Sierra Nevada Memorial Hospital is situated in Nevada County, located at 155 Glasson Way in Grass Valley, California. Since opening in 1958, the hospital has expanded in numerous ways to meet the growing needs of the community. The hospital currently has 104 licensed acute-beds, including coronary, intensive, and perinatal care, a 21-bed emergency department, and is supported by over 800 employees and 100 medical staff. Sierra Nevada Memorial Hospital offers the following specialized services, including:

- Family Birth Center,
- Ambulatory Treatment Center,
- Community Cancer Center accredited by the Commission on Cancer of the American College of Surgeons,
- Diagnostic Imaging Center and Women's Imaging Center,
- Wound Care Healing & Hyperbaric Medicine Center, and,
- Certified Primary Stroke Center by the Joint Commission.

Sierra Nevada Memorial was also 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.

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

The hospital serves approximately 80,000 residents who reside in the rural, mountainous communities located on the western slope of the Sierra Nevada Foothills, and extending into Tahoe National Forest. A summary description of the community is below, and additional details can be found in the CHNA report online.

The largest incorporated area in the SNMH community is the City of Grass Valley, which is home to 14,126 residents. Nearly adjacent to Grass Valley is the much smaller City of Nevada City, where 3,168 individuals reside. Nevada City serves as the county seat of Nevada County. The Hospital also serves the communities of Alta Sierra, Lake Wildwood, North San Juan, Penn Valley, Smartsville, and Washington, California. The community served by the Hospital includes the following zip codes, as geographically depicted in Figure 1:

- 95945 - Grass Valley; Alta Sierra
- 95946 - Penn Valley
- 95949 - Grass Valley
- 95959 - Nevada City
- 95960 - North San Juan
- 95975 - Rough and Ready
- 95977 - Smartsville
- 95986 - Washington

The community does not exclude any low-income or underserved populations and includes all members of the community. The communities served by the Hospital align with the residence location (contiguous zip codes) for more than 75% of all inpatient discharges. Nevada County is also served by Tahoe Forest Hospital in Truckee and the entire County is supported by the Nevada County Public Health Department.

Demographics within Sierra Nevada Memorial Hospital's service area as derived from the U.S. Census include:

- Total population: 79,880
- Median age (years): 50.6
- Percent Hispanic or Latino(a): 9.9%
- Percent White alone, not Hispanic or Latino(a): 81.8%
- Median household income range: $40,099 - $100,909
- Percent of families living in poverty (below 100% federal poverty level): 7.2%
- Unemployment rate: 4.5%
- Percent with less than a high school diploma, 25 years and over: 5.1%
- Percent, age 5 and older who speak English less than “very well”: 2.3%
- Percent without health insurance: 5.3%
- No. of Partnership HealthPlan of California Members (Medi-Cal administrator): 28,772

Figure 1. Sierra Nevada Memorial Hospital Communities Served

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 May, 2025. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request.

CHNA web address:
https://www.dignityhealth.org/sacramento/locations/sierra-nevada-memorial-hospital/community-health-and-community-benefit

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.

Community Groups that Attended or Engaged with the CHNA:

- Nevada County Public Health Department
- Bright Futures for Youth
- Hospitality House
- Foothills Compassionate Care
- North San Juan Community Center
- Women of Worth
- FREED Center for Independent Living

Vulnerable Populations Represented by These Groups:

- Black/African American community
- Individuals identifying as lesbian, gay, bisexual, transgender or queer
- Individuals with limited English proficiency
- Seniors
- Low income and disabled adults
- Unhoused adults
- Youth

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

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?
Unmet vital conditions, including transportation, finances, housing (including the unhoused population), and education.	This systemic issue compromises access to vital resources like transportation, housing, healthy food, education, and healthcare, leading to increased health risks and reduced life expectancy for residents in impoverished areas. Additionally, the high rates of poverty significantly impact youth and families in several Nevada County communities, as evidenced by high rates of free or reduced-price lunch at schools. Childhood poverty is linked to developmental delays, health issues, and a higher likelihood of lifelong poverty, perpetuating generational cycles.	☑
Access to behavioral health, including substance use disorder treatment and navigation of services.	Mental health is a critical concern in Nevada County, with high rates of overdose deaths and prevalent anxiety and depression. The community recognizes the need for better support addressing trauma and life stressors impacting well-being. Furthermore, a significant portion of local children on Medi-Cal show high Adverse Childhood Experiences scores, highlighting the urgent need for targeted interventions.	☑
Access to primary care and dental care	Obtaining primary and dental healthcare is a major community challenge. Nevada County faces a severe physician shortage and finding a new primary care doctor can take years. For dental care there is only one dental provider that accepts Medi-Cal, which disproportionately affects low-income individuals. These factors make prolonged waits for both medical and dental care common.	☑
Community belonging	Civic engagement capacity and local, self-driven solutions are critical to addressing local needs. Community belonging and civic muscle refers to a community where an individual feels valued. Civic muscle is the power to work across differences for a thriving future.	☑

2025 Report and 2026 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 FY25 and planned activities for FY26, 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

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its staff, clinicians and board, and in collaboration with community partners. Hospital and health system participants included the Community Board and the Community Engagement and Advisory Panel 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.

Additionally, the Community Health and Outreach staff engage 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 and help define appropriate processes, procedures and methodologies for measuring outcomes.

The programs and initiatives described in this report were selected on the basis of a comprehensive set of criteria, aiming for strategic and impactful community health improvement. These criteria include:

- Alignment with Mission: Ensuring the initiatives support the hospital's core purpose.
- Best Practices Research: Incorporating evidence-based approaches.
- Community Readiness: Considering the community's capacity and willingness to act on the issue.
- Equity Focus: Prioritizing needs that disproportionately affect vulnerable populations and contribute to health disparities.
- Leveraging Existing Strengths: Identifying issues where existing infrastructure (programs, systems, staff) and established relationships with community partners are already in place.
- Measurability: Selecting issues where there is a clear ability to have a measurable impact.
- Problem Assessment: Evaluating the magnitude and severity of the health issues.
- Resource Availability: Assessing the availability of both hospital and external community resources.
- Sustainability: Ensuring there is ongoing investment and commitment of resources (staff time and financial) for the chosen initiatives.

Furthermore, selection involves research on best practices, alignment with local, state, or national health priorities, and a strong emphasis on collaboration with community stakeholders. Where possible, initiatives are designed to employ upstream prevention models to address the social determinants of health, with a critical focus on building and strengthening relationships with community-based providers to ensure long-term success and sustainability.

Community Health Core Strategies

The hospital intends that program activities to help address significant community health needs reflect a strategic use of resources. CommonSpirit Health has established three community health improvement core strategies to help ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable 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 goals and anticipated impact, and any collaboration with other organizations in their delivery.

Health Need: Access to behavioral healthcare, including substance use disorder treatment and navigation of services

Strategy or Program	Summary Description	Active FY25	Planned FY26
Nevada County Health Collaborative Integrated Network	A collaborative network to increase access, integration, and coordination of rural health services including primary care, behavioral health, and telemedicine.	x	x
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 that provides patients in acute psychiatric crises to receive appropriate care for their psychiatric emergency.	x	x
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.	x	x
Substance Use Navigation	Funded through grants, the Substance Use Navigation program provides 24/7 high-quality care for individuals with substance use disorder. The program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives.	x	x
Care Transition Intervention Program	Collaborative focusing on care transition and patient navigation between organizations and develops a "no wrong door" system of referral.	x	x
Financial Assistance	Sierra Nevada provides patient financial assistance to patients and	x	x

	families who meet certain income requirements.		

Goal and Impact: These programs will strengthen the continuum of care and increase awareness for behavioral health needs, including enhanced substance use navigation and a unified, accessible entry point for all individuals seeking support.

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

Health Need: Access to Primary Care and Dental Care

Strategy or Program	Summary Description	Active FY25	Planned FY26
Mobile Clinic	A mobile acute care clinic to broaden service delivery. The unit, staffed by an Advanced Practice Provider and Medical Assistant, will provide walk-in services at four designated sites within the hospital's primary service area. This outreach addresses significant barriers to care, including transportation limitations and issues of healthcare professional trust enhancing our community presence and partnerships.	☐	x
Patient Navigator Program	A collaboration with Partnership HealthPlan, a Medi-Cal managed care plan,to assist patients that rely on the emergency department for non-urgent needs by connecting them to a medical home and schedule follow up appointments	x	x
Health Professions Education-Other	Provides a clinical setting for training 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.	x	x

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.	x	x
Dental Care	Explore opportunities to partner with Nevada County Health and Human Services - Public Health Branch to improve access to dental services.	☐	x
Financial Assistance	Sierra Nevada provides patient financial assistance to patients and families who meet certain income requirements.	x	x

Goal and Impact: These programs will help increase access to care and reduce Social Determinants of Health barriers to accessing care (e.g. transportation) through improved health care utilization.

Collaborators: The hospital will partner with local medical clinics and local community based organizations to deliver this access to quality primary care health services.

Health Need: Unmet Vital Conditions, including transportation, finances, housing (including the unhoused population, and education)

Strategy or Program	Summary Description	Active FY25	Planned FY26
HealthSpan	A community health collaborative in Nevada County, California dedicated to improving overall well-being by supporting and expanding existing successful projects and activities that support regional wellness.	☐	x
Community Health Workers for Rural Regions	This program connects health and social services with community members. Community Health Workers educate on health, enhance access to care, and champion health equity by empowering individuals to manage their well-being and navigate complex systems.	x	x

Medical Respite/Recuperative Care Program	A collaborative partnership with Foothill House of Hospitality, Sierra Nevada Memorial and Partnership located at Hospitality House to provide a respite/recuperative care shelter for those experiencing homelessness and wrap around services for up to 29 days.	x	x
Patient Navigator Program	A collaboration with Partnership to assist patients that rely on the emergency department for non-urgent needs by connecting them to a medical home and schedule follow up appointments.	x	x
Resources for Low Income and Unhoused Patients	The hospital partially or fully subsidizes the cost of transportation, medication, medical supplies, basic needs, and short-term room and board in the community for patients unable to access these resources after being discharged from the hospital.	x	x
Connecting Youth to Positive Social Determinants of Health	A partnership between Bright Futures for Youth, Community Beyond Violence, Western Sierra Medical Clinic, and Granite Wellness to improve access to basic needs, health care, mental health supports, substance use prevention and intervention services.	x	x

Goal and Impact: Improved coordination and access to basic needs, recuperative and respite services, and medical referrals; improved health outcomes for those at-risk of and/or experiencing homelessness; and reduction of the prevalence of chronic disease in the community.

Collaborators: The hospital will continue to 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 other local community based organizations to deliver this access to increase basic needs such as housing, jobs and food.

Health Need: Community Belonging

Strategy or Program	Summary Description	Active FY25	Planned FY26
Cultural Competency and Humility Training	Provide training opportunities for staff and community organizations that address the specific health needs of the community. This collaboration can improve care coordination and strengthen social connections.	☐	x
Community Outreach	Foster an inclusive environment by participating in culturally responsive activities that celebrate diverse populations (e.g., youth summits, pride events, health fairs).	☐	x
Community Engagement	Strengthen trust and relationships with key populations through targeted outreach, activities, and communication.	☐	x
Goal and Impact: Reduced disparities and enhanced community relations			
Collaborators: Community Based Organizations			

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working 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 FY25, the hospital awarded the grants below totaling $95,000. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Bright Futures for Youth	Home Away from Home Meals	Access to Basic Needs Such as Housing, Jobs, and Food	$95,000

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 Care
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.
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.
FY 2025 Report	
Activities Summary	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 patient navigators in the emergency department (ED), promoting cancer awareness in the community, and working with community partners as needed.
Performance / Impact	1,438 persons served
Hospital's Contribution / Program Expense	$38,874
FY 2026 Plan	
Program Goal / Anticipated Impact	Improve patient outcomes by ensuring timely access to treatment and other resources for those with cancer, with a focus on providing care to underserved individuals who cannot afford care.
Planned Activities	There is no planned change from the FY2025 Activities Summary. In FY2026 the oncology nurse navigator will continue providing community outreach activities.

Substance Use Navigation

Significant Health Needs Addressed	• Access to behavioral healthcare, including substance use disorder treatment and navigation of services
Program Description	The substance use navigation program works to ensure people with substance use disorders (SUD) receive 24/7 high-quality care. A Substance Use Navigator (SUN) and Medication Assisted Treatment (MAT) training for ED physicians fully integrates addiction treatment into standard medical practice. A SUN builds a trusting relationship with the patient and motivates 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 ED to local MAT clinics.
FY 2025 Report	
Activities Summary	Provided education to OB providers on suboxone initiation in the outpatient setting. Continued 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.
Performance / Impact	657 persons served
Hospital's Contribution / Program Expense	This program is funded through a CA Department of Health Care Services Behavioral Health grant and managed by the hospital.
FY 2026 Plan	
Program Goal / Anticipated Impact	Achieve comprehensive, stigma-free integration of addiction treatment into standard medical practice, leveraging Community Health Workers to enhance patient engagement and access, and treating substance use disorder as any other illness.
Planned Activities	There is no planned change from the FY2025 Activities Summary. In FY2026 the substance use navigator will continue to meet with local providers to facilitate expedited access to follow-up appointments. The patient navigator will also communicate regularly with Partnership Healthplan regarding trends, resources needed and challenges connecting patients to care.

Sierra Community Palliative Care	
Significant Health Needs Addressed	• Access to Specialty and Extended Care
Program Description	Funded through Dignity Health Community Grants Program, Sierra Community Palliative Care partner organizations use an integrative approach prioritizing pain relief and enhanced quality of life.
Population Served	Western Nevada County residents with life-limiting illnesses
Program Goal / Anticipated Impact	Offer care for up to seventy patients for six months. Success is measured through symptom assessment tools, hospital admission rates, and referrals to community programs.

FY 2025 Report	
Activities Summary	Provide three to five day a week outpatient palliative care services to Western Nevada County residents for up to six months prioritizing pain relief and enhancing quality of life.
Performance / Impact	70 persons served
Hospital's Contribution / Program Expense	$94,479

FY 2026 Plan
The hospital will continue to support and promote this community-based program; however, due to revised health priority needs identified in the 2025 Community Health Needs Assessment, it will no longer be reported on in future community benefit reports.

Alzheimer's Outreach Program

Significant Health Needs Addressed	• Access to Care
Program Description	In collaboration with Sierra Nevada Memorial Hospital Foundation, and Nevada County Health and Human Services, the Hospital 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	Any community member suffering from a memory impairment, their caregiver, or family member.
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 2025 Report	
Activities Summary	Continue to provide one-on-one crisis care and case management support for families, support groups, caregiver education, community education and outreach, and respite care funds for families in need.
Performance / Impact	424 persons served

Hospital's Contribution / Program Expense	$61,880
FY 2026 Plan	
Program Goal / Anticipated Impact	Improve the well-being and functional capacity of individuals experiencing memory impairment, and their caregivers, through a dual-component program offering essential education and targeted clinical support.
Planned Activities	In FY2026, staffing will be increased to enable an expansion of client services, community education, and respite support.

Patient Navigator Program

Significant Health Needs Addressed	• Access to Care • Unmet Vital Conditions
Program Description	The Patient Navigator program focuses on assisting patients who rely on EDs 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, Partnership Medi-Cal, 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 and need immediate assistance to schedule with their primary care.
Program Goal / Anticipated Impact	This program assists underserved ED patients with finding primary care medical homes or reconnecting them with their assigned provider. Also assist patients with enrolling in Medi-Cal and provide other social support services.
FY 2025 Report	
Activities Summary	Patient Navigators scheduled follow-up primary care appointments for individuals in the ED. They also provided assistance with social service resources, health insurance eligibility and linkages to other community health care services.

Performance / Impact	403 persons served
Hospital's Contribution / Program Expense	This program is funded by a California Health and Wellness Medi-Cal grant.
FY 2026 Plan	
Program Goal / Anticipated Impact	Enhance the health and well-being of un- and underinsured ED patients by effectively navigating them to appropriate medical homes and community resources, thereby reducing non-emergent ED visits and improving access to comprehensive care.
Planned Activities	There is no planned change from the FY2025 Activities Summary. In FY2026 the patient navigator will continue to meet with local providers to facilitate expedited access to follow-up appointments. The patient navigator will also communicate regularly with Partnership Healthplan regarding trends, resources needed and challenges connecting patients to care.

Community Belonging

Significant Health Needs Addressed	• Community belonging
Program Description	Strengthen trust and relationships with key populations through trainings, targeted outreach activities, and communication.
Population Served	Vulnerable populations who are at a higher risk of social exclusion, isolation, and loneliness (e.g. older adults, youth, LGBTQ+, racial and ethnic minorities, people with disabilities, people with low socioeconomic status, immigrants and refugees)
Program Goal / Anticipated Impact	Reduced disparities and enhanced community relations
FY 2025 Report	
Activities Summary No activities are reportable for FY2025. Community belonging activities have been added in response to the updated significant health needs identified in the 2025 Community Health Needs Assessment.	
FY 2026 Plan	
Program Goal /	Activities reducing disparities and enhancing community relations are expected to increase feelings of acceptance and connection

Anticipated Impact	among residents, fostering an environment where everyone feels valued. This cultivates stronger social networks, boosts local participation, and deepens collective identity, ultimately strengthening community belonging.
Planned Activities	● Provide training opportunities for staff and community organizations that address the specific health needs of the community. This collaboration can improve care coordination and strengthen social connections. ● Foster an inclusive environment by participating in culturally responsive activities that celebrate diverse populations (e.g., youth summits, pride events, health fairs). ● Strengthen trust and relationships with key populations through targeted outreach, activities, and communication.

Other Community Health and Community Building Programs

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.

- North San Juan Community Health Worker Program – Through CommonSpirit Health's Mission and Ministry Fund, a community health worker program was implemented in North San Juan, CA. North San Juan is an impoverished and vulnerable population within the community. The program is a two-year effort and program priorities include building trust with a leery patient population, engaging the community through active listening sessions and identifying and meeting community needs.

- Enrollment Assistance – The hospital and Nevada County employees provide enrollment assistance at the hospital to low-income patients, in an effort to get coverage by 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.

- Community Vision (formerly Northern California Community Loan Fund) – In 2017 and 2023 CommonSpirit approved two 7-year loans totaling $7,000,000 respectively—the first as lending capital in a "FreshWorks" Fund for $1,000,000 supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts"), and the second $6,000,000 for lending capital for Community Vision's many projects.

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, including Granite Wellness Center, Nevada County Arts Council, Nevada City Chamber of Commerce, American Heart Association, and others.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid, other means-tested programs and Medicare 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.

The hospital provided $2,579,571 in patient financial assistance, and $2,654,697 in community health improvement services, cash contributions and other community benefits. The net benefit of Medicaid is reported as $0 due to Medicaid Provider Fee revenue making revenues greater than expenses.

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$2,579,571		$2,579,571
Medi-Cal	$0		$0
Other Means-Tested Government (Indigent Care)	$0		$0
Sum Financial Assistance and Means-Tested Government Programs	**$2,579,571**		**$2,579,571**
Other Benefits			
Community Health Improvement Services	$121,947	$135,605	$257,552
Community Benefit Operations	$99,874	$26,322	$126,196
Health Professions Education	$0	$1,580,384	$1,580,384
Subsidized Health Services	$0	$781	$781
Research	$0	$0	$0
Cash and In-Kind Contributions for Community Benefit	$589,784	$100,000	$689,784
Other Community Benefits	$0	$0	$0
Total Other Benefits	**$811,605**	**$1,843,092**	**$2,654,697**
Community Benefits Spending			
Total Community Benefits	**$3,391,176**	**$1,843,092**	**$5,234,268**
Medicare	$23,972,574		$23,972,574
Total Community Benefits with Medicare	**$27,363,750**	**$1,843,092**	**$29,206,842**

Hospital Board and Committee Rosters

Bob Long, Chair
Retired Healthcare Executive

Jason Fouyer, Vice Chair
President, Cramer Engineering

Ann Guerra, Secretary
Retired, Executive Director of 211 Connecting Point

Daryl Grigsby, Director
Retired Public Works Director of San Luis Obispo

Ed Sylvester, Director
Retired Civil Engineer

Jennifer Singer, Director
Executive Director Bright Futures for Youth

Rodger Page, Director
Corporate Member (Dignity Health)

Shannan Moon, Director
Sheriff

Stephanie Ortiz, Director
Interim Dean Sierra College

Tom Boyle, MD, Director
Past Chief of Staff, General Surgeon