Dignity Health
Sierra Nevada Memorial Hospital

Sierra Nevada Memorial Hospital

2022 Community Health Needs Assessment – Main Report

Acknowledgements

We are deeply grateful to all those who contributed to this community health needs assessment conducted on behalf of Sierra Nevada Memorial Hospital. Many dedicated healthcare, community health experts, and members of various social service organizations serving the most vulnerable members of the community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section in the Service Provider Survey section. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. To everyone who supported this important work, we extend our heartfelt gratitude.

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

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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.

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Sierra Nevada Memorial Hospital (SNMH) service area. The priorities identified in this report help to guide SNMH community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

Dignity Health Commitment and Mission Statement

The hospitals' 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. As part of 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.

Community Definition

The eight ZIP code areas of Nevada County (95945, 95946, 95949, 95959, 95960, 95975, 95977, and 95986) were chosen for the CHNA 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. Furthermore, 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 (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 23 community health experts, members of the county's department of public health, social service providers, and medical personnel. Also, 11 community residents or service provider organizations participated in 2 focus groups across the service area. Finally, 19 service providers responded to a Service Provider (SP) survey asking about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity, as well as social and economic factors such as income, educational attainment, and employment. In addition, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was impacting communities across the United States, including SNMH's service area. The process for conducting the CHNA remained fundamentally the same. However, some adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

[1] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

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 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs across Northern California. Data were analyzed to discover which, if any, of the PHNs remained present in the service area. After these were identified, PHNs were prioritized based on rankings provided by the primary data sources described. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

The dynamic and evolving nature of community health needs can result in significant health needs changing over time. For this assessment, two health needs (that were not identified in the previous assessment conducted in 2019) met the threshold of significance to be included in this assessment: Increased Community Connections and System Navigation. Moreover in 2022, Access to Dental Care and Preventative Services along with Healthy Physical Environment did not meet the threshold of significance to be included.

List of Prioritized Significant Health Needs

The following significant health needs identified for Sierra Nevada Memorial Hospital are listed below in prioritized order.

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. Access to Functional Needs
8. Injury and Disease Prevention and Management
9. Active Living and Healthy Eating
10. Safe and Violence-Free Environment

Communities of Concern

Communities of Concern are geographic areas within the service area 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. ZIP codes 95945, 95960, and 95986 were identified as Communities of Concern for Sierra Nevada Memorial Hospital. The total population of the Communities of Concern was 26,121, which is 33.6% of the hospital's service area.

Resources Potentially Available to Meet the Significant Health Needs

In all, 301 resources were identified in the service area that are potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

This CHNA details the process and findings of a comprehensive community health needs assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of SNMH's service area and clearly details the needs of community members living in parts of the service area where the residents experience more health disparities. This report also serves as a resource for community organizations in their effort to improve health and well-being of the communities they serve.

Report Adoption, Availability and Comments

The Board of Directors voted, approved, and adopted the Community Health Needs Assessment for Sierra Nevada Memorial Hospital on April 14, 2022.

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

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the significant health needs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: "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]

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sierra Nevada Memorial Hospital (SNMH), located at 155 Glasson Way, Grass Valley, CA 95945. SNMH's primary service area includes eight ZIP codes consisting of 95945, 95946, 95949, 95959, 95960, 95975, 95977, and 95986. According to 2019 American Community Survey 5-year estimates, the total population of the service area was 77,842.

SNMH is an affiliate of Dignity Health, a nonprofit healthcare system. The CHNA was conducted over a period of 12 months, beginning in February 2021, and concluding in February 2022. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a community health needs assessment at least once every three years.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of SNMH. Community Health Insights is a Sacramento-based, research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[3] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted Implementation Strategy. The 2019 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 website 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.

[2] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.
[3] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

At the time of the development of this CHNA report, SNMH had not received written comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, and the Service Provider Survey. SNMH will continue to use its website as a tool to solicit public comments and ensure that these comments are integrated as community input in the development of future CHNAs.

Data Used in the CHNA

Data collected and analyzed included both primary (qualitative) and secondary (quantitative) data. Primary data included 9 interviews with 23 community health experts, 2 focus groups conducted with a total of 11 community residents or community-facing service providers (see the full listing of all participants in the technical section), and 19 responses to the Service Provider Survey.

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the hospital's service area 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. Additionally, socioeconomic indicators were 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 to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 68 different health outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the SNMH service area. This included identifying 12 potential health needs (PHNs) in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the SNMH service area. In all, 10 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

The dynamic and evolving nature of community health needs can result in significant health needs changing over time. For this assessment, two health needs (that were not identified in the previous assessment conducted in 2019) met the threshold of significance to be included in this assessment: Increased Community Connections and System Navigation. Moreover in 2022, Access to Dental Care and Preventative Services along with Healthy Physical Environment did not meet the threshold of significance to be included.

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of service provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each significant health need.

Table 1: Health need prioritization inputs for SNMH service area.

Prioritized Health Needs	**Percentage of Key Informants and Focus Groups Identifying Health Need**	**Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority**	**Percentage of Survey Respondents that Identified Health Need as a Top Priority**
Access to Basic Needs Such as Housing, Jobs, and Food	100%	19%	74%
Access to Mental/Behavioral Health and Substance Use Services	75%	31%	42%
Access to Quality Primary Care Health Services	92%	15%	16%
Access to Specialty and Extended Care	83%	12%	26%
System Navigation	67%	6%	21%
Increased Community Connections	75%	2%	11%
Access to Functional Needs	58%	4%	16%
Injury and Disease Prevention and Management	58%	8%	~
Active Living and Healthy Eating	17%	2%	~
Safe and Violence-Free Environment	8%	~	5%

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and that were more frequently identified among the top priority needs.[4] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top to lowest priority at the bottom.

[4] Further details regarding the creation of the prioritization index can be found in the technical section.

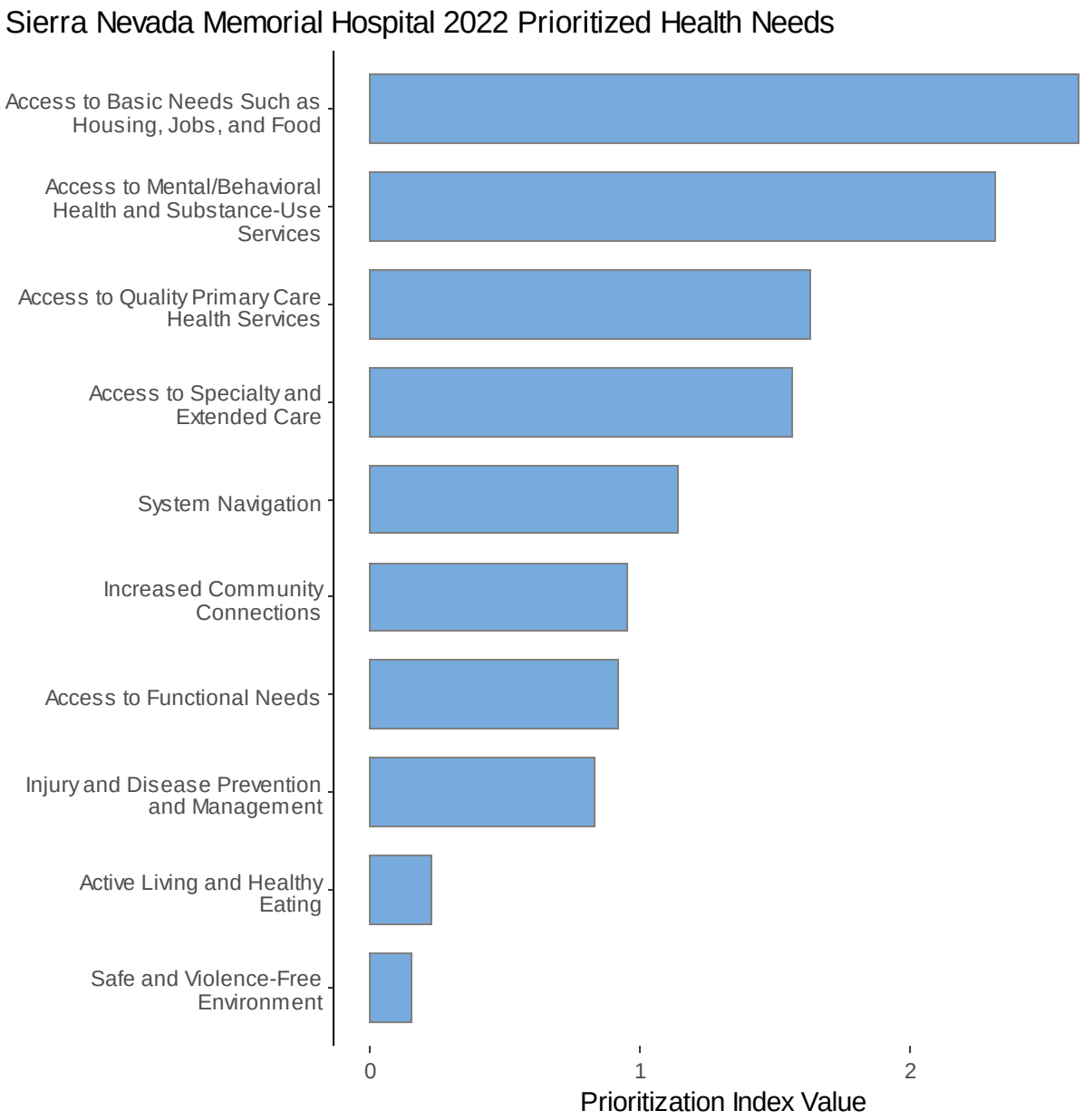


Figure 1: Prioritized, significant health needs for SNMH service area.

COVID-19 was top of mind for many participating in the primary data collection process, and feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The significant health needs are described below in prioritized order. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health and ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the section. Secondary indicators that were associated with a health need were assigned to that health need based on expert review. Lastly, some indicators were assigned to multiple health needs.

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[5] 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.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td></tr>
<tr><td>- Services for homeless residents in the area are insufficient.
- Lack of affordable housing is a significant issue in the area.
- Poverty in the county is high (intergenerational poverty)
- Employment opportunities in the area are limited.
- Many people in the area do not make a living wage.
- Educational attainment in the area is low.
- Many residents struggle with food insecurity.
- Services are inaccessible for Spanish-speaking and immigrant residents.
- It is difficult to find affordable childcare.
- Clear need to ensure all county residents have adequate access to technology and internet (reduce the digital divide).</td><td>- Lack of affordable housing is a significant issue in the area.
- The area needs additional low-income housing options.
- It is difficult to find affordable childcare.
- Many people do not make a living wage.
- Many residents struggle with food insecurity.
- Poverty in the county is high.
- Services for homeless residents in the area are insufficient.
- Employment opportunities in the area are limited.
- Services are inaccessible for Spanish-speaking and immigrant residents.
- Educational attainment in area is low.</td><td>- Life Expectancy
- Premature Age-Adjusted Mortality
- Premature Death
- Hypertension Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Drug Induced Death
- Limited Access to Healthy Foods
- Food Environment Index
- Medically Underserved Area
- COVID-19 Cumulative Full Vaccination Rate
- Disconnected Youth
- Median Household Income</td></tr>
</table>

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 an essential ingredient for a healthy community where residents can obtain additional support when needed.

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- There aren't enough mental health providers or treatment centers in the area, e.g., psychiatric beds, therapists, support group. - It's difficult for people to navigate for mental/behavioral healthcare. - The area lacks the infrastructure to support acute mental health crises. - The stigma around mental health treatment keeps people from seeking care. - The cost for mental/behavioral health treatment is too high. - Treatment options in the area for those with Medi-Cal are limited. - Additional services are needed for those who are homeless and dealing with mental/behavioral health issues. - Opioid use and misuse is a notable problem in the county. - There are feelings of isolation and experiences of racism and discrimination in diverse communities due to the social political anti-immigration climate. - Substance use is a problem in the area (e.g., use of opiates, methamphetamine, alcohol abuse).	- Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. - There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). - Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). - There aren't enough services here for those who are homeless and dealing with substance use issues. - It's difficult for people to navigate for mental/behavioral healthcare. - Treatment options in the area for those with Medi-Cal are limited. - There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). - The area lacks the infrastructure to support acute mental health crises. - Substance use is an issue among youth in particular. - Substance use treatment options for those with Medi-Cal are limited. - Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in schools). - Awareness of mental health issues among community members is low. - The stigma around mental health treatment keeps people from seeking care. - The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community.	- Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Liver Disease Mortality - Suicide Mortality - Poor Mental Health Days - Frequent Mental Distress - Excessive Drinking - Drug Induced Death - Adult Smoking - Primary Care Shortage Area - Mental Health Care Shortage Area - Medically Underserved Area - Psychiatry Providers - Firearm Fatalities Rate - Juvenile Arrest Rate - Disconnected Youth

- There are too few substance use treatment services in the area (e.g., detox centers). - There is desire among some participants to decriminalize drugs.	- The cost for mental/behavioral health treatment is too high. - There are substance use treatment services available here, but people do not know about them. - Mental/behavioral health services are available in the area, but people do not know about them.	

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 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.

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- Accessing primary care service providers in the area is difficult. - Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, specific population needs). - Primary care service are difficult for many people to navigate. - It is difficult to recruit and retain primary care providers in the region. - Wait times for appointments are excessively long. - Quality health insurance is unaffordable or limited. - The quality of care is low (e.g., appointments are rushed, providers lack cultural competency). - Out-of-pocket costs are too high. - Bringing care (street medicine) to the community is needed.	- The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). - There aren't enough primary care service providers in the area. - Wait times for appointments are excessively long. - Patients have difficulty obtaining appointments outside of regular business hours. - Patients seeking primary care overwhelm local emergency departments. - Primary care services are available but are difficult for many people to navigate. - Quality health insurance is unaffordable. - Too few providers in the area accept Medi-Cal. - It is difficult to recruit and retain primary care providers in the region.	- Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Heart Disease Mortality - Hypertension Mortality - Cancer Mortality - Liver Disease Mortality - Kidney Disease Mortality - Alzheimer's Disease Mortality - Influenza and Pneumonia Mortality - Poor Mental Health Days - Frequent Mental Distress - Breast Cancer Prevalence - Primary Care Shortage Area - Medically Underserved Area

- There is increased need for more prenatal care in the county.	- Out-of-pocket costs are too high. - Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).	- Primary Care Providers - COVID-19 Cumulative Full Vaccination Rate

4. Access to Specialty and Extended Care

Extended care services, which include specialty care, are care 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 that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- The area lacks a variety of specialist or extended care options (e.g., dementia care, diabetes care). - The area needs more extended care options for the aging population (e.g., skilled nursing facilities, adult day centers). - Too few specialty and extended care providers accept Medi-Cal. - People have to travel a long distance or out of the county to reach specialists. - There isn't enough OB/GYN care available. - It is difficult to recruit and retain specialists in the area. - Wait times for specialist appointments are excessively long. - Increased access to telehealth specialty care is needed.	- People have to travel to reach specialists. - Too few specialty and extended care providers accept Medi-Cal. - It is difficult to recruit and retain specialists in the area. - Not all specialty care is covered by insurance. - The area lacks a kind of specialist or extended care option not listed here. - The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). - There isn't enough OB/GYN care available. - Wait times for specialist appointments are excessively long.	- Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Heart Disease Mortality - Hypertension Mortality - Cancer Mortality - Liver Disease Mortality - Kidney Disease Mortality - Alzheimer's Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Drug Induced Death - Psychiatry Providers - Specialty Care Providers

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.[6] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td></tr>
<tr><td>- Some people just don't know where to start in order to access care or benefits.
- People may not be aware of the services they are eligible for.
- More integrated care teams for disease management are needed.
- Case managers help community members navigate the care system.</td><td>- It is difficult for people to navigate multiple, different healthcare systems.
- People may not be aware of the services they are eligible for.
- Dealing with medical and insurance paperwork can be overwhelming.
- Some people just don't know where to start in order to access care or benefits.
- The area needs more navigators to help to get people connected to services.
- Automated phone systems can be difficult for those who are unfamiliar with the healthcare system.
- Medical terminology is confusing.
- People have trouble understanding their insurance benefits.</td><td>No secondary indicators were assigned to this health need.</td></tr>
</table>

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."[7] Ensuring 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

[6] Natale-Pereira, A. et. al .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

[7] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. See: https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td></tr>
<tr><td>- Health and social service providers operate in silos; we need cross-sector collaboration.
- Building community connections doesn't seem like a focus in the area.
- Relations between law enforcement and the community need to be improved.
- Connecting with Native communities is needed in regard to them accessing information.</td><td>- Building community connections doesn't seem like a focus in the area.
- City and county leaders need to work together.
- People in the community face discrimination from local service providers.
- Relations between law enforcement and the community need to be improved.
- There isn't enough funding for social services in the county.</td><td>- Life Expectancy
- Premature Age-Adjusted Mortality
- Premature Death
- Stroke Mortality
- Heart Disease Mortality
- Hypertension Mortality
- Suicide Mortality
- Unintentional Injuries Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Excessive Drinking
- Drug Induced Death
- Access to Exercise Opportunities
- Primary Care Shortage Area
- Mental Health Care Shortage Area
- Medically Underserved Area
- Psychiatry Providers
- Specialty Care Providers
- Primary Care Providers
- COVID-19 Cumulative Full Vaccination Rate
- Firearm Fatalities Rate
- Juvenile Arrest Rate
- Disconnected Youth
- Access to Public Transit</td></tr>
</table>

7. Access to Functional Needs

Functional needs include adequate transportation access and conditions, which promote access for individuals with physical disabilities. 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.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- Many residents do not have reliable personal transportation. - Public transportation service routes and services are limited. - Medical transport in the area is limited. - Using public transportation to reach providers can take a very long time. - Public transportation is more difficult for some residents to use given proximity to access stops.	- Many residents do not have reliable personal transportation. - Medical transport in the area is limited. - Public transportation service routes are limited. - Roads and sidewalks in the area are not well maintained. - The distance between service providers is inconvenient for those using public transportation. - There aren't enough taxi and ride-share options (e.g., Uber, Lyft). - The geography of the area makes it difficult for those without reliable transportation to get around. - Using public transportation to reach providers can take a very long time. - Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). - Public transportation schedules are limited. - The cost of public transportation is too high.	- Disability - Frequent Mental Distress - COVID-19 Cumulative Full Vaccination Rate - Access to Public Transit

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.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). - Prevention efforts need to be focused on specific populations in the community (e.g., seniors, prenatal pregnant mothers). - Additional HIV and STI prevention efforts are needed. - Vaccination rates are lower than they need to be. - The county lacks a focus on prevention. - Improve the digital divide.	- No themes were identified in the Service Provider Survey for this health need.	- Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Heart Disease Mortality - Hypertension Mortality - Liver Disease Mortality - Kidney Disease Mortality - Suicide Mortality - Unintentional Injuries Mortality - Alzheimer's Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Excessive Drinking - Drug Induced Death - Adult Smoking - COVID-19 Cumulative Full Vaccination Rate - Firearm Fatalities Rate - Juvenile Arrest Rate - Motor Vehicle Crash Death - Disconnected Youth

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 often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families. This can lead to relying on food pantries and school meals which often lack sufficient nutrition for maintaining health.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- There is increased need for better access to healthy food. - A sustainable food system is needed.	- No themes were identified in the Service Provider Survey for this health need.	- Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Heart Disease Mortality - Hypertension Mortality - Cancer Mortality - Kidney Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Breast Cancer Prevalence - Limited Access to Healthy Foods - Food Environment Index - Access to Exercise Opportunities - Access to Public Transit

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, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[8]

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider Survey.		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	
- Rates of incarceration have increased in the county.	- Gang activity is an issue in the area. - Human trafficking is an issue in the area. - People feel unsafe because of crime.	- Life Expectancy - Premature Death - Hypertension Mortality - Poor Mental Health Days - Frequent Mental Distress - Access to Exercise Opportunities

[8] Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

	- Specific groups in this community are targeted because of characteristics like race/ethnicity or age. - There are not enough resources to address domestic violence and sexual assault. - Youth need more safe places to go after school.	- Firearm Fatalities Rate - Juvenile Arrest Rate - Motor Vehicle Crash Death - Disconnected Youth

Description of Community Served

The definition of the community served was the primary service area of SNMH. Sierra Nevada Memorial Hospital is located in Grass Valley, California. The service area for the hospital occupies the majority of the western portion of Nevada County, California with a total population of the service area of 77,842[9]. The service area is shown in Figure 2.

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. Nevada County is in the heart of California's historic Gold Country and includes the small cities of Grass Valley, Nevada City, and Truckee, as well as nine other unincorporated cities. Nevada City's downtown district is a national historical landmark with "old fashion hospitality. " Since the Gold Rush of 1849, the region experienced a dramatic transformation of its landscape, with open-range cattle grazing, orchards, timber production, and deep, hard-rock gold mining becoming economic mainstays. By the mid-1950s, however, the last major commercial mines closed, and the traditional natural resource-based economy went into decline. By 1998, employment in agriculture, forestry, and mining (together) in Nevada County dwindled to about 2% of all local jobs. Today, employment by sector paints a picture of economic health by industry in the county overall.

[9] 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 2: Community served by SNMH.

Population characteristics for each ZIP Code in the service area are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. ZIP Code with values that compared negatively to the county are highlighted.

Table 2: Population characteristics for each ZIP Code located in the SNMH service area.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (years)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95945	25,381	16.8	49.5	$48,648	14.4	7.1	7.2	7.0	44.2	19.0
95946	8,977	12.2	57.7	$62,434	12.4	2.9	5.0	3.9	45.6	16.0
95949	21,036	12.5	53.6	$71,059	8.3	4.4	4.7	6.0	38.7	14.3
95959	18,343	14.7	53.6	$69,314	11.2	5.0	8.9	5.1	37.3	10.0
95960	684	3.5	41.3	$36,000	17.8	4.6	28.4	10.1	36.0	13.3

95975	1,877	7.7	59.3	$69,082	20.7	0.0	3.5	6.9	45.6	36.5
95977	1,488	8.7	36.8	$50,536	14.7	7.5	13.1	5.2	64.2	15.8
95986	56	0.0	70.5	$60,714	0.0	0.0	0.0	0.0	18.8	37.5
Nevada	99,244	14.8	50.5	$66,096	11.0	4.6	6.5	5.6	40.3	14.3
California	39,283,497	62.8	36.5	$75,235	13.4	6.1	7.5	16.7	40.6	10.6

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

California Healthy Places Index

Figure 3 displays the California Healthy Places Index (HPI)[10] values for the SNMH service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

Areas with the darkest blue shading in Figure 3 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

[10] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved from https://healthyplacesindex.org/about/.

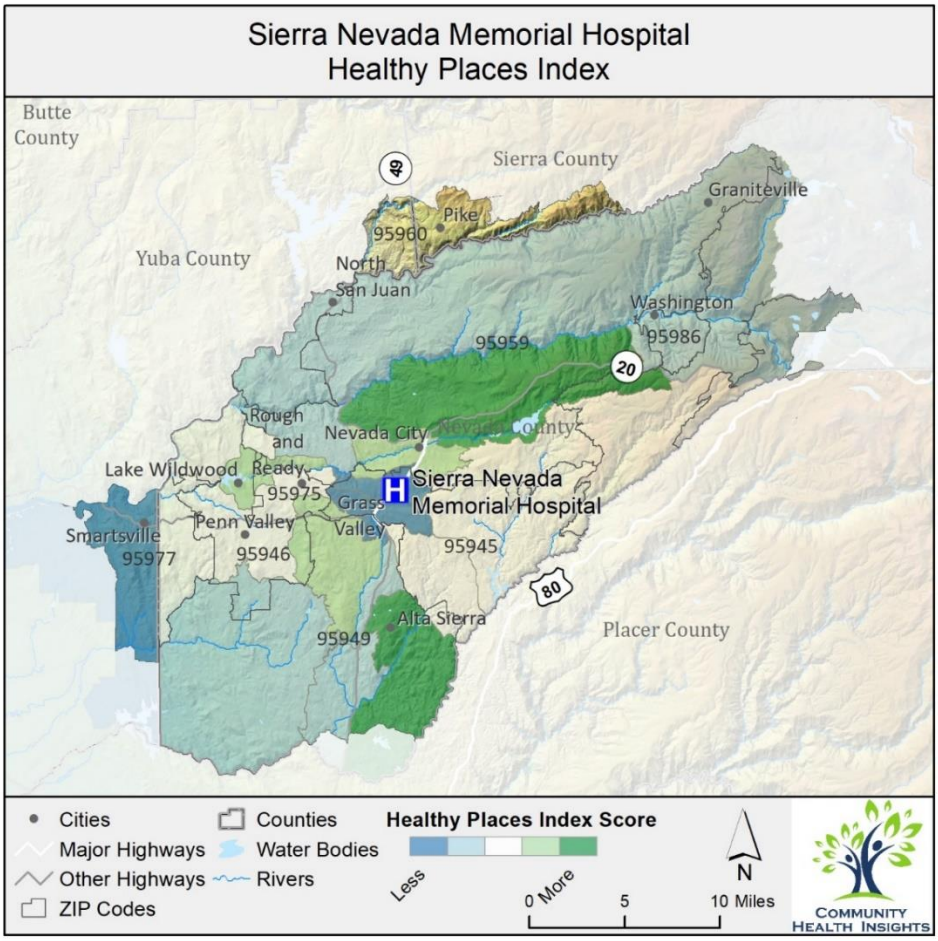


Figure 3: Healthy Places Index for SNMH.

Communities of Concern

Communities of Concern are geographic areas within the service area 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 methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed two ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 3, with the census population provided for each, and they are also displayed in Figure 4.

Table 3: Identified Communities of Concern for the SNMH service area.

ZIP Code	Community\Area	Population
Primary Communities of Concern		
95945	Grass Valley	25,381
Secondary Communities of Concern		
95960	North San Juan	684

95986	Washington	56
Total Population in Communities of Concern		*26,121*
Total Population in Hospital Service Area		*77,842*
Percentage of Service Area Population in Community of Concern		*33.6%*
Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.		

Figure 4 displays the ZIP Codes that are Communities of Concern for the SNMH service area.

Figure 3: SNMH Communities of Concern.

Health Equity

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity.

> "*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including*

powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[11]

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are 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 ethnicity, gender, education or income, disability, geographic location or sexual orientation."[12]

In the U.S., and many parts of the world inequities are most apparent when comparing health outcomes of various racial and ethnic groups to one another. Comparisons of outcomes between racial and ethnic populations demonstrate that health inequities persist across communities, including Nevada County.

This section of the report shows inequities in health outcomes and health factors, comparing these between racial and ethnic groups. These differences inform better planning for more targeted interventions. The data provided in this section are a high-level summary of health equity in Nevada County and not intended to provide an extensive exploration of inequity in the area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community.

Health Outcomes - the Results of Inequity

Table 4 displays disparities among racial and ethnic groups for the health service area (HSA) for life expectancy, mortality, and low birthweight.

Table 4: Health outcomes by race and ethnicity in the SNMH service area.

Health Outcomes	Description	Asian	Hispanic	White	Overall
Life Expectancy	Average number of years a person can expect to live.	86.1	84.5	81.2	81.3
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	~	191.3	281.5	276.5
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	4,616.3	6,094.8	6,068.4
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	9.5%	6.2%	5.7%	5.9%

Data on health outcomes by race and ethnicity were only available for the groups shown in Table 4. Whites had the lowest life expectancy, highest premature age- adjusted mortality, and highest premature death. These data may represent the large proportion of Whites in the SNMH area, and greater differences in socioeconomic status among the group, more than anything. However, Asians had the highest percent of low birthweight babies.

[11] Robert Wood Johnsons Foundation. (2017, April). What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1. Retrieved from: https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf

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

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, such as education attainment and income. These health factors are displayed in Table 5 and are compared across racial and ethnic groups.

Table 5: Health factors by race and ethnicity in the SNMH service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	76%	71.4%	70.3%	60%	77.5%	76%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	93.6%	83.1%	81.2%	80.6%	95.9%	94.4%
Third Grade Reading Level	Average grade level performance for 3rd graders - English Language Arts standardized tests	~	~	~	2.6	3.1	3
Third Grade Math Level	Average grade level performance for 3rd graders - math standardized tests	~	~	~	2.6	2.9	2.8
Children in Poverty	Percentage of people under age 18 in poverty.	~	~	~	17.5%	11.8%	13.5%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$48,750	$79,637	$77,898	$56,569	$66,268	$69,550

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	9.3%	12.5%	9.8%	14.7%	5.5%	6.5%

~ Data not available
Unless otherwise noted, data sources are included in the technical section.
[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b]From 2019 American Community Survey 5-year estimates table S2701

Health factor data by race and ethnicity show that Hispanics, in comparison to other groups, have the lowest percentage of residents attending college or completing high school, lowest third grade math and reading levels, highest percentage of children living in poverty, and highest percent of the population being uninsured.

Population Groups and Locations Experiencing Disparities

The figure and table that follow describe populations and specific geographic locations in the SNMH service area mentioned in qualitative data 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?

For populations, responses were analyzed by counting the total number of times all key informants and focus group participants mentioned a particular group as one experiencing disparities. Figure 5 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

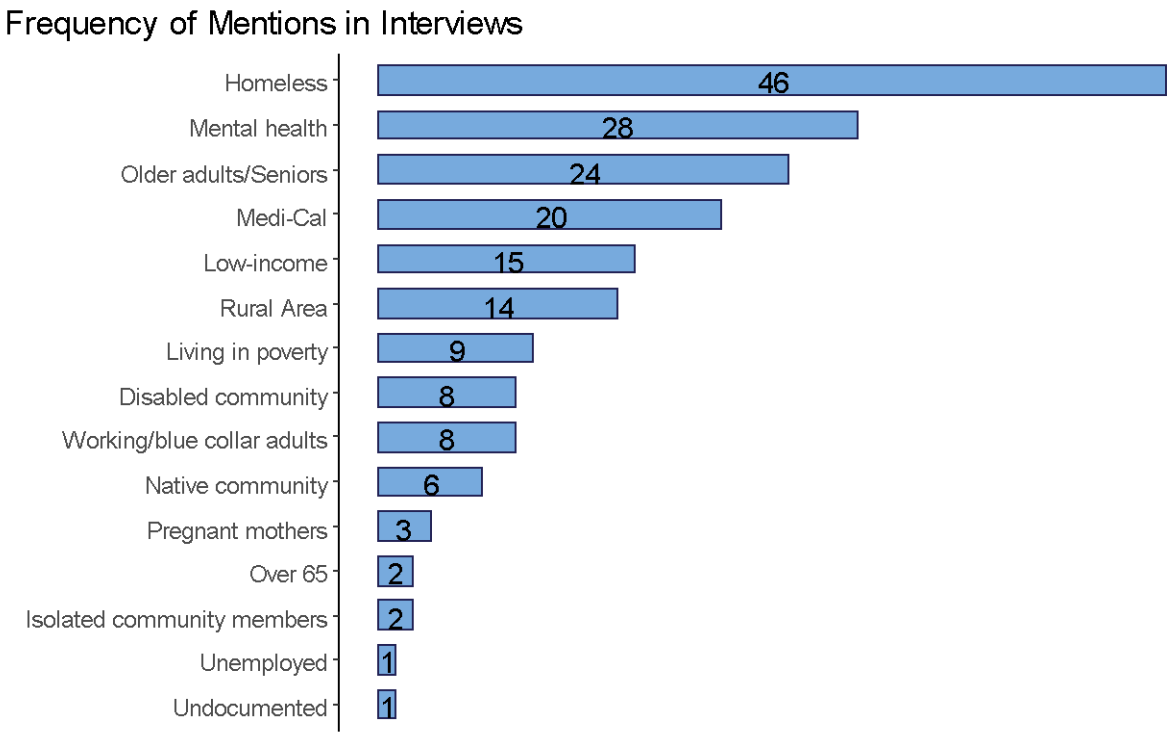


Figure 4: Populations experiencing disparities the SNMH service area.

Table 6 details responses from a total of 34 key informants and focus group participants related to geographic locations in the service area struggling disproportionately with health issues. The detailed descriptive data from this question are organized by specific location and presented below.

Table 6: Geographic locations struggling with health issues.

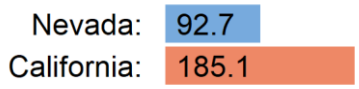
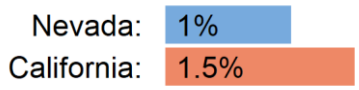
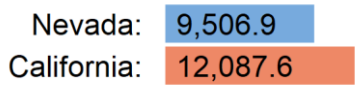
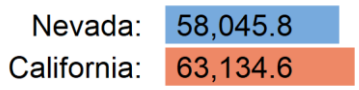
"What specific geographic locations struggle with health issues the most?"	
Geographic Locations Mentioned in Interviews	**Attributes of Locations**
Grass Valley	Lower-income areas face issues with substance use. High population density with low primary care access. Inadequate health and social resources. Urban area of the county. Historically comprised of miners, Nevada City comprised of mine owners. Low-income seniors in Grass valley experience more health disparities due to low access to care and other comorbidities. Brunswick Basin – High homelessness. Old Tunnel Road has significant amount of seniors with high rates of impaired physical and cognitive decline.
North San Juan	Transportation to services is limited. Lack of access to internet. Issues with substance use. Wealthy growers of cannabis. No home health access. Increased need for street medicine. Large homeless camp in the area.

Washington	Transportation to services is limited. Lack of access to internet. Issues with substance use. Isolated and remote area of the county.
Penn Valley	Farming and agricultural area.
Rural Areas	Lack of access to healthy food, health care. Lack of transportation to services a barrier. Lack of access to clinics, limited caregivers.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators for the hospital service area (HSA) are noted in Table 7.

Table 7: COVID-19-related rates for the SNMH service area.

Indicators	Description	Nevada	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	92.7	185.1	
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.0%	1.5%	
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	9,506.9	12,087.6	
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	58,045.8	63,134.6	

Source: COVID19.CA.GOV. Retrieved November 17, 2021.

COVID-19 data for Nevada County shows that COVID-19 mortality, case fatality, and cumulative incidence rates are better than the state rates. However, full vaccination rates for Nevada County are lower than the state rate.

Key informants and focus group participants were asked how the COVID-19 pandemic impacted the health needs they described during interviews. Community service provider survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 8.

Table 8: The impacts of COVID-19 on health need as identified in primary data sources.

Key Informant and Focus Group Responses	Service Provider Survey Responses
- Basic physical needs were deepened with COVID-19. - Seniors became very isolated. - Many social support services were minimized or shut down.	- Isolation is harming the mental health of community members. - Residents encounter economic hardships from lost or reduced employment.

- Staffing shortages in service organizations are a major concern related to COVID-19. - Access to technology to access telehealth care challenging. - Providers saw an increase in homelessness. - Federal funding from COVID-19 allowed for expansion of services for some health organizations. - Food scarcity became more apparent in the pandemic. - Wait times for healthcare appointments increased. - There are increased mental health needs and sexually transmitted diseases (STDs).	- Resident's delay or forgo healthcare to limit their exposure to the virus. - Residents in the community are being evicted from their homes. - Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services).

Resources Potentially Available to Meet the Significant Health Needs

In all, 301 resources were identified in the SNMH service area that are potentially available to meet the identified significant health needs. These resources were provided by a total of 99 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sierra Nevada Memorial Hospital CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 9.

Table 9: Resources potentially available to meet significant health needs in priority order.

Significant Health Needs (in Priority Order)	**Number of Resources**
Access to Basic Needs Such as Housing, Jobs, and Food	59
Access to Mental/Behavioral Health and Substance Use Services	46
Access to Quality Primary Care Health Services	34
Access to Specialty and Extended Care	9
System Navigation	26
Increased Community Connections	44
Access to Functional Needs	4
Injury and Disease Prevention and Management	23
Active Living and Healthy Eating	24
Safe and Violence-Free Environment	32
Total Resources	301

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

Impact/Evaluation of Actions Taken by Hospital since 2019 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)."[13]

Priority Health Need Addressed: Access to Basic Needs, such as Housing, Jobs and Food	
Homeless Recuperative Care Program	
Program Description	In FY18, Sierra Nevada Memorial began a collaborative partnership with Nevada County Health and Human Services and Hospitality House, to develop a recuperative care program. Located at Hospitality House, the program provides recuperative care for up to 29 days, housing assistance, and wrap around services, and is a critical safety net for individuals experiencing homelessness who are exiting an in-patient hospital stay.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	✓ Access to Basic Needs, such as Housing, Jobs, and Food ❑ Access to Mental, Behavioral and Substance Use Services ✓ Access to Quality Primary Care Health Services ✓ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	The program is located at Hospitality House, and provides recuperative care for up to 29 days, housing assistance, and wrap around services. 80 individuals received services through the program.
Dignity Health Contribution / Program Expense[2]	$263,334

Priority Health Need Addressed: Access to mental, behavioral and substance use services	
Crisis Stabilization Unit	
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.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Basic Needs, such as Housing, Jobs, and Food

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

	✓ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ❑ Injury and Disease Prevention and Management ❑ Access to Specialty and Extended Care ✓ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	1,568 behavioral health encounters in FY19, 1,256 CSU admissions and 4,155 crisis evaluations were completed in FY20 and FY21. There were 1,960 Medicaid patients.
Dignity Health Contribution / Program Expense[2]	$720,000
Substance Use Navigation	
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.
Fiscal Years Active	❑ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	✓ Access to Basic Needs, such as Housing, Jobs, and Food ✓ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ❑ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ✓ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	Connected with 345 patients admitted through the ED and provided services to connect to care at local MAT agencies.
Dignity Health Contribution / Program Expense[2]	$23,645 in staff expenses. This program is funded through a California Department of Health Care Services Behavioral Health Pilot Project grant. Leadership from the Emergency Department, Care Coordination and Community Health and Outreach help manage the program.

Priority Health Need Addressed: Access to quality primary care health services	
Patient Navigator 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, and the hospital.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020

	✓ FY 2021
Secondary Health Needs Addressed	✓ Access to Basic Needs, such as Housing, Jobs, and Food ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Quality Primary Care Health Services ✓ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	4,310 patients were assisted and connected to a variety of health resources including primary care.
Dignity Health Contribution / Program Expense[2]	$23,082 in staff expenses. Staff from Community Health and Outreach help manage the program.
Oncology Nurse Navigation	
Program Description	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Basic Needs, such as Housing, Jobs, and Food ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ✓ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	872 persons served between FY19-FY21, 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]	$68,637

Priority Health Need Addressed: Injury and disease prevention and management	
Alzheimer's Outreach Program	
Program Description	The hospital's Home Care Department, in collaboration with Sierra Nevada Memorial Hospital Foundation, and Nevada County Health and Human Services offers an Alzheimer's Outreach Program that serves as a unique community education, resource and support center. A licensed social worker is dedicated to the program who provides education and caregiver support via home visits and personal consultations, and links those that need specialized care to important resources, including assisted living/care centers.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020

	✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Basic Needs, such as Housing, Jobs, and Food ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ✓ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	709 persons served between FY19-FY21.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]	$214,020

Priority Health Need Addressed: Access to specialty and extended care	
Congestive Heart Active Management Program (CHAMP®)	
Program Description	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through regular phone interactions to support, educate and assist primary care physicians/cardiologists to manage this disease and monitoring of symptoms or complications.
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Needs Addressed	❑ Access to Basic Needs, such as Housing, Jobs, and Food ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ❑ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ❑ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	1,481 persons served between FY19-FY21.
Dignity Health Contribution / Program Expense[2]	$133,481

Priority Health Need Addressed: Safe and violence-free environment	
Rapid Access to Wellness	
Program Description	This is an innovative partnership funded by the hospital's community grants program and brings together Granite Wellness Center, 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 alternative to incarceration through addiction treatment. Grant funding for this project ended at the end of 2020.

Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ❑ FY 2021
Secondary Health Needs Addressed	✓ Access to Basic Needs, such as Housing, Jobs, and Food ✓ Access to Mental, Behavioral and Substance Use Services ❑ Access to Quality Primary Care Health Services ✓ Injury and Disease Prevention and Management ✓ Access to Specialty and Extended Care ✓ Safe and Violence-Free Environment
Program Performance / Outcomes[1]	27 individuals have accessed residential treatment through the Rapid Access to Wellness program. 35 individuals have accessed emergency shelter, before or after substance use disorder treatment, at HH. Another 14 were supported in GWC Transitional Housing.
Dignity Health Contribution / Program Expense[2]	$148,918

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.
2. Outcomes and expenses are also shared between the Dignity Health hospitals indicated by the boxes checked in the 'Active Hospitals' section of the table for each program.

Collaboration

During FY19-21, 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 hospital 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.

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 one or more of the following priority top health needs:

1. Access to Behavioral Health Services: Includes access to mental health and substance abuse prevention and treatment services.
2. Access to High Quality Health Care Services: Includes access to primary and specialty care, dental care and maternal and infant care. Additionally, this category includes health education and literacy, continuity of care, care coordination and patient navigation including linguistically and culturally competent services.
3. Disease Prevention, Management and Treatment: Includes disease prevention and/or management programs that improve health status.

In FY 2019 through FY 2021, the Sierra Nevada Memorial Hospital collectively awarded 6 grants totaling $256,597. The table below highlights the grantees.

Community Grants					
Lead Grant Recipient	**Priority Health Need(s) Addressed**	**Project Name**	**Fiscal Years Funded**		
			FY19	FY20	FY21
Community Recovery Resources	Access to Mental, Behavioral and Substance Use Services; Access to Quality Primary Care Health Services; Injury and Disease Prevention and Management; Safe and Violence-Free Environment	Direct Access to Treatment Pilot Program	$92,958		
Granite Wellness Center	Access to Mental, Behavioral and Substance Use Services; Access to Quality Primary Care Health Services; Injury and Disease Prevention and Management; Safe and Violence-Free Environment	Rapid Access to Wellness		$55,960	
Gold Country Community Services	Injury and Disease Prevention and Management; Access to Basic Needs, such as food	Senior Grocery Bag Program		$25,000	
Bright Horizons for Youth	Access to Mental, Behavioral and Substance Use Services; Injury and Disease Prevention and Management; Safe and Violence-Free Environment	The Friendship Club			$57,679
Sierra Family Health Center	Access to Quality Primary Care Health Services; Injury and Disease Prevention and Management; Access to Basic Needs	Patient Transportation Gas Card Program			$15,000

Spirit Peers for Independence and Recovery	Access to Mental, Behavioral and Substance Use Services; Access to Basic Needs	Coronavirus Pandemic Community Benefit Support Grant			$10,000
Grand Total			**$92,958**	**$80,960**	**$82,679**

Conclusion

Community Health Assessments play an important role in helping community partners determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in this report can help nonprofit hospitals, local health departments, and community service providers work in collaboration to engage in meaningful community health improvement efforts.