Dignity Health
Sierra Nevada Memorial Hospital

Sierra Nevada Memorial Hospital

2019 Community Health Needs Assessment – Main Report

Acknowledgements

We are deeply grateful to all those who contributed to the joint community health needs assessment/community health assessment conducted on behalf of Sierra Nevada Memorial Hospital and Nevada County Public Health Department. Many dedicated community health experts and members of various social-service organizations working with the most vulnerable members of Nevada County supported the Community Health Need Assessment (CHNA)/Community Health Assessment (CHA) findings of this joint assessment. We also express our deepest appreciation to the many Nevada County residents who participated as focus group participants or completed the countywide survey. To everyone who supported this important work, we extend our deepest heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the work on behalf of the partners. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California. This joint report was authored by:

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Table of Contents – Main Report

Data and Technical Section of the report can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

List of Tables

List of Figures

Executive Summary

Purpose

The purpose of this joint community health needs assessment (CHNA)/community health assessment (CHA) was to identify and prioritize significant health needs of the Sierra Nevada Memorial Hospital Service area. The priorities identified in this report help to guide health improvement efforts of both Sierra Nevada Memorial Hospital and Nevada County Department of Public Health.

This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and, in California, Senate Bill 697) that not-for-profit hospitals conduct a CHNA at least once every three years, as well as the Public Health Accreditation Board (PHAB) CHA requirements. The CHNA/CHA was conducted by Community Health Insights (www.communityhealthinsights.com).

Dignity Health Commitment and Mission Statement

The hospital's dedication to engagement with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with our mission. Dignity Health is committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Community Definition

The seven ZIP Code area of Nevada County which includes 95945, 95946, 95949, 95959, 95960, 95975 and 95986 was chosen for the CHNA/CHA because it is the primary service area of Sierra Nevada Memorial Hospital.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary and secondary data. Primary data included interviews with 32 community health experts, social-service providers, and medical personnel in one-on-one and group interviews, as well as one town hall meeting. Further, 15 community residents participated in three focus groups across the county, and 394 residents completed the community health assessment survey.

Using a social determinants focus to identify and organize secondary data, datasets included measures to described mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, measures also included indicators to describe health behaviors, clinical care (both quality and access), and data to describe the physical environment.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in the previously conducted health assessments with area hospitals. Data were analyzed to discover which, if any, of the PHNs were present in the area. After these were identified, the health needs were prioritized based on an analysis of primary data sources that identified the PHN as a significant health need (SHN).

List of Prioritized SHNs

The following SHNs were identified and are listed below in prioritized order:

1. Access to basic needs such as housing, jobs and food
2. Access to mental/behavioral/substance abuse services
3. Access to quality primary care health services
4. Injury and disease prevention and management
5. Access to specialty and extended care
6. Access and functional needs
7. Active living and health eating
8. Access to dental care and preventive services
9. Pollution-free living environment
10. Safe and violence-free environment

Resources Potentially Available to Meet the Significant Health Needs

In all, 103 resources were identified that were potentially available to meet the identified SHNs in the Sierra Nevada Memorial Hospital service area. The identification method included starting with the list of resources from previous area health assessments, verifying that the resource still existed, and then adding newly identified resources identified as part of the 2019 assessment.

Conclusion

This CHNA/CHA report details the needs of the hospital service area as a part of a successful collaborative partnership between Sierra Nevada Memorial Hospital and Nevada County Department of Public Health. It provides both an overall health and social examination of the service area and a deeper examination of the needs of community members living within the area experiencing disproportionately unmet health needs. The work provides a comprehensive profile to guide decision-making for implementation of community-health-improvement efforts.

Report Adoption, Availability and Comments

The Board of Directors voted, approved and adopted the Community Health Needs Assessment for Sierra Nevada Memorial Hospital on May 9th, 2019.

This main report and the data and technical section is widely available to the public on the hospital's web site (https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment), and a paper copy is available for inspection upon request at Dignity Health, Community Health and Outreach Department, 3400 Data Drive, Rancho Cordova, CA 95670.

Written comments on this report can be submitted by email to DignityHealthGSSA_CHNA@dignityhealth.org.

Introduction and Purpose

The health of a community is greatly influenced by the environmental and structural components of the community, and personal characteristics of its members. Community health includes the health status of the people, and the conditions in the community that promote, protect and preserve their health. A thriving health community is one in which members have economic opportunities, are engaged in their community, have good personal mind body wellness, strong social connections, and are deeply connected to the health of the natural environment in which they live.[1]

Figure 1: What are the biggest health needs in the community? Word cloud of the results from the 2019 assessment interviews

Sierra Nevada Memorial Hospital (SNMH) and Nevada County Department of Public Health (NCDPH) both work to assure that residents of Nevada County live healthy lives. In doing so both engage in conducting community health assessments to direct community health improvement efforts as part of a strategic community health improvement focus. In 2018, SNMH and NCDPH worked to conduct a collaborative community health assessment, and in 2019 will combine efforts for investment in community improvements. The community health assessment aims to: 1) Identify and prioritize the health needs of the community; 2) provide social and health data at both the Nevada County level, as well as sub-county level for directed community health examination; 3) provide resources available in the community to address the needs of the community; and 4) inform community health improvement efforts.

Hospital and Local Public Health Department Partnership

California state and federal law require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years. Nationally, state, local and tribal health departments are pursuing "public health accreditation" from the national Public Health Accreditation Board (PHAB), and a community health assessment (CHA) is a crucial component of this.

The definition of a community health need is similar for the CHNA and the CHA. Federal regulations define a *health need* accordingly for CHNAs: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)" (p. 78963).[2] Meanwhile, PHAB refers to health needs as "those demands required by a population or community to improve their health status" (p. 18).[3] Both CHNAs and CHAs guide the development of community health improvement efforts aimed at addressing the identified needs. Hospital CHNAs refer to these as implementation plans, while public health agencies call them community health improvement plans or

[1] Culturalseed. (2019). Framework for thriving Global Communities: The Five Indicators of Thriving Communities.
[2] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.
[3] Public Health Accreditation Board (2011, September). Acronyms and Glossary of Terms, Version 1.0.

CHIPs. Given the similarities between the CHNA and CHA processes, national experts are calling for nonprofit hospitals and public health departments to work together on local health assessments and community health improvement efforts.[4]

This report documents the processes, methods, and findings of a collaborative CHNA/CHA conducted on behalf of a partnership between SNMH and NCDPH covering the SNMH service area. The collaboration between the hospital and the county emphasized a team approach to addressing the key components of the CHNA/CHA. Each partner was committed to the process and, engaged in regular meetings, provided timely feedback for analysis, and willingly shared expertise to support the successful completion of the report. The CHNA/CHA was conducted over a period of eight months, beginning in February 2018 and concluding in October 2018.

Organization of This Report

This report follows federal guidelines issued on how to document a CHNA/CHA. First, it describes the prioritized listing of significant health needs identified through the assessment, along with offering a description of the process and criteria used in identifying and prioritizing these needs. Next, it details the methods used to conduct the CHNA/CHA, including how data were collected and analyzed. Third, it details the community served by partners and how the community was identified. Fourth, it provides a description of how partner organizations solicited and considered the input received from persons who represented the broad interests of the community served. Next it identifies and describes resources potentially available to meet these needs. Finally, it gives a summary of the impact of actions taken by SNMH to address significant health needs identified in the hospital's previous assessment.

A detailed methodology section titled "Sierra Nevada Memorial Hospital 2019 Community Health Needs Assessment – Data and Technical Section" includes an in-depth description of the methods used for collection and analysis of data and compiling the results to identify and prioritize significant health needs. This section can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

Findings

Prioritized Significant Health Needs

The analysis of data included both primary and secondary to identify and prioritize the significant health needs within the SNMH service area. In all, 10 significant health needs were identified. After these were identified they were prioritized based on an analysis of primary data sources (key informant interviews and focus groups using instruments contained in Appendix A of the data/technical section) that mentioned the health need as a priority health need. The findings are listed below and displayed in Figure 2.

1. Access to basic needs such as housing, jobs and food
2. Access to mental/behavioral/substance abuse services
3. Access to quality primary care health services
4. Injury and disease prevention and management
5. Access to specialty and extended care
6. Access and functional needs
7. Active living and health eating

[4] Burnett, K. (2012, February). Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices and Future Potential. Public Health Institute on behalf of Center for Disease Control and Prevention.

8. Access to dental care and preventive services
9. Pollution-free living environment
10. Safe and violence-free environment

In the figure, the blue portion of the bar represents the percentage of primary data sources that referenced the health need, while the green portion shows the percentage of times any theme associated with a health need was mentioned as one of the top three health needs in the community. These findings are also displayed in Table 1.

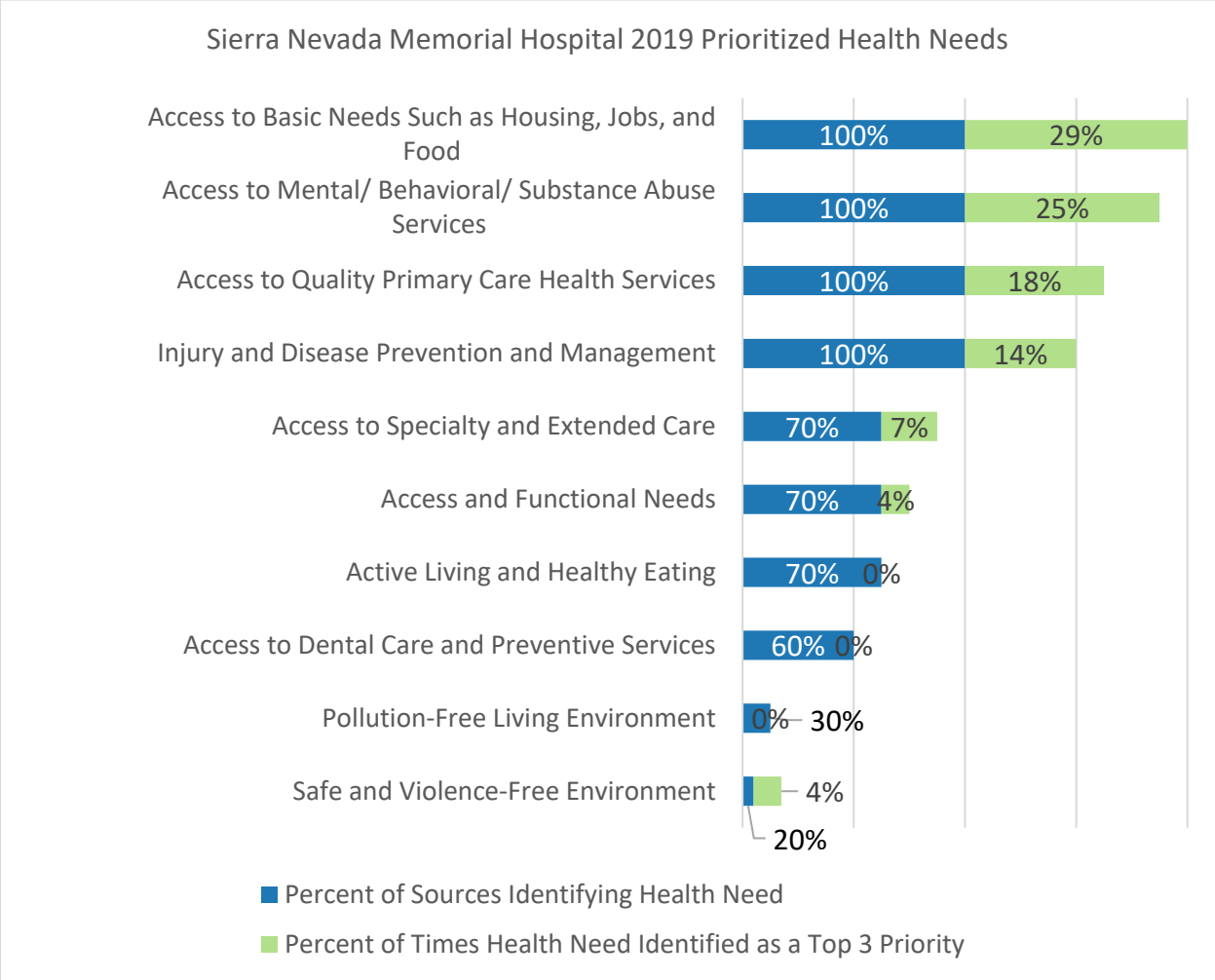

Figure 2: Prioritized, significant health needs for SNMH service area

Table 1: Community Member Measures Used for Health Need Prioritization

Significant Health Need	**Percentage of Sources (Key Informants and Focus Groups) Identifying Health Need (Blue Bar)**	**Percentage of Times (Key Informants and Focus Groups) Identified Health Need as a Top Three Priority (Green Bar)**
Access to Basic Needs such as Housing, Jobs, and Food	100%	29%

Significant Health Need	Percentage of Sources (Key Informants and Focus Groups) Identifying Health Need (Blue Bar)	Percentage of Times (Key Informants and Focus Groups) Identified Health Need as a Top Three Priority (Green Bar)
Access to Mental/ Behavioral/ Substance Abuse Services	100%	25%
Access to Quality Primary Care Health Services	100%	18%
Injury and Disease Prevention and Management	100%	14%
Access to Specialty and Extended Care	70%	7%
Access and Functional Needs	70%	4%
Active Living and Healthy Eating	70%	0%
Access to Dental Care and Preventive Services	60%	0%
Pollution-Free Living Environment	30%	0%
Safe and Violence-Free Environment	20%	4%

The significant health needs are described below. Those secondary data indicators used in the CHNA/CHA that performed poorly compared to a benchmark are listed in the table below each of the significant health needs. Qualitative themes that emerged during analysis are also provided in the table. Survey results that help to further describe the health need for Nevada County are also displayed, but were not used in health need determination.

1. Access to Basic Needs, Such as Housing, Jobs and Food

The highest-priority significant health need for the SNMH service area was access to meeting basic needs such as housing, jobs, and food security. 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[5] says 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.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Years of Potential Life Lost - HPSA Medically Underserved Area - High School Graduation	- Access to affordable housing – costs for housing are high - Housing that is suitable for living, safe and healthy – Many residents living in unpermitted structures especially in more rural areas of the county - Limited housing for seniors, low-income, working families and homeless residents	- Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? - A flu shot is an influenza vaccine injected into your arm. During the past 12

[5] McLeod, S. (2014). *Maslow's Hierarchy of Needs*. Retrieved from: http://www.simplypsychology.org/maslow.html

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Median Household Income - Limited Access to Healthy Food - Immunization Rates 7th Grade - Immunization Rates Kindergarten	- Homelessness a significant issue – living in isolation, near the river, few shelters in the area - Poverty and isolation throughout the county – hard to indicate where people are that struggle more - Lack of jobs in the area – lack of economic opportunities for young people - Food insecurity – food access issues are more prevalent in rural outlying areas - Food insecurity for the aging population due to limited physical access to food, lack of transportation to access healthy foods, and economic insecurity - Limited access to healthy foods in many areas throughout the county - Remote rural area still lack water for some county residents - Lack of access to technology – limited cell and internet service inhibiting access to resources and information - Lack of law enforcement presence in outlying rural area	months, have you had a seasonal flu shot? - Do you act as a caregiver for another ADULT, such as spouse, sibling, aunt, uncle, parent or grandparent? - Housing ranked as a top three biggest health need in the community

2. Access to Mental, Behavioral, and Substance Abuse 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 also occur. Adequate access to mental, behavioral, and substance abuse services help community members obtain additional support when needed.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Liver Disease Mortality - Suicide Mortality - Poor Mental Health Days - Drug Overdose Deaths - Excessive Drinking - HPSA Mental Health - Psychiatry Providers - Nonfatal Poisoning - Opioid Overdose Deaths	- County lacking adult and adolescent inpatient care for substance abuse - Need for behavioral care across the spectrum of mental illness – especially for severe mental illness diagnosis - Need for youth psychiatrists - A few participants reporting high rates of suicide in the county (though not supported by secondary data)	- Would you say that in general your health is: - Do you now smoke cigarettes every day, some days or not at all? - Do you currently use chewing tobacco, snuff, or snus every day, some days or not at all? - Has a doctor or other healthcare provider EVER told you that you have: A depressive disorder (including depression, major depression,

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results

- Substance Use Hospitalizations
- ED Utilization Substance Use
- Unintentional Poisonings
- ED Visit Opioid Overdose
- E Products Use
	- Substance abuse major issue in the county
	  o Alcohol, heroin, meth, opioids and marijuana usage
	  o Marijuana availability and usage normalized in the county, multiple generational usage; high usage in pregnant mothers; brings transient workers to the area for seasonal work.
	- Many coming to area to live off the grid – isolation increases anxiety and depression
	- Little to do for youth in the county – need to focus on prevention of childhood traumatic experiences and increasing youth resiliency
	- High schools in the area lack comprehensive drug education
	- Outlying rural areas lack law enforcement presence – which increases substance abuse usage and reduces enforcement
		dysthymia, or minor depression)
		- Mental health problems ranked as a top three biggest health need in the community

3. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. 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 a community's common diseases and injuries.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Cancer Mortality - CLD Mortality - Heart Disease Mortality - Hypertension Mortality	- Need for increased access to timely and quality care - Participants reporting long wait times for primary care access in the county at community clinics and private providers - Primary care in geographic silos in the county	- Would you say that in general your health is: - Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Influenza Pneumonia Mortality - Kidney Disease Mortality - Liver Disease Mortality - Stroke Mortality - Cancer Female Breast - Diabetes Prevalence - Cancer Prostate - HPSA Primary Care - HPSA Medically Underserved Area - Female Breast Cancer Mortality - Invasive Cancer Incidence - Prostate Cancer Mortality - Immunization Rates 7th Grade - Immunization Rates Kindergarten - Prenatal Care	- Need for practitioners to engage in trauma informed care - Lack of services in outlying rural areas - Distance required to travel for care in the county a barrier due to lack of adequate public transportation systems – especially for the aging population - Local hospital lacking in advanced care practitioners – must leave the county for advanced care - Insurance barriers around coverage and availability of providers in the county – many providers in the area not taking new patients - Need for patient navigation – community lacking in a medical home due to timeliness of care - Self-employed county residents have access to care issues due to lack of stable insurance - Need for more pain management providers - Lack of advanced care providers in the area for referrals from primary care	your physical health not good? - A flu shot is an influenza vaccine injected into your arm. During the past 12 months, have you had a seasonal flu shot? - Have you ever had sigmoidoscopy and colonoscopy exams? - Have you EVER been told by a doctor, nurse or other health professional you had cancer? - Has a doctor or other healthcare provider EVER told you that you have: A depressive disorder (including depression, major depression, dysthymia, or minor depression) - Access to health care as a top three biggest health need in the community

4. Injury-and Disease-Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at 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 focused on reducing cases of injury and around infectious disease control (e.g., STI prevention, influenza shots) and intensive strategies around the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Alzheimer's Mortality - CLD Mortality - Heart Disease Mortality - Hypertension Mortality - Influenza Pneumonia Mortality - Kidney Disease Mortality - Liver Disease Mortality - Stroke Mortality - Suicide Mortality - Unintentional Injury Mortality - Diabetes Prevalence - Drug Overdose Deaths - Excessive Drinking - Adult Smokers - Motor Vehicle Crash Deaths - E Products Use - Immunization Rates 7th Grade - Immunization Rates Kindergarten - Prediabetes	- Few opportunities for youth to engage in healthy recreational activities in the county - Community resources not keeping up with pace of rapid county population growth - Access to preventive services is lacking - Low immunizations rates – many charter schools in the county - Insufficient access to activities for seniors to engage and connect - Need more educational resources for adults and children around basic prevention of chronic disease needed - More resources for chronic disease management and substance abuse – especially hypertension, diabetes, hepatitis C, and dementia - Need increased understanding for the community on how they can connect with resources in the county - Need increased knowledge around navigation of the healthcare system including insurance coverage and how to access various types of care - Need opportunities to learn how to cook healthy meals – many health providers lack basic knowledge to disseminate to patients	- Would you say that in general your health is: - Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? - Do you have asthma? - Do you now smoke cigarettes every day, some days or not at all? - Do you currently use chewing tobacco, snuff, or snus every day, some days or not at all? - During the past 30 days, how many DAYS per WEEK did you have at least one drink of any alcoholic beverages? - During the past 30 days, how many DAYS per MONTH did you have at least one drink of any alcoholic beverages? - Think specifically about the past 30 days, from today up to and including today. During the past 30 days, on how many days did you use marijuana or hashish? - A flu shot is an influenza vaccine injected into your arm. During the past 12 months, have you had a seasonal flu shot? - Have you ever had sigmoidoscopy and colonoscopy exams? - Have you EVER been told by a doctor, nurse or other health professional you had cancer? - Has a doctor or other healthcare provider EVER told you that you have: A depressive disorder (including depression, major depression, dysthymia, or minor depression) - Do you act as a caregiver for another ADULT, such as spouse, sibling, aunt, uncle, parent or grandparent? - Access to health care as a top three biggest health need in the community

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
	- Need more services/education around the prevention and management of chronic pain - Fatal traffic accidents – many drive very fast on county roads resulting in death	

5. Access to Specialty and Extended Care

Specialty care is devoted to a particular branch of medicine and often focuses 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 chronic diseases such as diabetes and high blood pressure on their own. In addition to specialty care, extended care refers to care needed in the community that supports overall physical health and wellness and that extends beyond primary care services, such as skilled nursing facilities, hospice care, in-home healthcare, and the like.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Alzheimer's Mortality - Cancer Mortality - CLD Mortality - Heart Disease Mortality - Hypertension Mortality - Kidney Disease Mortality - Liver Disease Mortality - Stroke Mortality - Diabetes Prevalence - Psychiatry Providers	- Need for increased specialty care providers across the county – especially endo, cardio, and rheumatology - SNMH lacking in specialty providers - Participants reporting that there are no skilled nursing facilities (SNFs) in the county - Waiting for specialty care takes too long - Need for elderly care – specifically home healthcare - Need a managed care provider network in the county - Patient navigation for specialty care is important and needed due to lack of county providers - Lack of transportation to get to specialty care which includes the need to travel outside the county, or travel a far distance within the county - Need for end-of-life/homeless care	- Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? - Have you ever had sigmoidoscopy and colonoscopy exams? - Have you EVER been told by a doctor, nurse or other health professional you had cancer? - Has a doctor or other healthcare provider EVER told you that you have: A depressive disorder (including depression, major depression, dysthymia, or minor depression) - Do you act as a caregiver for another ADULT, such as spouse, sibling, aunt, uncle, parent or grandparent? - Mental health problems ranked as a top three biggest health need in the community

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Specialty Care Providers - Prenatal Care - Prediabetes		- Access to health care as a top three biggest health need in the community

6. Access and Functional Needs-Transportation and Disability that prevents Access through *Movement*

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 that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to assure that all community members have access to necessities for a high quality of life.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Public Transit Proximity - Percent With Disability	- Increased need for transportation expressed across the county - Lack of adequate coverage with current public transportation system - Outlying rural areas of the county lacking access to services and care due to no transportation – sometimes using the ambulance for transportation. - Many families lacking personal transportation (their own vehicle) - Lack of transportation hard on seniors, who have difficulty getting to transportation hubs	Survey questions mapped to health need had favorable rates/or lacked a compared state benchmark rate.

7. Active Living and Healthy Eating

Physical activity and eating a healthy diet are extremely 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.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results

- Cancer Mortality - Heart Disease Mortality - Hypertension Mortality - Kidney Disease Mortality - Stroke Mortality - Cancer Female Breast - Diabetes Prevalence - Cancer Prostate - Limited Access to Healthy Food - Access to Exercise - Female Breast Cancer Mortality - Invasive Cancer Incidence - Prostate Cancer Mortality - Prediabetes	- Price of healthy food "fresh" food is expensive - Community needs more information and skills on how to cook and eat with limited access to healthy food and a small budget, including how to prepare healthy food - Outlying rural areas have little access to healthy food – only small grocery entities - farmer's markets only in summer; limited supplies at the food pantry**;** especially difficult for those without transportation and for seniors. - Low-income and homeless populations lacking access to healthy foods - Finding affordable, accessible exercise opportunities for kids is difficult in the county - Gyms too expensive for most families	Survey questions mapped to health need had favorable rates/or lacked a compared state benchmark rate.

8. Access to Dental Care and Preventative Services

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Poor oral health impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

Secondary Quantitative Indicators	**Qualitative Interview Themes**	**Community Health Survey Results**
No indicators	- Need for more dental providers – participants reporting a perception that there is only one Medi-Cal dental provider (Denti-Cal) in the county - Long wait times for care – few providers - Area providers lacking capacity to meet the need, including the local community clinics	Survey questions mapped to health need had favorable rates/or lacked a compared state benchmark rate.

9. Pollution-Free Living Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built)

and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.[6]

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Cancer Mortality - CLD Mortality - Cancer Female Breast - Cancer Prostate - Adult Smokers - Drinking Water Violations - E Products Use - Invasive Cancer Incidence	- High asthma rates in the county - Forest fires negatively impacting the air quality - Pesticide exposure – participants reporting that growth of area agricultural (grapes, marijuana) exposes area residents to pesticides	- Do you have asthma? - Do you now smoke cigarettes every day, some days or not at all? - Do you currently use chewing tobacco, snuff, or snus every day, some days or not at all? - Think specifically about the past 30 days, from today up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?

10. Safe and Violence-Free Environment

Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, clothing) is physical safety. Feeling unsafe affects, the way people act and react to everyday life occurrences.

Secondary Quantitative Indicators	Qualitative Interview Themes	Community Health Survey Results
- Poor Mental Health Days - Motor Vehicle Crash Deaths - Opioid Overdose Deaths - ED Visit Opioid Overdose	- Lack of law enforcement presence in rural outlying areas of the county - High volume of traffic accidents and mortality on major roads – people driving very fast - Large amount of domestic abuse in the county - Safety issues related to behavior while under the influence of drugs and/or alcohol	- During the past 30 days, how many DAYS per WEEK did you have at least one drink of any alcoholic beverages? - During the past 30 days, how many DAYS per MONTH did you have at least one drink of any alcoholic beverages? - Think specifically about the past 30 days, from today up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?

Populations and Locations Experiencing Health Disparities

A health disparity is defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or

[6] See Blum, H. L. (1983). *Planning for Health*. New York: Human Sciences Press

ethnicity, gender, education or income, disability, geographic location or sexual orientation."[7] The figure and table below describe populations and geographical locations in the SNMH service area identified via qualitative data collection that were indicated as experiencing health disparities.

Interview participants were asked two separate questions:

1. What specific groups of community members experience health issues the most?
2. What specific geographic locations struggle with health issues the most?

Interview results were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities during an interview. Figure 3 displays the results of this analysis. In addition, locations consistently mentioned by participants as being disproportionately affected by disparities were noted and are detailed in alphabetical order in Table 2.

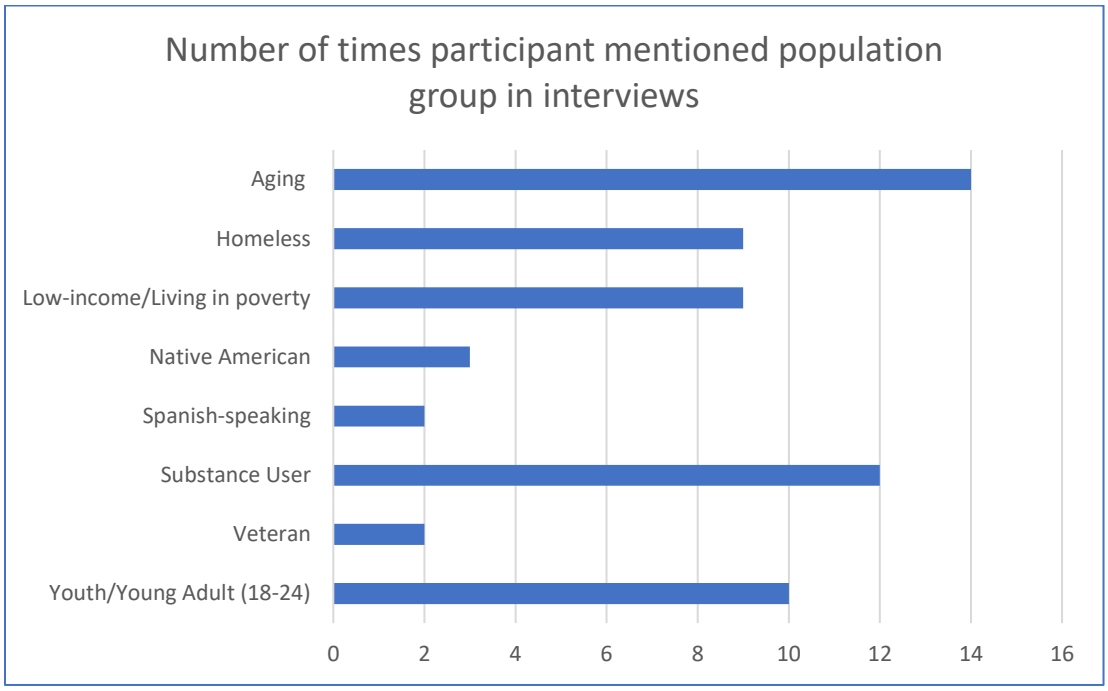

Figure 3: Populations experiencing disparities in the SNMH service area

Table 2 displays geographic locations across the SNMH service area mentioned as areas of the county experiencing social and health disparities. Data presented were collected from key informant interviews where participants were asked to identify and describe areas of the county where disparities existed. In most cases, participants were provided with a map of the county to draw and write on for recording the detailed data contained in Table 2. The attributes in Table 2 come directly from the written maps and key informant interview notes.

Table 2: Geographic Locations Experiencing Disparities

Geographic Locations Mentioned in Interviews	Attributes of Locations
Grass Valley	Large percentage of aging population; homelessness; transportation issues; low-income;

[7] Modified from: Center for Disease Control and Prevention. (2008) Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Service.

	many families with young children; presence of marijuana in the area; many "trimmigrants"
North San Juan	Poverty; social isolation; substance abuse; lacking services; homelessness; presence of marijuana in the area;; lack of transportation; veteran population; large aging population; large percentage of aging population; many families with young children
Rough and Ready	Social isolation; poverty; substance abuse; lacking services
Washington	Low population density; lacking services; homelessness; presence of marijuana in the area;; mistrust of government services, isolation; lack of transportation; large veteran population; large aging population
Penn Valley	Low-income; transportation issues

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA/CHA methodology because, after the county has been assessed more broadly, identifying them allows for a focus on those portions of the county likely experiencing the greatest health disparities.

Geographic Communities of Concern were identified using a combination of primary and secondary data sources. A general description of this process is provided here. (Refer to the data/technical section for an in-depth description). Three secondary data factors were considered in determining if ZIP Codes within the service area would be identified as geographic Communities of Concern: 1) whether they were identified as Communities of Concern in the 2016 CHNA, 2) if they intersected census tracts with the highest 20% of Community Healthy Vulnerability Index (CHVI) scores in the service area, and 3) if they consistently had among the highest mortality indicator values in the county. ZIP Codes with any of these three criteria were combined with the list of geographic locations consistently mentioned in initial area-wide primary data (detailed in Table 2) to result in a final set of geographic Communities of Concern. (Population experiencing disparities were identified based on the results of primary data and are detailed previously in Figure 3).

Analysis of both primary and secondary data revealed one ZIP Codes that met the criteria to be classified as Communities of Concern. One ZIP Code was identified as a primary Community of Concern, while two ZIP Codes were identified as secondary. These two ZIP Codes were labeled as secondary Communities of Concern for two reasons: 1) they were identified by local experts of geographic areas of the county with vulnerable populations and 2) they have small population census counts. These are noted in Table 3, with the census population provided for each. The Communities of Concern are also displayed in Figure 4, with the primary Community of Concern ZIP Code in pink and the secondary in blue.

Table 3: Identified Communities of Concern for the SNMH Service Area

ZIP Code	***Community/Area****	***Population***
Primary Communities of Concern		
95945	Grass Valley	25,712
Secondary Communities of Concern		
95960	North San Juan	752

95986	Washington	79
Total Population in Communities of Concern		**26,543**
Total Population in SNMH Service Area		**75,157**
Approximate Percentage of SNMH Service Area Population		**35.3%**

(Source: 2012 - 2016 American Community Survey 5-year estimates; U.S. Census Bureau)
* Includes population outside of Nevada County

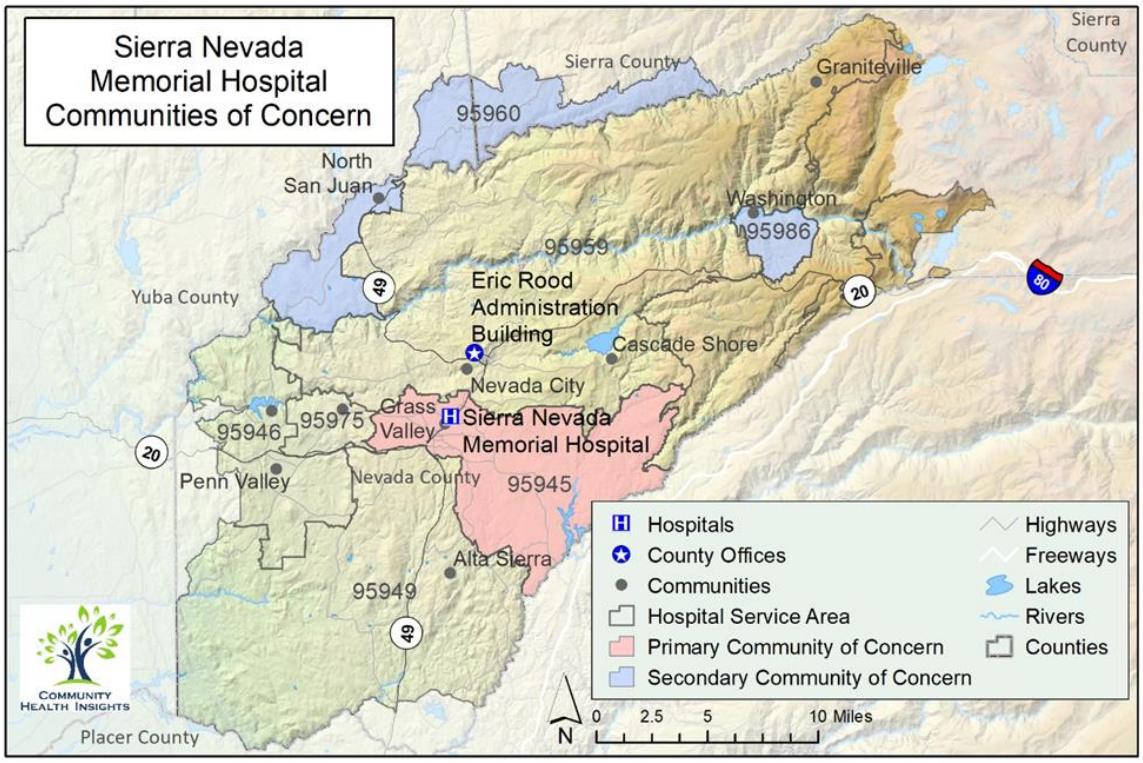

Figure 4: Communities of Concern for the SNMH

Method Overview

Conceptual and Process Models

The data used to conduct the CHNA/CHA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[8] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. For a detailed overview of methods see the data/technical section.

Public Comments from Previously Conducted CHNAs by SNMH

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. The 2016 CHNA was made public for Sierra Nevada Memorial Hospital. The community was invited to provide written comments on the CHNA report and Implementation Strategy both within the documents and on the web site where they are widely available to the public. The email address of DignityHealthGSSA_CHNA@dignityhealth.org was created to ensure comments were received and responded to. No written comments have been received.

Data Used in the CHNA

Data collected and analyzed included both primary and secondary data. Primary data included eight interviews with 31 community health experts as well as three focus groups conducted with a total of 15 community residents. In addition, a survey was conducted with 394 community members in the SNMH service area (details about CHNA/CHA participants can be seen in the data/technical section of this report).

Secondary data included four datasets selected for use in the various stages of analysis. A combination of mortality and socioeconomic datasets collected at sub county levels were used to identify portions of Nevada County with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. A set of socioeconomic indicators was also collected to help describe the overall social conditions within the service area. Health-outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health-factor indicators included measures of 1) health behaviors, such as diet and exercise and, tobacco, alcohol, and drug use; 2) clinical care, including access and quality of care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) the physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 92 different health-outcome and health-factor indicators were collected for the CHNA/CHA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the SNMH service area. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in the previously conducted CHNAs for the SNMH CHNA. Data were analyzed to discover which, if any, of the PHNs were present in the area. Those health needs that were most present in the area are referred to as Significant Health Needs (SHNs).

[8] See http://www.countyhealthrankings.org/

Primary data results were used as the basis for SHN prioritization to reflect the importance of the voice of the community. Key informants and focus group participants were asked to identify the health needs of the community and separately to identify the three most significant health needs. Responses were reviewed to identify which of the SHNs they were associated with. Prioritization was based on the percentage of key informants that discussed a given SHN and the percentage of times each SHN was identified as one of the top three significant health needs.

For a more in-depth description of the processes and methods used to conduct the CHNA/CHA, including primary and secondary data collection, analysis, and results, see the data/technical section of this report.

Description of Community Served

Sierra Nevada Memorial Hospital is located in Grass Valley, CA. The service area for the hospital occupies the majority of the western portion of Nevada County, California. Nevada County is located on the western slope of the Sierra Nevada foothills consisting of approximately 978 square miles. The county is rural with deep historical significance for the state of California as the home of the California Gold Rush of 1849. The three major incorporated cities in the county are Grass Valley, Nevada City and the Town of Truckee. Nevada City was founded in 1849, and the county was later named Nevada County in 1851. (The founding of the state of Nevada followed in 1861.) Nevada City downtown district is a national historical landmark with "old fashion hospitality."

Community service providers and community members described Nevada County during primary data collection for the CHNA/CHA as: diverse in income and in age, and largely rural with many long time county residents. Participants also expressed their appreciation for the area describing it as "physically beautiful", "a small close knit community with very friendly people", and a "community with a heart."

A map of the SNMH service area as a part of Nevada County is shown in Figure 5.

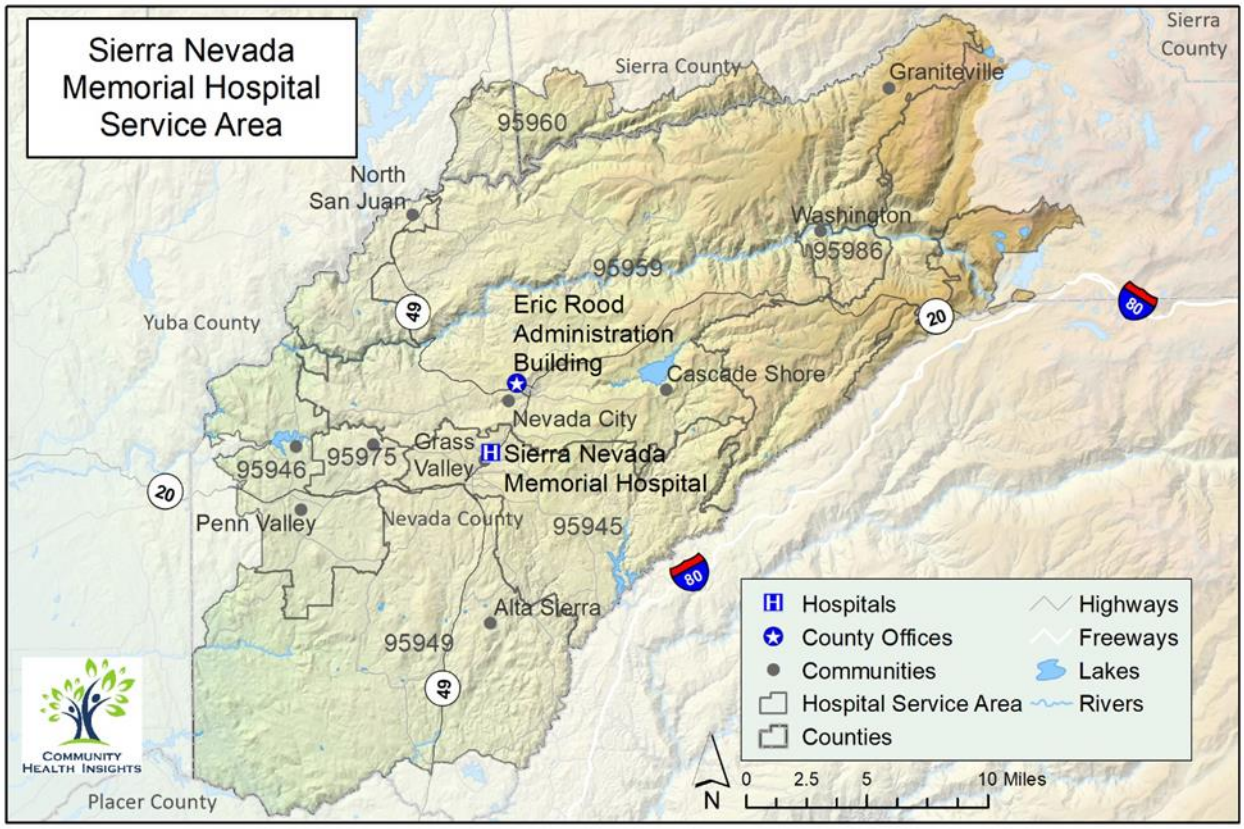

Figure 5: Community served by Sierra Nevada Memorial Hospital (SNMH)

Population characteristics for each ZIP Code in the SNMH service area are presented in Table 4. The data provided below help give a deep understanding of how the county's communities differ based on various social determinants of health. Data provided are compared to the state and county rates, and ZIP Codes that deviated when compared to the county benchmark are highlighted. Cells where ZIP Code data were not available are denoted with a double hash mark (--).

Table 4: Population Characteristics for each ZIP Code Located in the SNMH Service Area

ZIP Code	Total Population	% Minority*	Median Age	Median Income	% Poverty	% Unemployed	% Uninsured	% No HS Graduation	% Living in High Housing Costs	% with Disability
95945	25,712	12.7 %	50.9	$43,636	19.3 %	10.0 %	11.1 %	7.3%	43.9%	21.8 %
95946	9,694	15.9 %	52.3	$62,351	14.3 %	10.9 %	12.8 %	4.6%	40.0%	15.0 %
95949	19,575	8.9%	53.9	$58,861	7.6%	8.2%	9.5%	6.2%	39.6%	14.4 %
95959	17,534	13.4 %	53.1	$59,446	11.9 %	10.3 %	11.4 %	5.7%	37.7%	11.4 %

95960	752	12.6%	37.1	$37,500	29.9%	11.5%	23.8%	12.6%	32.8%	14.9%
95975	1,811	37.1%	50.1	$65,221	16.5%	5.0%	18.2%	9.5%	27.8%	28.4%
95986	79	0.0%	69.9	--	24.1%	0.0%	0.0%	24.1%	11.1%	50.6%
Nevada County	98,639	14.4%	49.5	$57,429	12.1%	8.8%	11.2%	6.7%	40.1%	14.8%
California	38,654,206	61.6%	36.0	$63,783	15.8%	8.7%	12.6%	17.9%	42.9%	10.6%

(Source: 2012 - 2016 American Community Survey 5-year estimates; U.S. Census Bureau)

* Percentage of the population that is Hispanic or reports at least one race that is not white; ** Percentage of the population for whom total housing costs exceed 30% of income

Community Health Vulnerability Index

Figure 6 displays the Community Health Vulnerability Index (CHVI) for the service area. The CHVI is a composite index used to help understand the distribution of health disparities within the service area. Like the *Community Needs Index* or *CNI*[9] on which it was based, the CHVI combines multiple sociodemographic indicators (listed in Table 5) to help identify those locations experiencing health disparities. CHVI values indicate a greater concentration of groups supported in the literature as being more likely to experience disparities. (Readers are referred to the data/technical of this report for further details as to the CHVI construction).

Table 5: Community Health Vulnerability Index Indicators

Percentage Minority (Hispanic or Nonwhite)	Percentage Families with Children in Poverty
Percentage 5 Years or Older Who Speak Limited English	Percentage Households 65 Years or Older in Poverty
Percentage 25 or Older without a High School Diploma	Percentage Single Female-Headed Households in Poverty
Percentage Unemployed	Percentage Renters
Percentage Uninsured	

[9] Barsi, E. and Roth, R. (2005) The Community Needs Index. *Health Progress*, Vol. 86, No. 4, pp. 32-38.

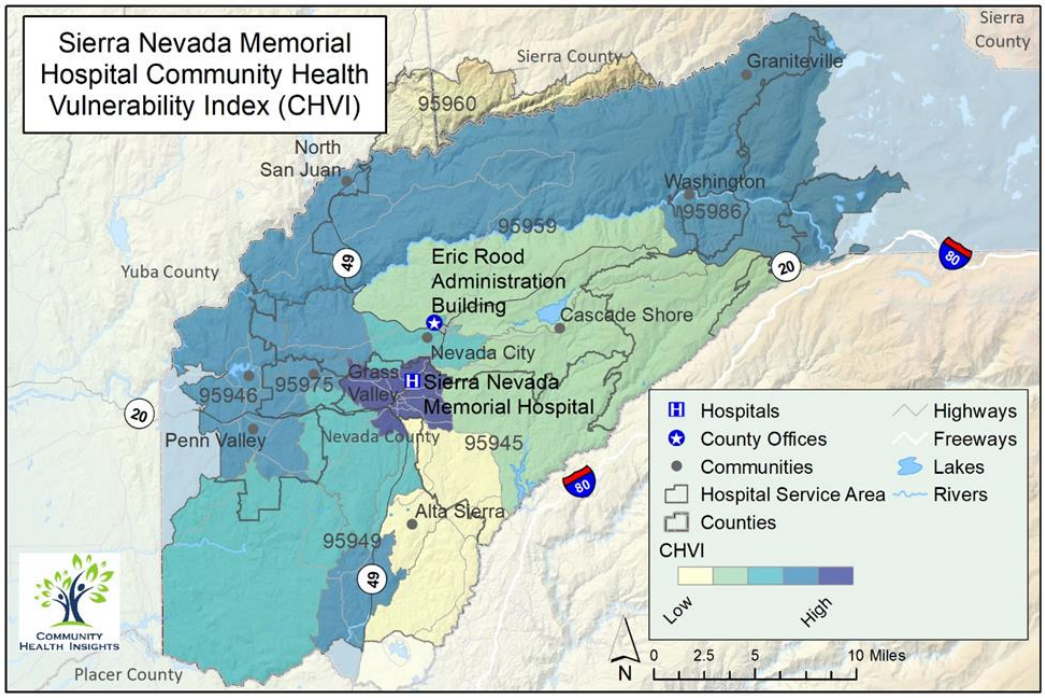

Figure 6: Community Health Vulnerability Index for SNMH

`The census tracts with the highest overall CHVI scores (greatest vulnerability – top 20th percentile) included the main area of central Grass Valley. Further, outlying rural areas including North San Juan, Washington, and Penn Valley fell into the second highest CHVI score category (top 40 percentile) for vulnerability.

Resources Potentially Available to Meet the SHNs

In all, 103 resources were identified in the SNMH service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2016 hospital-based CHNAs, verifying that each resource still existed, and then adding newly identified resources into the 2019 CHNA/CHA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 6.

Table 6: Resources Potentially Available to Meet Significant Health Needs in Priority Order for SNMH

Significant Health Need (in priority order)	Number of resources
Access to basic needs such as housing, jobs, and food	64
Access to quality primary healthcare services	34
Access to mental/behavior/substance abuse services	42
Injury and disease prevention and management	21
Access to specialty and extended care	9
Active living and healthy eating	23
Access and functional needs (transportation and physical mobility)	5
Access to dental care and preventive services	5
Pollution-free living environment	3
Safe and violence free environment	30

For more specific examination of resources by significant health need and by geographic locations, as well as the detailed method for identifying these, see the data/technical section of this report.

Impact/Evaluation of Actions Taken by Hospital since 2016 CHNA

Regulations require that each hospital's CHNA report include: "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."[10]

Priority Health Need Addressed: Access to Behavioral Health Services	
Crisis Stabilization Unit	
Program Description	The Crisis Stabilization Unit (CSU) is a 4 bed, 23 hour mental health facility on the hospital campus. It opened in partnership with Nevada County Behavioral Health serving primarily Medi-Cal patients experiencing an acute mental health condition. Nevada County Behavioral Health contracts with Sierra Mental Wellness to staff and operate the CSU.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to High Quality Health Care and Services ❑ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	1,753 persons served between FY16-FY18.
Dignity Health Contribution / Program Expense[2]	$422,400 expense from SNMH.
Angel Bed Pilot Program	
Program Description	This is an innovative partnership funded by the hospital's community grants program and brings together Community Recovery Resources (CoRR), Grass Valley Police Department (GVPD), and Western Sierra Medical Clinic (WSMC) to provide direct access to residential treatment beds for individuals whose addictions issues have led to frequent interactions with law enforcement. This program hopes to reduce the negative long term impact of addiction by offering an alternate to incarceration through addiction treatment.
Fiscal Years Active	❑ FY 2016 ❑ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Access to High Quality Health Care and Services ✓ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating • Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	For period of February 2018- June 30, 2018: 23 Patients were placed into residential treatment (22 were homeless); 226 nights provided at no cost prior to identifying an ongoing funding source; 132 transitional bed nights; 91% of patients connected to primary care; 57% of patients completed their treatment plan and met recovery goals;

[10] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

	3 patients were placed into transitional housing post residential; and reduction in law enforcement encounters.
Dignity Health Contribution / Program Expense[2]	$77,983 in FY 18
Integrated Family Wellness (FREED Partnership)	
Program Description	The program focuses on Care Transition and Patient Navigation between organizations and services and develops a "no wrong door" system of referral. It increases access to primary, mental health, substance use, and preventative health care for vulnerable populations.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ❑ FY 2018
Secondary Health Needs Addressed	✓ Access to High Quality Health Care and Services ❑ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	1,045 persons served between FY16-FY17. This program was not funded in FY18. This partnership provided a great opportunity for innovative ideas to be developed and serve as a foundation for future projects such as the Angel Bed Pilot program.
Dignity Health Contribution / Program Expense[2]	$136,121 expense from SNMH.
Rural Integrated Health Network Development Grant	
Program Description	Through funding from the Health Resources and Service Administration (HRSA), the Rural Integrated Health Network Development provided Sierra Nevada Memorial Hospital, in partnership with Nevada County Health and Human Services, to develop and refine a community-wide commitment to work collaboratively on challenging health related issues that impact the entire region. Multi-disciplinary community, public, private, and non-profit stakeholders are collectively creating a strategic vision for Nevada County. Collaborations include: o Nevada County Health Collaborative o Mental Health and 5150's Collaboration o Substance Use Disorder Collaborative
Fiscal Years Active	❑ FY 2016 ❑ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Access to High Quality Health Care and Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	Services implemented in the first year include: • Screening Brief Intervention and Referral to Treatment (SBIRT) training for providers; • Tele-Health including primary, specialty and behavioral health to increase access to services; • Creation of an EMS high utilizer targeted program to provide access to social support services; • Development of a social determinants of health assessment and referral to services through a partnership with 211 at Connecting Point; and • Expansion of chronic disease workshops offered in the community setting.

Dignity Health Contribution / Program Expense[2]	Programs and services fully funded by HRSA Grant.

Priority Health Need Addressed: Access to High Quality Health Care and Services	
Emergency Department Navigation Program	
Program Description	The Patient Navigator program focuses on assisting patients who rely on emergency departments for non-urgent needs. The navigators connect patients to a medical home and assist them with scheduling a follow up appointment along with identifying any barriers that may create obstacles with accessing ongoing care. The Patient Navigator Program represents a unique collaboration between California Health and Wellness, a Medi-Cal insurance plan, Western Sierra Medical Clinic, and the hospital.
Fiscal Years Active	❑ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	1,949 patients were assisted in FY18; 57% (1,109 individuals) of the patients assisted had a follow up appointment scheduled with a primary care or other type of provider. All patients received education or referrals to resources. Outcomes show a decrease in low to mid acuity level ED visits by 55% for the population served.
Dignity Health Contribution / Program Expense[2]	The patient navigator position is funded by California Health and Wellness. Staff from Community Health and Outreach and Care Coordination manage program.
Oncology Nurse Navigator	
Program Description	The Oncology Nurse Navigator is designed to help patients navigate the maze of options related to cancer and to complement and enhance services provided by physicians. Nurse navigators provide information, resources and referrals for follow-up biopsies and other treatments that low-income patients otherwise would not be able to access. In addition, through this program patients are linked to survivor peer support partners.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	4,034 persons served between FY16-FY18, including those seen at outreach events in the community to increase awareness of prevention, services, and the program itself.
Dignity Health Contribution / Program Expense[2]	$428,424, which is an expense from SNMH.
Medi-Cal Enrollment Assistance	
Program Description	The program places county eligibility workers and financial counselors in the hospital to assist in enrolling eligible individuals into Medi-Cal insurance programs while helping them get linked to a medical home.

Fiscal Years Active	✓ FY 2016 ❑ FY 2017 ❑ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ❑ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	In FY16, 835 persons served. With expansion of the Affordable Care Act and Nevada County's involvement, this program was no longer sponsored Dignity Health.
Dignity Health Contribution / Program Expense[2]	$48,142 in FY16.

Priority Health Need Addressed: Disease Prevention, Management and Treatment	
Alzheimer's Outreach Program	
Program Description	Offered by the hospital's Home Care group, the Alzheimer's Outreach Program offers a series of classes and support groups designed to assist and empower caregivers with knowledge and skills to help them prevent the mental and physical challenges involved in caring for those with Alzheimer's and other forms of dementia.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	2108 persons served between FY16-FY18.The program teaches caregivers and family members how to provide quality care for Alzheimer's patients still living at home. Home visits, telephone consultations, support groups, and a resource website are important components of the program.
Dignity Health Contribution / Program Expense[2]	$137,633 expense from SNMH.
Falls Prevention Program	
Program Description	The Falls Prevention Program is offered at the hospital and in the community and consists of education about fall risk factors and prevention strategies for older adults and their caregivers. Participants also learn appropriate exercises for enhanced balance and strength.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ❑ Access to High Quality Health Care and Services ❑ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	In FY16, 407 Persons served

Dignity Health Contribution / Program Expense[2]	$2,953 in FY16

Priority Health Need Addressed: Basic Needs	
Homeless Recuperative Care Program	
Program Description	In FY18, Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services, to develop a 4-bed homeless recuperative care program located at Hospitality House.
Fiscal Years Active	❑ FY 2016 ❑ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ✓ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ❑ Active Living and Healthy Eating
Program Performance / Outcomes[1]	This program went before the County Board of Supervisors in August of 2018, and began services in October of 2018. The program is located at Hospitality House, and provides recuperative care for up to 29 days, housing assistance, and wrap around services.
Dignity Health Contribution / Program Expense[2]	Initial investment was provided in FY19.

1. All program outcomes and expenses are reflective of the timeframe (fiscal years) indicated by the boxes checked in the 'Fiscal Years Active' section of the table for each program.

Collaboration

During FY16-FY18, Sierra Nevada Memorial Hospital utilized collaborative strategies to assess current strengths, weaknesses and gaps, and engaged non-traditional partners in community health programs to increase access to expanded services and increase the continuum of care beyond hospitals walls for its patients and community it serves.

Collaborative programs and partnerships across these various initiatives include:

- Western Sierra Medical Center Patient Navigation
- Hepatitis C Eradication Program
- Human Trafficking Community Response Program
- Homeless Outreach Project
- Nevada County Community Health Improvement Plan Steering Committee:
- Mental Health Services Act Steering Committee
- Mental Health Forensic Task Force.
- Nevada County Dental Care Steering Committee

Community Grants

The theme for Dignity Health's Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Dignity Health hospitals; leveraging resources that address priority health issues, and utilize creative strategies

that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of 3 community partners. Program/Project responds to two or more of the following priority health needs:

1. Access to Behavioral Health Services
2. Access to High Quality Health Care Services
3. Disease Prevention, Management and Treatment
4. Safe, Crime and Violence Free Communities
5. Basic Needs (including homelessness)

In FY 2016 through FY 2018, the Sierra Nevada Memorial Hospital awarded 2 grants totaling $212,612. The table below highlights the grantees.

Community Grants

Lead Grant Recipient	Priority Health Need(s) Addressed	Project Name	Fiscal Years Funded			Amount
			FY16	FY17	FY18	
FREED Center for Independent Living	Access to High Quality Health Care and Services Access to Behavioral Health Servicess	Integrated Care Coordination for Family Wellness	$62,508	$72,121		$134,629
Community Recovery Resources	Access to Behavioral Health Services Access to High Quality Health Care and Services Disease Prevention, Management, and Treatment	Direct Access to Treatment Pilot Program			$77,983	$77,983
			Total Amount:			**$212,612**

Conclusion

This joint CHNA/CHA report details the identified health needs of the Nevada County community as a part of a successful collaborative partnership between SNMH and NCPHD. It provides both an overall health and social examination of Nevada County, and a deeper examination of the needs of community members living within areas of the county experiencing disproportionate burdens. The findings of this assessment will work to inform joint implementation efforts to improve the health of Nevada County residents.