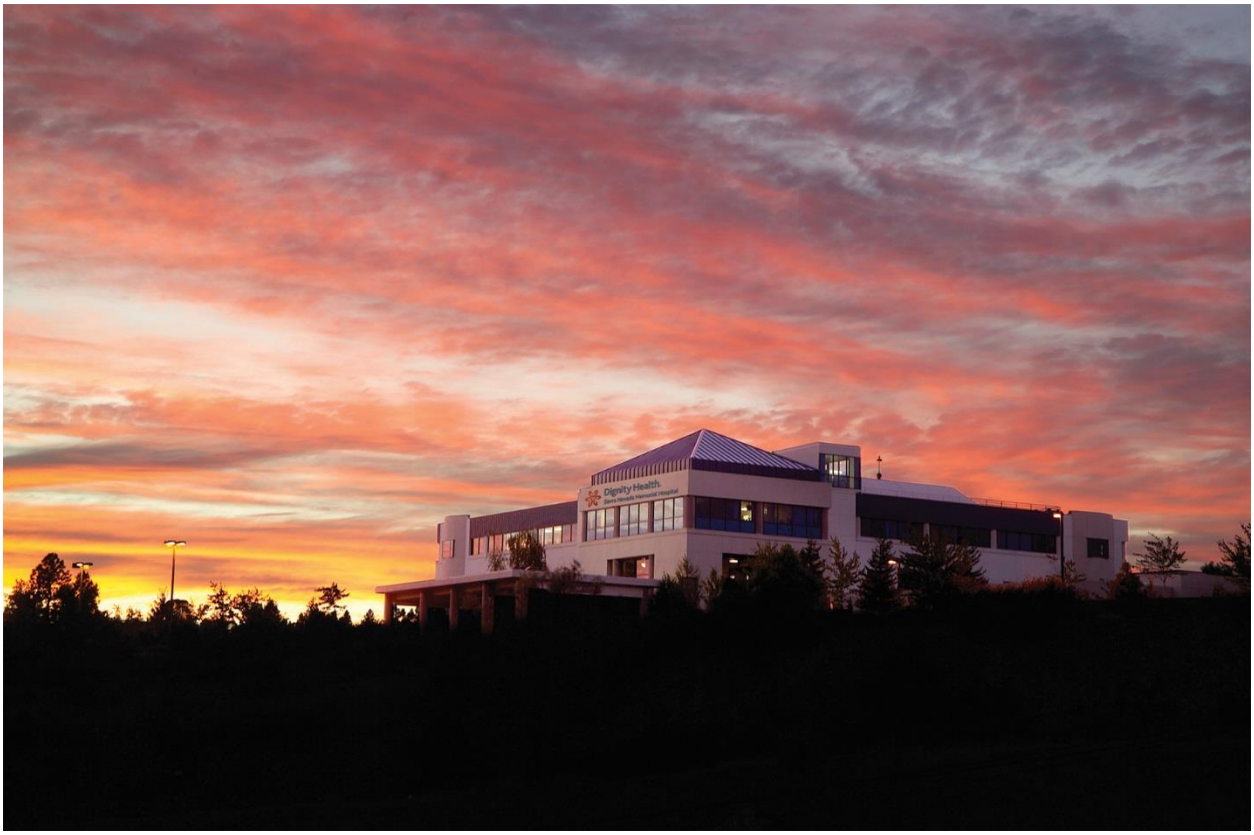
Sierra Nevada Memorial Hospital

2022 Community Health Implementation Strategy

Adopted October 2022



Dignity Health
Sierra Nevada Memorial Hospital

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At-a-Glance Summary

Community Served

Sierra Nevada Memorial Hospital is located in western Nevada County and has 787 employees, more than 100 active medical staff, and offers 104 licensed acute care beds and 21 emergency department beds. The hospital's service area encompasses the communities of Grass Valley, Penn Valley, Rough and Ready, Nevada City, North San Juan and Washington. 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. Therefore, the community is heavily dependent on the hospital to often serve all its health needs.

Significant Community Health Needs Being Addressed

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

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Access to Specialty and Extended Care
5. System Navigation
6. Increased Community Connections
7. Injury and Disease Prevention and Management
8. Safe and Violence-Free Environment

Strategies and Programs to Address Needs

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

- Crisis Stabilization Unit (CSU): partnership with Nevada County Behavioral Health for patients experiencing acute mental health needs.
- Care Transitions: partnership with FREED to provide navigation and increase access to healthcare services for vulnerable populations.
- 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.
- Oncology Nurse Navigator: information and resource for low-income patients who otherwise may not have access to care.
- Alzheimer's Outreach Program: education and support to those caring for persons with Alzheimer's disease and other forms of dementia.
- Homeless Recuperative Care program: collaborative partnership with Foothill House of Hospitality to provide shelter for those experiencing homelessness to receive housing assistance and wrap around services.

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program highlights on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health.

The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Health and Outreach staff, hospital executive leadership, Board of Directors, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

- Nevada County Public Health
- Sierra Care Physicians
- Nevada County Behavioral Health
- Connecting Point
- Granite Wellness Centers
- Nevada County School District
- Nevada County Sherriff
- Aegis
- Grass Valley
- Turning Point
- Western Sierra Medical Clinic
- Sierra Mental Wellness
- Chapa De Indian Health
- Nevada County Superior Court
- Common Goals
- SPIRIT Peer Empowerment
- Sierra Family Medical Clinic
- FREED
- Foothill House of Hospitality
- Communities Beyond Violence
- National Alliance on Mental Illness (NAMI)
- Wayne Brown Correctional Facility
- Nevada County Sheriff Office
- Nevada City Police Department
- Falls Prevention Coalition
- Sound Physicians
- Swope Medical Group
- AMI Housing
- Dignity Health Tele-network
- Sierra Care Physicians
- Dignity Health Medical Group
- California Forensic Medical Group

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

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

Our Hospital and the Community Served

About Sierra Nevada Memorial Hospital

Sierra Nevada Memorial 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.

Today, the hospital has 787 employees, more than 100 active medical staff, and offers 104 licensed acute care beds and 21 emergency department beds. Services include: a Family Birth Center, providing family-centered care in private, homelike, comfortable, and safe surroundings; an Ambulatory Treatment Center; a Community Cancer Center that is nationally accredited by the Commission on Cancer of the American College of Surgeons; state-of-the-art Diagnostic Imaging Center and Women's Imaging Center; and Wound Care Healing & Hyperbaric Medicine Center. The hospital is a certified Primary Stroke Center by The Joint Commission and has earned the Gold Plus Achievement Award for Stroke from the American Heart Association and American Stroke Association. The hospital continues to be the only acute care hospital serving this region.

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

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

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 defined as the geographic area (by ZIP code) in which the hospital receives its top 75% of discharges. The hospital's service area encompasses seven zip codes in the communities of Grass Valley, Penn Valley, Rough and Ready, Nevada City, North San Juan and Washington (95945, 95946, 95949, 95959, 95960, 95975, and 95986). A summary description of the community is below. Additional details can be found in the CHNA report online.

Northwest of Lake Tahoe in the woodlands and forests of the Sierra Nevada Mountains, Nevada County is in the heart of California's historic Gold Country and includes the small cities of Grass Valley, Nevada City and Truckee, and nine other unincorporated cities. Since the Gold Rush of 1849, the region experienced a dramatic transformation of its landscape, with open-range cattle grazing, orchards, timber production and deep, hard-rock gold mining becoming economic mainstays. By the mid-1950s, however, the last major commercial mines closed and the traditional natural resource-based economy went into decline. Today, employment by sector paints a picture of economic health by industry in the County overall. The Service-Providing sector leads in the number of people employed (64.8%), followed by Government (20.7%), and Goods Producing (13.2%) sectors. 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. Residents of Nevada County are primarily white (92.7%), and a high proportion of adults over the age of 65 (28.5%). 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 2022 estimates provided by SG2's Analytics Platform (*Source: Claritas Pop-Facts® 2022; SG2 Market Demographic Module)*:

- Total Population: 76,537
- Race/Ethnicity: Hispanic or Latino: 8.9%; White: 80.3%; Black/African American: 0.5%; Asian/Pacific Islander 1.3%; All Other 9.0%
- % Below Poverty: 5.4%
- Unemployment: 2.6%
- No High School Diploma: 4.8%
- Medicaid: 23.5%
- 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 health implementation strategy 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 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 challenges occur. Access to mental, behavioral, and substance-use services is	✓

Significant Health Need	Description	Intend to Address?
	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 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	✓

Significant Health Need	Description	Intend to Address?
	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 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	✓

Significant Health Need	Description	Intend to Address?
	depression and anxiety and demonstrate more aggressive, violent behavior.	

Significant Needs the Hospital Does Not Intend to Address

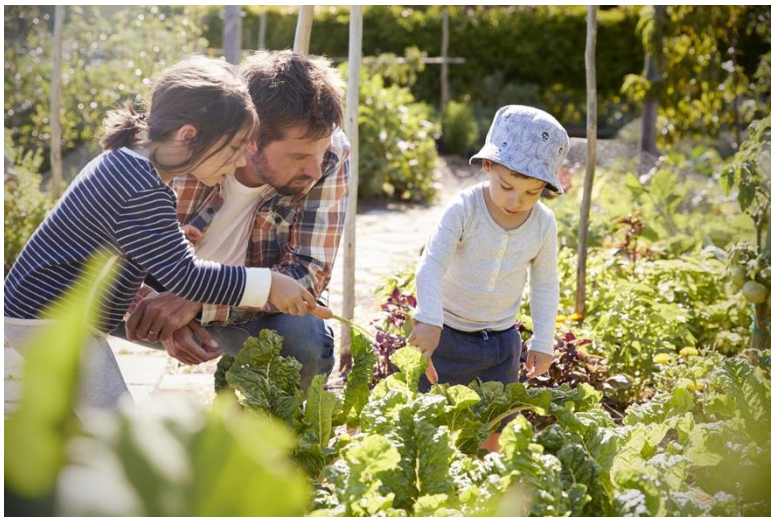
Sierra Nevada Memorial, as a rural community hospital, does not have the capacity or resources to address all priority health issues identified in Nevada County; although, the hospital will continue to seek collaborative opportunities that address needs that have not been selected as priorities. The 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.

2022 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others on to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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 Implementation Strategy



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

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

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

The following outlines the approach taken when planning and developing initiatives to address priority health issues. At the onset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the 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.

Advance Community Health Alignment and Integration

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

Expand Clinical - Community Partnerships and Linkages

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

Build Capacity for More Equitable Communities

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

Inspire, Innovate and Scale High Impact Initiatives

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

Strategies and Program Activities by Health Need

	**Health Need: Access to Basic Needs Such as Housing, Jobs, and Food**				
Anticipated Impact (Goal)	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.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Homeless Recuperative Care Program	Sierra Nevada Memorial in a collaborative partnership with Nevada County Health and Human Services and Hospitality House, developed a recuperative care program. Located at Hospitality House, the program provides recuperative care for up to 29 days, housing assistance, and wrap-around services, and is a critical safety net for individuals experiencing homelessness who are exiting an in-patient hospital stay.	✓	✓	✓	✓
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to basic needs such as housing, jobs, and food, and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
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	✓		✓	

	Health Need: Access to Basic Needs Such as Housing, Jobs, and Food				
	to pay for or access these resources after being discharged from the hospital.				
Resources for Homeless Patients	The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community resources to homeless patients being discharged from the hospital, with the intent to help prepare them for return to the community.	✓		✓	
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	The hospital will partner with Nevada County Health and Human Services, Hospitality House 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				
Anticipated Impact (Goal)	The hospital's initiative to address access to behavioral health services are anticipated to result in: intended growth and strengthening services and resources available in the community. These efforts aim to improve the ease of access to quality services, remove barriers, expand capacity, and create a coordinated continuum system of care thereby improving behavioral health outcomes and reducing the negative health and social impacts of behavioral health conditions on individuals and the community.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact

	Health Need: Access to Mental/Behavioral Health and Substance Use Services				
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 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	✓	✓	✓	✓

	Health Need: Access to Mental/Behavioral Health and Substance Use Services				
	disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.				
Care Transition Intervention Program	The collaborative including FREED Center for Independent Living, (Granite Wellness Center) and 211Connecting Point focuses on care transition and patient navigation between organizations and services and develops a "no wrong door" system of referral. This collaborative addresses all three priority health needs by increasing access to primary, mental health, substance use, and preventative health care for vulnerable populations.	✓	✓	✓	✓
Tele-Psychiatry	Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care. Access is available to both the ED and inpatient setting.	✓	✓	✓	
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to mental/behavioral health and substance use services and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	The hospital will partner with Nevada County Behavioral Health, FREED Center for Independent Living (Granite Wellness Center), 211Connecting Point, 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				
Anticipated Impact (Goal)	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; and improve collaborative efforts between all health care providers.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
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 211Connecting Point focuses on care transition and patient navigation between organizations and services and develops a "no wrong door" system of referral. This collaborative addresses all three priority health needs by increasing access to primary, mental health, substance use, and preventative health care for vulnerable populations.	✓	✓	✓	✓
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,	✓	✓	✓	✓

	Health Need: Access to Quality Primary Care Health Services				
	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.	✓	✓	✓	✓
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to quality primary care health services and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned 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: Access to Specialty and Extended Care
Anticipated Impact (Goal)	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.

	Health Need: Access to Specialty and Extended Care				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Oncology Nurse Navigator	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of 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.	✓	✓	✓	✓
Hepatitis C Eradication Program	The building of the collaboration for this program began in 2018 and is a partnership between Sierra Nevada Memorial Hospital, Sierra Nevada Gastroenterology, Nevada County Public Health, and FREED. This program targets low income, uninsured,	✓	✓	✓	✓

	Health Need: Access to Specialty and Extended Care				
	underinsured, and homeless individuals who have received a positive Hepatitis C diagnosis, and assists in navigating through the health system to access the new medications available with the potential to cure this disease. FREED will utilize the Care Transitions Intervention coaching model and assist patients in obtaining insurance and a primary care provider as necessary, and will remain in contact with the patient throughout the length of their HCV treatment at Sierra Nevada Gastroenterology.				
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to specialty and extended care and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	The hospital will partner with local medical clinics, Sierra Nevada Gastroenterology, Nevada County Public Health, FREED Center for Independent Living, (Granite Wellness Center), and local community based organizations to deliver this access to specialty and extended care.				

	Health Need: System Navigation
Anticipated Impact (Goal)	The hospital's initiatives to address system navigation 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.

	Health Need: System Navigation				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
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.	✓	✓	✓	✓
Crisis Stabilization Unit	The Crisis Stabilization Unit (CSU), operated by Nevada County, is a 23-hour 4-bed mental health urgent care and crisis unit on the hospital campus. The CSU is an innovative partnership between the Sierra Nevada Memorial and Nevada County Behavioral Health in which the hospital leases the land at no fee and funds 3 dedicated psychiatric beds in the unit. The CSU allows patients in acute psychiatric crisis to receive rapid access to appropriate care for their psychiatric emergency.	✓	✓	✓	✓
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.	✓	✓	✓	✓

	Health Need: System Navigation				
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing system navigation and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	The hospital will partner with local medical clinics, Nevada County Behavioral Health, FREED Center for Independent Living, (Granite Wellness Center), 211 Connecting Point and local community based organizations to deliver this access to system navigation.				

	Health Need: Increased Community Connections				
Anticipated Impact (Goal)	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 will have opportunities to connect with each other through programs, and services resulting in fostering a healthier community. Healthcare and community support services will be more effective when they are delivered in a coordinated fashion and in collaboration to build a network of care.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact

	Health Need: Increased Community Connections				
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	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.	✓	✓	✓	✓

	Health Need: Increased Community Connections				
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing community connections and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned 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 increased community connections.				

	Health Need: Injury and Disease Prevention and Management				
Anticipated Impact (Goal)	The initiative to address this health need by the hospital is anticipated to result in: a reduction of hospital admissions related to poor chronic disease management; prevent chronic disease; improve the health and quality of life for those with a chronic illness; enable participants to manage their disease by creating a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
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	✓	✓	✓	✓

	Health Need: Injury and Disease Prevention and Management				
	open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics and community partners to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.				
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.	✓	✓	✓	✓
Support Groups	Hospital-sponsored support groups for cancer, brain injury, pulmonary issues, and stroke provide an opportunity for patients and family members to share their concerns while learning to manage their condition.	✓	✓	✓	✓
Alzheimer's Outreach Program	The hospital's Home Care Department, in collaboration with Sierra Nevada Memorial Hospital Foundation, and Nevada County Health and Human Services offers an Alzheimer's Outreach Program that serves as a unique community education, resource and support center. A licensed social worker is dedicated to the program who provides education and caregiver support via home visits and personal consultations, and links those that need specialized care to important resources, including assisted living/care centers.	✓	✓	✓	✓
Falls Prevention Program	The program, offered in partnership with the hospital, Sierra Nevada Memorial Hospital Foundation, and the Falls Prevention Coalition, provides education to the community about fall risk	✓	✓	✓	✓

	Health Need: Injury and Disease Prevention and Management				
	factors and prevention strategies for older adults and caregivers. Participants also learn appropriate exercises for enhanced balance and strength.				
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing injury and disease prevention management and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned 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				
Anticipated Impact (Goal)	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.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact

	Health Need: Safe and Violence-Free Environment				
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking within the hospital; • Provide victim-centered, trauma-informed care; • Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy	✓	✓	✓	✓
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing a safe and violence-free environment and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	✓	✓	✓	✓
Planned Resources	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	The hospital will partner with local shareholder advocacy groups and local community based organizations to deliver this access to increase safe and violence-free environment.				

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.

	Homeless Recuperative Care Program
Significant Health Needs Addressed	✓ Access to Basic Needs Such as Housing, Jobs, and Food ☐ Access to Mental/Behavioral Health and Substance Use Services ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ☐ System Navigation ☐ Increased Community Connections ✓ Injury and Disease Prevention and Management ☐ Active Living and Healthy Eating ☐ Safe and Violence-Free Environment
Fiscal Years Active	✓ FY 2022 ✓ FY 2023 ✓ FY 2024
Program Description	Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services and Hospitality House, to develop a recuperative care program. Located at Hospitality House, the program provides recuperative care for up to 29 days, housing assistance, and wrap-around services, and is a critical safety net for individuals experiencing homelessness who are exiting an in-patient hospital stay.
Population Served	The primary beneficiaries of this program are homeless individuals in need of a safe environment to fully recover when discharged from the hospital.
Program Goal / Anticipated Impact	This program provides a safe discharge plan, and a clean, dry, supportive place to recover from a recent hospitalization for patients who are homeless. Improves access to ongoing health care through a medical home, provides wrap-around services and assists in accessing housing services available.
Collaborations and Partnerships	Sierra Nevada Memorial Hospital, Nevada County Health and Human Services, Nevada County Behavioral Health, Hospitality House, Western Sierra Medical Clinic, Chapa De Indian Health, FREED, Community Recovery Resources, Grass Valley Police Department, Sierra Nevada Gastroenterology, AMI Housing.

	Crisis Stabilization Unit

Significant Health Needs Addressed	□ Access to Basic Needs Such as Housing, Jobs, and Food ✓ Access to Mental/Behavioral Health and Substance Use Services □ Access to Quality Primary Care Health Services □ Access to Specialty and Extended Care □ System Navigation □ Increased Community Connections □ Injury and Disease Prevention and Management □ Active Living and Healthy Eating ✓ Safe and Violence-Free Environment
Fiscal Years Active	✓ FY 2022 ✓ FY 2023 ✓ FY 2024
Program Description	The Crisis Stabilization Unit (CSU), operated by Nevada County, is a 23-hour 4-bed mental health urgent care and crisis unit on the hospital campus. The CSU is an innovative partnership between the Sierra Nevada Memorial and Nevada County Behavioral Health in which the hospital leases the land at no fee and funds 3 dedicated psychiatric beds in the unit. The CSU allows patients in acute psychiatric crisis to receive rapid access to appropriate care for their psychiatric emergency.
Population Served	The primary beneficiaries of this program are individuals experiencing a mental health crisis and especially those in need of more in-depth treatment and assessment by mental health crisis workers.
Program Goal / Anticipated Impact	Reduce the length of time it takes to connect patients in the emergency department experiencing a psychiatric emergency to an appropriate level of psychiatric care. Create a seamless transition from the ED to the CSU. Improve the level of psychiatric care in the community. Reduce readmissions for psychiatric emergencies by providing appropriate and supportive care in our community. Reduce the need for transfers to inpatient psychiatric hospitals.
Collaborations and Partnerships	Sierra Nevada Memorial Hospital, Swope Medical Group, Nevada County Behavioral Health, Sierra Mental Wellness, Law Enforcement Agencies.

Substance Use Navigation

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

	□ Safe and Violence-Free Environment
Fiscal Years Active	✓ FY 2022 ✓ FY 2023 ✓ FY 2024
Program Description	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.
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.
Collaborations and Partnerships	Continue work with local MAT agencies to include Granite Wellness Center, Aegis, Stallant Health, Western Sierra Medical Clinic, Chapa De Indian Health, Swope Medical Group and Sound Physicians.

	Community Health Improvements Grants
Significant Health Needs Addressed	✓ Access to Basic Needs Such as Housing, Jobs, and Food ✓ Access to Mental/Behavioral Health and Substance Use Services ✓ Access to Quality Primary Care Health Services ✓ Access to Specialty and Extended Care ✓ System Navigation ✓ Increased Community Connections ✓ Injury and Disease Prevention and Management ✓ Active Living and Healthy Eating ✓ Safe and Violence-Free Environment
Fiscal Years Active	✓ FY 2022 ✓ FY 2023 ✓ FY 2024
Program Description	Community Health Improvement Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the

	Community Health Needs Assessment. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Sierra Nevada Memorial Hospital, leveraging resources that address priority health issues and utilizing creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families.
Population Served	The primary beneficiaries are individuals in the community that are the low-income, vulnerable, underserved and uninsured population in Nevada County.
Program Goal / Anticipated Impact	To deliver services and strengthen service systems by actively partnering with the community non-profit organizations in order to improve the health status and quality of life for the most vulnerable and underserved populations in the community.
Collaborations and Partnerships	Sierra Nevada Memorial Hospital and local community based organizations addressing priority health needs in Nevada County.