Dignity Health
Sierra Nevada Memorial Hospital

# Sierra Nevada Memorial Hospital

## Community Benefit 2018 Report and 2019 Plan

Dignity Health.
Sierra Nevada Memorial Hospital

## A message from

Katherine Medeiros president and CEO of Sierra Nevada Memorial Hospital, and Ed Sylvester Chair of the Sierra Nevada Memorial Hospital Board of Directors.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Sierra Nevada Memorial Hospital (Sierra Nevada Memorial) shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2018 (FY18), Sierra Nevada Memorial provided $3,048,154 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $27,829,957 in unreimbursed costs of caring for patients covered by Medicare.

Sierra Nevada Memorial's Board of Directors reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its November 8th, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (916) 851-2005.

Katherine A. Medeiros
President/CEO

Edward B. Sylvester
Chairperson, Board of Directors

# TABLE OF CONTENTS

# At-a-Glance Summary

| | |
|---|---|
| **Community Served** | Sierra Nevada Memorial is located in western Nevada County and continues to be the only acute care hospital serving this region. The hospital's service area is home to nearly 75,000 residents, with over 27% of the population age 65 years of age and older. While a number of health resources are available within its more populated communities, Nevada County's rural environment contributes to barriers in accessing health care and health-related services for individuals and families living in the country. Therefore, the community is heavily dependent on the hospital to often serve all its health needs. |
| **Economic Value of Community Benefit** | $3,048,154 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits.<br><br>$27,829,957 in unreimbursed costs of caring for patients covered by Medicare. |
| **Significant Community Health Needs Being Addressed** | The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are:<br>1) Access to Behavioral Health Services<br>2) Access to High Quality Health Care and Services<br>3) Disease Prevention, Management and Treatment<br>4) Safe, Crime and Violence Free Communities<br>5) Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **FY18 Actions to Address Needs** | • In FY18, Sierra Nevada Memorial implemented the Rural Health Network Development Program through Health Resources and Services Administration (HRSA). As part of the a three year grant, the program looks to strengthen the collaborative network within the rural area and increase access and coordination to a variety of services including primary care, substance use and telemedicine. Services implemented in the first year include:<br>o Screening Brief Intervention and Referral to Treatment (SBIRT) training for providers;<br>o Tele-Health including primary, specialty and behavioral health to increase access to services;<br>o Creation of an EMS high utilizer targeted program to provide access to social support services;<br>o Development of a social determinants of health assessment and referral to services through a partnership with 211 at Connecting Point; and<br>o Expansion of chronic disease workshops offered in the community setting.<br>• Through the Community Grants, Angel Bed pilot program was launched and allowed for "bridge bed funding" for patients with high law enforcement involvement due to their addiction to access immediate residential addiction treatment services.<br>• Continued to strengthen and build the hospital partnerships with Nevada County Health and Human Services and Nevada County Public Health department and |

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| | work collaboratively on initiatives including the Homeless Medical Recuperative Care capability and joint 2019 Community Health Assessment |
| **Planned Actions for FY19** | For FY19, the hospital plans to build upon many of the FY18 initiatives and explore new partnership opportunities with Nevada County. Sierra Nevada Memorial will continue to serve as a lead in building collaborative efforts to address behavioral health and substance use issues that continue to rise in addition to the growing number of individuals experiencing homelessness.<br><br>In FY19, the Homeless Recuperative Care program will be opened in partnership with Nevada County and Hospitality House to provide recuperative care beds for medically fragile individuals. The hospital will continue to build on the success in year one of the Rural Health Network Development Program through (HRSA) to strengthen the integration of critical services within the community. |

This document is publicly available at dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment. It will be distributed to hospital leadership, members of the Board of Directors and Health Committee and widely to management and employees of the hospital, as it serves as a valuable tool for ongoing community benefit awareness and training. The document will also be broadly distributed externally to Community Health Needs Assessment partners, community leaders, government and public health officials, program partners and other agencies and businesses throughout the region.

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

# MISSION, VISION AND VALUES

Sierra Nevada Memorial is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

## Our Mission

We are 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.

## Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

## Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

***Dignity*** - Respecting the inherent value and worth of each person.

***Collaboration*** - Working together with people who support common values and vision to achieve shared goals.

***Justice*** - Advocating for social change and acting in ways that promote respect for all persons.

***Stewardship*** - Cultivating the resources entrusted to us to promote healing and wholeness.

***Excellence*** - Exceeding expectations through teamwork and innovation.

# OUR HOSPITAL AND THE COMMUNITY SERVED

## About Sierra Nevada Memorial Hospital

Sierra Nevada Memorial's roots in western Nevada County date back to the 1930s, when mining engineer Errol MacBoyle and local doctor Carl Jones led an effort to build a new community hospital with funds and land donated by MacBoyle's Idaho-Maryland Mine. World War II interrupted construction of the hospital and by the mid-1950s both MacBoyle and Jones had passed away. Several years later the unfinished hospital building was sold to businessman Charles Litton. With proceeds from the sale and community fundraising efforts, a new community hospital became a reality when Sierra Nevada Memorial opened its doors in 1958. The hospital has expanded in numerous ways since opening to meet the growing needs of the community. Today, the hospital has 810 employees and 117 medical staff, and offers 104 licensed acute care beds and 18 emergency department beds.

The Joint Commission certified Sierra Nevada Memorial as a Primary Stroke Center and the hospital received a Get with the Guidelines® - Stroke Gold Plus for Primary Stroke Center by the American Heart Association/American Stroke Association (2017). Sierra Nevada Memorial has also been recognized for the following: Certified Cardiac Rehabilitation Program by the American Association of Cardiovascular and Pulmonary Rehabilitation; Certified Quality Breast Center of Excellence by the National Quality Measures for Breast Centers program; Integrated Cancer Network Accreditation by Commission on Cancer (CoC); and Hospital C-Section Honor Roll by Smart Care California (2016-2017).

## Description of the Community Served

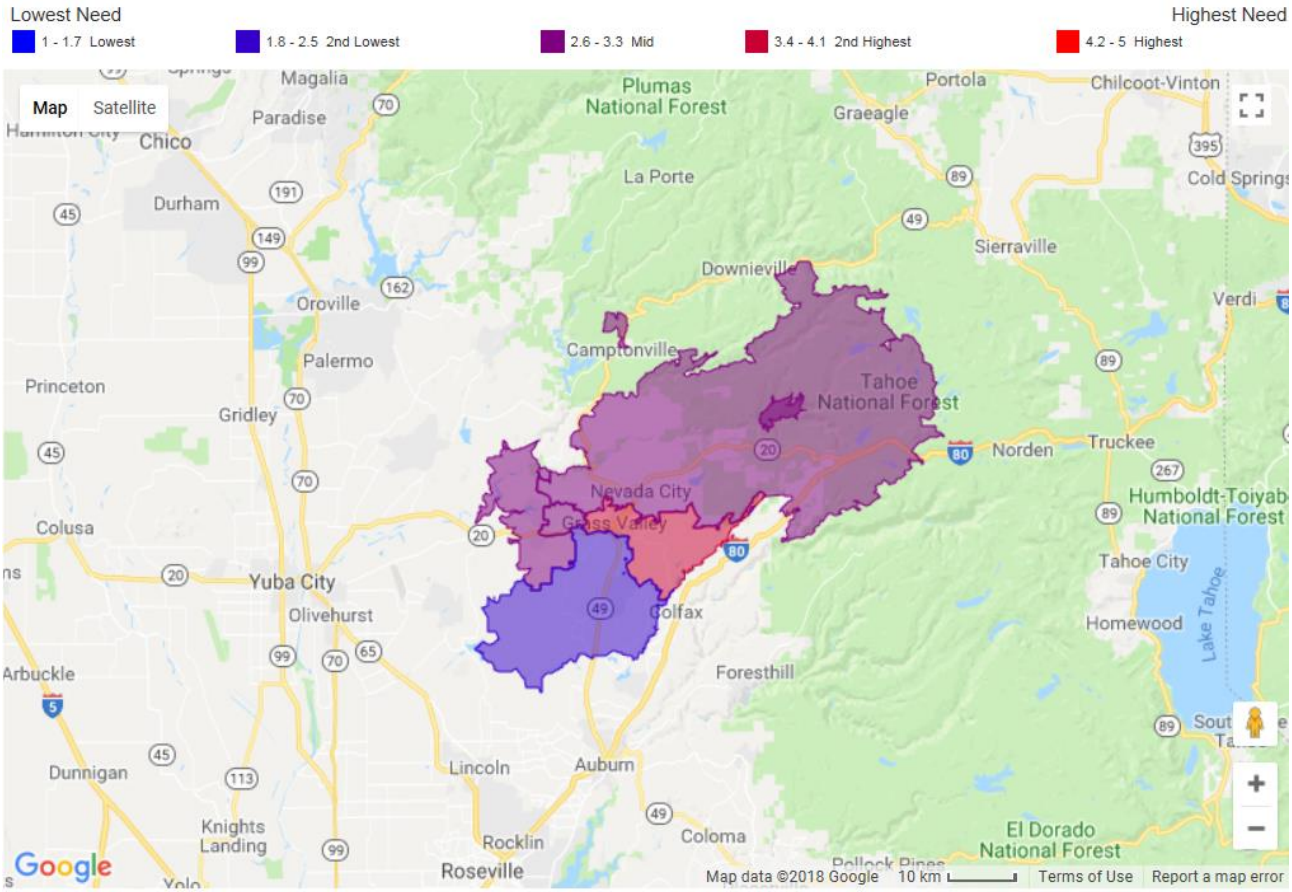
Located at 155 Glasson Way in Grass Valley, CA, Sierra Nevada Memorial has expanded in numerous ways since its early days to meet the growing needs of the community. Northwest of Lake Tahoe in the woodlands and forests of the Sierra Nevada Mountains, Nevada County is in the heart of California's historic Gold Country and includes the small cities of Grass Valley, Nevada City and Truckee, and nine other unincorporated cities. Since the Gold Rush of 1849, the region experienced a dramatic transformation of its landscape, with open-range cattle grazing, orchards, timber production and deep, hard-rock gold mining becoming economic mainstays. By the mid-1950s, however, the last major commercial mines closed and the traditional natural resource-based economy went into decline. By 1998, employment in agriculture, forestry and mining (together) in Nevada County dwindled to about 2% of all local jobs. Today, a large portion of the county's economy is based on income from non-wage-related sources such as dividends and pensions from a large retirement community, and local service-sector employment and businesses.

The hospital's service area is home to nearly 75,000 residents, with over 27% of the population age 65 years of age and older. The percentage of this population is twice that of California which is at 13%. While a number of health resources are available within its more populated communities, Nevada County's rural environment contributes to barriers in accessing health care and health-related services for individuals and families living in the country. Therefore, the community is heavily dependent on the hospital to often serve all its health needs. The hospital must continuously balance its responsibility caring for the acutely ill with the role it serves as a safety net provider for the poor and vulnerable in a region where public and community capacity is limited.

Sierra Nevada Memorial's community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives its top 87% of discharges. The inclusion of the five zip codes creates a contiguous service area and minimizes gaps between certain regions. The hospital's service area encompasses zip codes in the communities of Grass Valley, Penn Valley, Rough and Ready and Nevada City. A summary description of the community is below, and additional community facts and details can be found in the CHNA report online.

Demographics within Sierra Nevada Memorial's hospital service area are as follows, derived from estimates provided by Truven Health Analytics data:

- Total Population: 74,169
- Hispanic or Latino: 7.3%
- Race: 86.7% White, 0.6% Black/African American, 1.5% Asian/Pacific Islander, 3.9% All Other.
- Median Income: $54,284
- Uninsured: 8.9%
- Unemployment: 4.0%
- No HS Diploma: 6.3%
- CNI Score: 2.8
- Medicaid Population: 25.5%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes




Mean(zipcode): 2.8 / Mean(person): 2.9 CNI Score Median: 2.8 CNI Score Mode: None

| Zip Code | CNI Score | Population | City | County | State |
|---|---|---|---|---|---|
| 95945 | 3.6 | 24780 | Grass Valley | Nevada | California |
| 95946 | 2.6 | 9454 | Penn Valley | Nevada | California |
| 95949 | 2.2 | 19638 | Grass Valley | Nevada | California |
| 95959 | 2.8 | 18490 | Nevada City | Nevada | California |
| 95975 | 3 | 1807 | Rough And Ready | Nevada | California |

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

# COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Health Committee and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

## Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in June, 2016.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

## CHNA Significant Health Needs

The community health needs assessment identified the following significant community 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 and Services:** Encompasses access to primary care and specialty care, dental care and maternal and infant care.
3. **Disease Prevention, Management and Treatment:** Contains health outcomes that require disease prevention and/or management and treatment including: cancer, cardiovascular disease/stroke, HIV/AIDS/STDs and asthma.
4. **Affordable and Accessible Transportation:** Includes the need for transportation options, transportation to health services and options for person with disabilities.
5. **Safe, Crime and Violence Free Communities:** Consists of safety from violence and crime including violent crime, property crimes and domestic violence.
6. **Active Living and Healthy Eating:** Encompasses all components of active living and healthy eating including health behaviors, associated health outcomes and aspects of physical environment/living conditions.
7. **Basic Needs (Food Security, Housing, Economic Security, and Education):** Includes economic

security, food security/insecurity, housing, education and homelessness.

8. **Pollution-Free Living and Working Environments:** Contains measures of pollution such as air and water pollution levels.

Sierra Nevada Memorial, as a rural community hospital, does not have the capacity or resources to address all priority health issues identified in Nevada County. The hospital is not directly addressing the affordable and accessible transportation and active living and health eating priorities although programs are in place to assist community residents in limited capacity: In addition, the hospital will continue to seek collaborative opportunities that address needs that have not been selected as priorities. The hospital is not addressing Pollution-Free Living and Working Environments, as this priority is beyond the capacity and expertise of Sierra Nevada Memorial.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment or upon request at the hospital's Community Health office.

## Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, Sierra Nevada Memorial is dedicated to improving community health and delivering community benefit with the engagement of its management team, Board of Directors and Community Health Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

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

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

A general approach is taken when planning and developing initiatives to address priority health issues. At the onset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the Sierra Nevada Memorial leadership team, and Dignity Health leaders at the regional and local levels from Mission Integration, IT, Legal, Administration, and Finance. These core teams help shape initiatives, provide internal perspective on issues (i.e. utilization trends relative to the issue, gaps experienced in available follow-up or wraparound care for patients, etc.) and help define appropriate processes, procedures and methodologies for measuring outcomes.

The planning and development of each initiative also involves research on best practices to identify existing evidence-based programs and interventions, and relationship strengthening with community-based providers that serve target populations for intended initiatives. Once identified, community-based partners become part of the hospital's core project team. Core project teams for all initiatives meet

quarterly, or as needed, to evaluate program progress and outcomes, and to make program changes and/or improvements. When target populations and priority health issues are shared by other Dignity Health hospitals in the Greater Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

# 2018 REPORT AND 2019 PLAN

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

## Report and Plan Summary

| **Health Need**: Access to Behavioral Health Services | | | |
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| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Nevada County Health Collaborative Integrated Network | Sierra Nevada Memorial was awarded Rural Health Network Development Program through Health Resources and Services Administration (HRSA). The program strengthens the collaborative network to increase access, integration, and coordination of rural health services including primary care, behavioral health, and telemedicine.<br>*In addition to addressing access to behavioral health services, this program also responds to access to high quality health care and services and disease prevention, management, and treatment. | ☒ | ☒ |
| Crisis Stabilization Unit | The Crisis Stabilization Unit (CSU), operated by Nevada County, is a 23-hour 4-bed mental health urgent care and crisis unit on the hospital campus. The CSU is an innovative partnership between the Sierra Nevada Memorial and Nevada County Behavioral Health in which the hospital leases the land at no fee and funds 3 dedicated psychiatric beds in the unit. The CSU allows patients in acute psychiatric crisis to receive rapid access to appropriate care for their psychiatric emergency. | ☒ | ☒ |
| Mental Health Crisis Support Partnership | Nevada County contracted mental health crisis workers assist patients in the hospital's emergency department, providing support, identifying placement, and creating safe discharge plans. The program addresses the urgent need for mental health services and the steady increase emergency department crisis evaluations. | ☒ | ☒ |
| Tele-Psychiatry | Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with | ☒ | ☒ |

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| | patients, improving access to timely quality care. Access is available to both the ED and inpatient setting. In 2018 Sierra Nevada Memorial provided funding through the HRSA grant to Western Sierra Medical Clinic (WSMC) to purchase tele-health equipment for their clinic. In FY19, additional community based clinic will receive funding for the implementation of tele-psychiatry services through the HRSA grant. | | |
| Addiction Treatment Navigation Program | Through a partnership with Community Recovery Resources, the program provides a dedicated Chemical and Alcohol Dependency Counselor who works regular hours in the hospital emergency department, and on the inpatient floors to connect with patients struggling with addiction issues, and identify treatment services and funding that meets each patient's individual needs. In FY19, Nevada County Behavioral Health will add a mobile access worker who will come to the hospital to expedite the access to Drug Medi-Cal funds for these patients. | ☒ | ☒ |
| Angel Bed Pilot Program | Sierra Nevada Memorial's Community Grants program funded a collaboration between Grass Valley Police Department, Community Recovery Resources, and Western Sierra Medical Clinic. This program allows for "bridge bed funding" for patients with high law enforcement involvement due to their addiction to access immediate residential addiction treatment services. | ☒ | ☒ |
| Data 2000 Waiver Training and Medication Assisted Treatment Policy | Supported physicians in obtaining the Data 2000 DEA waiver, and developed a nursing Buprenorphine Induction policy and procedure, and trained nurses on the new policy. This new induction program allows patients to begin treatment while hospitalized, and then through navigation program, these patients experience a seamless transition to community based Medication Assisted Treatment programs. | ☒ | ☒ |
| Screening Brief Intervention and Referral to Treatment Training | Training provided by UCLA to clinicians in the hospital on Screening Brief Intervention and Referral to Treatment training, and motivational interviewing techniques to improve the opportunities to link patients to new addiction treatment resources. | ☒ | ☒ |
| Integrated Care Coordination to Family Wellness Program Expansion | Through the Community Grants, the collaborative including FREED Center for Independent Living, Community Recovery Resources (CoRR) and Western Sierra Medical Clinic (WSMC) focuses on care transition and patient navigation between organizations and services and develops a "no wrong door" system of referral. This collaborative addresses all three priority health needs by | ☒ | ☐ |

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| | increasing access to primary, mental health, substance use, and preventative health care for vulnerable populations. | | |
| **Anticipated Impact**: These programs and services are intended to grow and strengthen the services and resources available in the community. These efforts aim to improve the ease of access to quality services, remove barriers, expand capacity, and create a coordinated continuum system of care thereby improving behavioral health outcomes and reducing the negative health and social impacts of behavioral health conditions on individuals and the community. | | | |

| **Health Need**: Access to High Quality Health Care and Services | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Emergency Department Based Primary Care Navigation | 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. | ☒ | ☒ |
| Congestive Heart Active Management Program (CHAMP®) | This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits. | ☒ | ☒ |
| Oncology Nurse Navigator | The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of 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. | ☒ | ☒ |
| Western Sierra Medical Center Navigation Program | With funding from the HRSA grant, this program provides education on accessing primary care, assists patients in scheduling appointments, provides reminder and follow up calls, and assesses the patient's barriers to care. This program also targets high ED utilizers and | ☒ | ☒ |

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| | patients with frequent readmissions, and those needing ongoing community case management. | | |
| Hepatitis C Eradication Program | The building of the collaboration for this program began in 2018 and is a partnership between Sierra Nevada Memorial Hospital, Sierra Gastroenterology, Nevada County Public Health, and FREED. This program targets low income, uninsured, underinsured, and homeless individuals who have received a positive Hepatitis C diagnosis, and assist in navigating through the health system to access the new medications available with the potential to cure this disease. FREED will utilize the Care Transitions Intervention coaching model and assist patients in obtaining insurance and a primary care provider as necessary, and will remain in contact with the patient throughout the length of their HCV treatment at Sierra Gastroenterology. | ☒ | ☒ |
| Tele-Endocrinology | Sierra Nevada Memorial Hospital plans to expand its tele-health specialty care access in the ED and inpatient setting with the addition of Tele-Endocrinology services. | ☐ | ☒ |
| **Anticipated Impact**: The goal of these activities is to improve access to high quality health services, primary care, and specialty care services which can be a challenge given our remote rural location. | | | |

| **Health Need**: Disease Prevention, Management, and Treatment | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Cardiac Rehabilitation | Exercise and education provided to patients during rehabilitation from a cardiac related event or surgery. | ☒ | ☒ |
| Care Transition Intervention Program | The Care Transition Intervention Program is an evidenced based program offered in partnership with FREED. This is a model that utilizes coaching methods to assist patients with high risk of readmission, or highly complex health and social needs post hospitalization in managing their own health condition successfully. Patients are followed for 30 days post discharge, including a home visit. | ☒ | ☒ |
| Complex Discharge Management Assistance | Care Coordination provides a number of services to patients at discharge with challenges accessing resources necessary to healing including transportation, clothing, medication and transitional housing. | ☒ | ☒ |
| Support Groups | Hospital-sponsored support groups for cancer, brain injury, pulmonary issues, and stroke provide an opportunity for patients and family members to share their concerns while learning to manage their condition | ☒ | ☒ |
| Alzheimer's Outreach Program | The hospital's Home Care Department, in collaboration with Sierra Nevada Memorial Hospital Foundation, and Nevada County Health and Human Services offers an Alzheimer's Outreach Program that serves as a unique | ☒ | ☒ |

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| | community education, resource and support center. A licensed social worker is dedicated to the program who provides education and caregiver support via home visits and personal consultations, and links those that need specialized care to important resources, including assisted living/care centers. | | |
| Falls Prevention Program | The program, offered in partnership with the hospital, Sierra Nevada Memorial Hospital Foundation, and the Falls Prevention Coalition, provides education to the community about fall risk factors and prevention strategies for older adults and caregivers. Participants also learn appropriate exercises for enhanced balance and strength. | ☒ | ☒ |
| Diabetes Empowerment Education Program (DEEP™) | The Diabetes Empowerment Education Program™ (DEEP™) is an evidence-based diabetes education program for people with diabetes or prediabetes. DEEP encourages lifestyle changes while learning about diabetes and how it can impact the quality of life. The hospital has partnered with Nevada County Public Health and Connecting Point with HRSA grant funding to offer workshops in the community at no cost, including targeted outreach to diabetic and pre-diabetic clients utilizing community food bank services. | ☒ | ☒ |
| Chronic Disease Self-Management Program (CDSMP) | The Chronic Disease Self-Management program (CDSMP) is an evidenced based chronic disease workshop. In FY18, with HRSA grant funding support, the hospital again partnered with Connecting Point to provide these programs at no cost to the community. The hospital trained lay 3 leaders in CDSMP and will begin offering workshops in FY19. | ☒ | ☒ |
| Social Determinants of Health Assessment Program | In FY18 the hospital developed a Social Determinants of Health Assessment form to help to more broadly identify patients who may benefit from community services and resources. Through a HRSA grant funded partnership with Connecting Point, patients will be contacted to receive assistance in accessing resources. | ☒ | ☒ |
| **Anticipated Impact**: The initiatives in place to address this health need are anticipated to result in: a reduction of hospital admissions related to poor chronic disease management; prevent chronic disease; improve the health and quality of life for those with a chronic illness; enable participants to manage their disease by creating a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management. | | | |

| **Health Need**: Basic Needs (Food Security, Housing, Economic Security, and Education) | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Homeless Recuperative Care Program | 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. This program was approved by the County Board of Supervisors in August of 2018, and will begin services in October of 2018. The program will located at Hospitality House, and will provide recuperative care for up to 29 days, housing assistance, and wrap around services. | ☒ | ☒ |
| **Anticipated Impact**: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option. | | | |

| **Health Need**: Safe, Crime and Violence Free Communities | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Human Trafficking Community Response Program | The Human Trafficking Community Response Program initiative focuses on:<br>• Educating staff to identify and respond to victims within the hospital;<br>• Provide victim-centered, trauma-informed care;<br>• Collaborate with community agencies to improve quality of care;<br>• Access critical resources for victims; and<br>• Provide and support innovative programs for recovery and reintegration. | ☒ | ☒ |
| **Anticipated Impact**: The initiative to address safe, crime, and violence free communities are anticipated to result in: prevent unsafe environments; improve safety for the patient population served; provide education to all hospital staff on trauma informed care; increase the awareness of services available; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services. | | | |

## Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded one grant totaling $77,983. Below is the FY18 grant project which is also described in the Report and Plan and Program Digest sections.

| Grant Recipient | Project Name | Amount |
|---|---|---|
| Community Recovery Resources | Angel Bed Pilot Program | $77,983 |

## Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

## Planned Collaboration

The HRSA funded Rural Integrated Health Network Development grant has helped 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:

- Mental Health and 5150's Collaboration: Identifying strategies to increase and improve access to mental health crisis services, implement prevention strategies, and improve the continuum of services in the community. In February of 2018 this stakeholder group conducted a 2-hour strategic planning session, and identified mobile preventative mental health outreach to homeless and homebound mental health patients as a primary strategy to reduce crisis events for this vulnerable population, and a secondary strategy of engaging managed care providers around expanded psychiatric care access, and increased tele-psych funding and access in primary care settings.
- Substance Use Disorder Collaborative: Focused on increasing and improving access to addiction related services, implement prevention strategies, and improve the continuum of services in the community.

Additional collaborative efforts include:

- Nevada County Community Health Improvement Plan Steering Committee:
- 2019 Joint Community Health Needs Assessment

- Mental Health Services Act Steering Committee
- Mental Health Forensic Task Force.
- Nevada County Dental Care Steering Committee
- Housing Resource Team Meetings- 2019

These collaborative strategies continue to assess current strengths, weaknesses and gaps, and to engage non-traditional partners in community health programs and partnerships to increase access to expanded services. As further evidence of the commitment to collaborative community health planning, Sierra Nevada Memorial Hospital and Nevada County Public Health have partnered to conduct a joint County-wide Community Health Needs Assessment in 2019.

Collaborative partners across these various initiatives include:

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

## Financial Assistance for Medically Necessary Care

Sierra Nevada Memorial delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;

- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Sierra Nevada Memorial also includes the Financial Assistance Policy in the reports made publicly available, including the annual Community Benefit reports and triennial Implementation Strategies.

## Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

| Crisis Stabilization Unit | |
|---|---|
| **Significant Health Needs Addressed** | ✓ Access to Behavioral Health Services<br>❑ Access to High Quality Health Care and Services<br>❑ Disease Prevention, Management and Treatment<br>✓ Safe, Crime and Violence Free Communities<br>❑ Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **Core Principles Addressed** | ✓ Focus on Disproportionate Unmet Health-Related Needs<br>❑ Emphasize Prevention<br>✓ Contribute to a Seamless Continuum of Care<br>✓ Build Community Capacity<br>✓ Demonstrate Collaboration |
| **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. |
| **Community Benefit Category** | E1-a Cash Donations - General contributions to nonprofit organizations |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Reduce the length of time it takes to connect patients in the emergency department experiencing a psychiatric emergency to an appropriate level of psychiatric care. Create a seamless transition from the ED to the CSU. Improve the level of psychiatric care in the community. Reduce readmissions for psychiatric emergency by providing appropriate and supportive care in our community. Reduce the need for transfers to inpatient psychiatric hospitals. |
| **Measurable Objective(s) with Indicator(s)** | Length of psychiatric boarding time in ED, number of inpatient placements, number of tele-psych consults |
| **Intervention Actions for Achieving Goal** | Work collaboratively with partners to create a seamless transition of care including monthly interactions and meetings with CSU staff to monitor and evaluate program success and challenges. |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, Swope Medical Group, Nevada County Behavioral Health, Sierra Mental Wellness, Law Enforcement Agencies |
| **Program Performance / Outcome** | In FY18, 1487 outpatient behavioral health encounters, 829 of which were Medicaid patients, and 104 were uninsured. There was a 10.15% increase in volume over previous the year. Average length of stay for all patients of 8.2 hours. |
| **Hospital's Contribution / Program Expense** | $160,046 |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Continued strengthening partnerships to link more individuals to care in the CSU resulting in a further reduction of ED boarded length of stay and ultimately improving the quality of care for the patient. Reduce time to CSU transfer. |
| **Measurable Objective(s) with Indicator(s)** | Length of psychiatric boarding time in ED, number of inpatient placements. Number of tele-psych consults |
| **Intervention Actions for Achieving Goal** | Continue working collaboratively with partners to create a seamless transition of care including monthly interactions and meetings with CSU staff to monitor and evaluate program success and challenges and develop monthly reports on data that can be shared between partners |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, Swope Medical Group, Nevada County Behavioral Health, Sierra Mental Wellness, Law Enforcement Agencies |

| Emergency Department Navigation Program | |
|---|---|
| **Significant Health Needs Addressed** | ❑ Access to Behavioral Health Services<br>✓ Access to High Quality Health Care and Services<br>✓ Disease Prevention, Management and Treatment<br>❑ Safe, Crime and Violence Free Communities<br>❑ Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **Core Principles Addressed** | ✓ Focus on Disproportionate Unmet Health-Related Needs<br>✓ Emphasize Prevention<br>✓ Contribute to a Seamless Continuum of Care<br>✓ Build Community Capacity<br>❑ Demonstrate Collaboration |
| **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. |
| **Community Benefit Category** | A3-e Health Care Support Services – Information & Referral. |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Contact 100% of California Health and Wellness patients presenting to the emergency department for non-emergent health conditions. Assess barriers, connect patients to medical home, and assist in scheduling a follow up appointment as needed. Support patient in attending follow up care with their primary care provider to improve primary care access and reduce inappropriate ED utilization and recidivism. |
| **Measurable Objective(s) with Indicator(s)** | Number of patients served, services provided, and follow up appointments scheduled. Identify primary barriers to care and directly identify and assist high utilizers. |
| **Intervention Actions for Achieving Goal** | Meet with FQHC's to facilitate expedited access to follow up appointments. Communicate regularly with navigators and health plan regarding trends, resources needed and challenges connecting patients to care. |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, the local FQHC's, and California Health & Wellness. |
| **Program Performance / Outcome** | 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 |
| **Hospital's Contribution / Program Expense** | The patient navigator position is funded by California Health and Wellness. Staff from Community Health and Outreach and Care Coordination manage program. |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Contact 100% of California Health and Wellness patients presenting to the emergency department for non-emergent health conditions. Assess barriers, connect patients to medical home, and assist in scheduling a follow up appointment as needed. Support patient in attending follow up care with their primary care provider to improve primary care access and reduce inappropriate ED utilization and recidivism. |
| **Measurable Objective(s) with Indicator(s)** | Number of patients served, services provided, and follow up appointments scheduled. Identify primary barriers to care and directly identify and assist high utilizers. |
| **Intervention Actions for Achieving Goal** | Meet with FQHC's to facilitate expedited access to follow up appointments. Communicate regularly with navigators and health plan regarding trends, resources needed and challenges connecting patients to care. |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, the local FQHC's, and California Health & Wellness. |

| Oncology Nurse Navigator | |
|---|---|
| **Significant Health Needs Addressed** | ❑ Access to Behavioral Health Services<br>✓ Access to High Quality Health Care and Services<br>✓ Disease Prevention, Management and Treatment<br>❑ Safe, Crime and Violence Free Communities<br>❑ Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **Core Principles Addressed** | ✓ Focus on Disproportionate Unmet Health-Related Needs<br>✓ Emphasize Prevention<br>✓ Contribute to a Seamless Continuum of Care<br>❑ Build Community Capacity<br>✓ Demonstrate Collaboration |
| **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. |
| **Community Benefit Category** | A3-g Health Care Support Services - Case management post-discharge |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Improve access to treatments and continuity of care by navigating patients through the process of obtaining appropriate resources and referrals in a timely manner, and serve as an educational resource for patients and their families. |
| **Measurable Objective(s) with Indicator(s)** | Increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners. Provide education within the community setting. |
| **Intervention Actions for Achieving Goal** | Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with community clinics who serve the underserved. |
| **Planned Collaboration** | Cancer nurse navigators continue to work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance. Current partnerships include peer support, Sierra Family, Western Sierra Medical Center (WSMC) and Chapa-De. |
| **Program Performance / Outcome** | In FY18, program served 1322 individuals. In addition to direct navigation services, the hospital did outreach at 4 events in the community to increase awareness of prevention, services available, and the program. |
| **Hospital's Contribution / Program Expense** | $117,971 |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Continue to improve access to low cost and no-cost treatments and the continuity of care by navigating patients through the process of obtaining appropriate resources and referrals in a timely manner and serve as an educational resource for patients and their families. |
| **Measurable Objective(s) with Indicator(s)** | Increase outreach to FQHC's and Community Clinics on low cost or no cost mammography. Increase the number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners. Continue to provide education within the community setting. |
| **Intervention Actions for Achieving Goal** | Continue to promote services in the community and work with hospital and community partners to increase awareness of services and resources. This includes working with our patient navigators in the ED and community clinics who serve the underserved. |
| **Planned Collaboration** | Cancer nurse navigators continue to work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance. Current partnerships include peer support, Sierra Family, Western Sierra Medical Center (WSMC) and Chapa-De. |

| Angel Bed Pilot Program | |
|---|---|
| **Significant Health Needs Addressed** | ✓ Access to Behavioral Health Services<br>✓ Access to High Quality Health Care and Services<br>✓ Disease Prevention, Management and Treatment<br>✓ Safe, Crime and Violence Free Communities<br>❑ Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **Core Principles Addressed** | ✓ Focus on Disproportionate Unmet Health-Related Needs<br>❑ Emphasize Prevention<br>✓ Contribute to a Seamless Continuum of Care<br>✓ Build Community Capacity<br>❑ Demonstrate Collaboration |
| **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. |
| **Community Benefit Category** | E2-a Grants - Program grants |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Remove barriers to immediate residential treatment access and leverage the moment of potential increased motivation to enter treatment due to interaction with law enforcement. Impact includes increased willingness to enter treatment, improved access to treatment, successful participation in treatment, and reduced future interactions with law enforcement. |
| **Measurable Objective(s) with Indicator(s)** | Numbers served, connected to treatment resources and successfully engaged in treatment on an ongoing basis. Reduction in law enforcement encounters. |
| **Intervention Actions for Achieving Goal** | Meetings with ED physicians, care coordination, social work, Nevada County Behavioral Health to facilitate expedited placement and sustainable funding to expand capacity. |
| **Planned Collaboration** | Swope Medical Group, WSMC, Hospitality House, Wayne Brown Correctional Facility, GVPD, CoRR, Nevada County Behavioral Health. |
| **Program Performance / Outcome** | 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; 3 patients were placed into transitional housing post residential; and reduction in law enforcement encounters. |
| **Hospital's Contribution / Program Expense** | $77,983 |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Remove barriers to immediate residential treatment access and leverage the moment of potential increased motivation to enter treatment due to interaction with law enforcement. Impact includes increased willingness to enter treatment, improved access to treatment, successful participation in treatment, and reduced future interactions with law enforcement. Through financial support from Nevada County, direct bed capacity has been expanded and they dedicated one mobile access worker to expedite access Drug Medi-Cal funding. |
| **Measurable Objective(s) with Indicator(s)** | Numbers served, connected to treatment resources and successfully engaged in treatment on an ongoing basis. Reduction in law enforcement encounters. |
| **Intervention Actions for Achieving Goal** | Meetings with ED physicians, care coordination, social work, Nevada County Behavioral Health to facilitate expedited placement and sustainable funding to expand capacity. |
| **Planned Collaboration** | Swope Medical Group, WSMC, Hospitality House, Wayne Brown Correctional Facility, GVPD, CoRR, Nevada County Behavioral Health. |

| Homeless Recuperative Care Program | |
|---|---|
| **Significant Health Needs Addressed** | ❑ Access to Behavioral Health Services<br>✓ Access to High Quality Health Care and Services<br>✓ Disease Prevention, Management and Treatment<br>✓ Safe, Crime and Violence Free Communities<br>❑ Basic Needs (Food Security, Housing, Economic Security, and Education) |
| **Core Principles Addressed** | ✓ Focus on Disproportionate Unmet Health-Related Needs<br>✓ Emphasize Prevention<br>✓ Contribute to a Seamless Continuum of Care<br>✓ Build Community Capacity<br>❑ Demonstrate Collaboration |
| **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. |
| **Community Benefit Category** | E2-a Grants - Program grants |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Develop and have approved a program which will provide a safe discharge plan, and a clean, dry, supportive place to recover from a recent hospitalization for patients who are homeless. Improve access to ongoing health care through a medical home, provide wrap-around services and assist in accessing housing services available. |
| **Measurable Objective(s) with Indicator(s)** | Contract drafted, signed, and ready to present to the Board of Supervisors for approval. |
| **Intervention Actions for Achieving Goal** | Regular meetings with a recuperative care team to develop a program that meets the needs of the community and makes the most of available resources. Identify key metrics to track. Create partnerships |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, Nevada County Health and Human Services, Nevada County Behavioral Health, Hospitality House, Western Sierra Medical Clinic, Chapa De Indian Health, FREED, Community Recovery Resources, Grass Valley Police Department, Sierra Gastroenterology, AMI Housing. |
| **Program Performance / Outcome** | This program is scheduled to go before the County Board of Supervisors in August of 2018, and will begin services in October of 2018. The program will located at Hospitality House, and will provide recuperative care for up to 29 days, housing assistance, and wrap around services |
| **Hospital's Contribution / Program Expense** | Initial investment will be provided in FY19. |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Implementation of the program. Provide a safe discharge plan, and a clean, dry, supportive place to recover from a recent hospitalization for patients who are homeless. Improve access to ongoing health care through a medical home, provide wrap-around services and assist in accessing housing services available. |
| **Measurable Objective(s) with Indicator(s)** | Number of: patients served; linkages to wrap-around services provided; individuals connected to follow up appointments; and patients who access housing. Reduction in hospital readmissions. |
| **Intervention Actions for Achieving Goal** | Regular meetings with a recuperative care team to discuss individual placement successes and challenges. Connect Hospitality House staff to navigation resources to assist in supporting individuals in accessing services such as CTI services, Hepatitis C navigation, substance use navigation, direct entry bed, primary care navigation. |
| **Planned Collaboration** | Sierra Nevada Memorial Hospital, Nevada County Health and Human Services, Nevada County Behavioral Health, Hospitality House, Western Sierra Medical Clinic, Chapa De Indian Health, FREED, Community Recovery Resources, Grass Valley Police Department, Sierra Gastroenterology, AMI Housing. |

# ECONOMIC VALUE OF COMMUNITY BENEFIT

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

| | Persons Served | Net Benefit | % of Org. Expenses |
|---|---|---|---|
| **Benefits for Living in Poverty** | | | |
| **Financial Assistance** | **1,169** | **1,478,301** | **0.9** |
| **Medicaid *** | **21,926** | **0** | **0** |
| **Means-Tested Programs** | **3** | **1,753** | **0.0** |
| **Community Services** | | | |
| A - Community Health Improvement Services | 2,267 | 207,526 | 0.1 |
| E - Cash and In-Kind Contributions | 30 | 853,960 | 0.5 |
| F - Community Building Activities | 0 | 2,244 | 0.0 |
| G - Community Benefit Operations | 0 | 135,267 | 0.1 |
| **Totals for Community Services** | **2,297** | **1,198,997** | **0.7** |
| **Totals for Living in Poverty** | **25,395** | **2,679,051** | **1.6** |
| **Benefits for Broader Community** | | | |
| **Community Services** | | | |
| A - Community Health Improvement Services | 2,178 | 80,295 | 0.0 |
| B - Health Professions Education | 100 | 217,548 | 0.1 |
| C - Subsidized Health Services | 56 | 65,744 | 0.0 |
| E - Cash and In-Kind Contributions | 9 | 2,516 | 0.0 |
| F - Community Building Activities | 2 | 3,000 | 0.0 |
| **Totals for Community Services** | **2,345** | **369,103** | **0.2** |
| **Totals for Broader Community** | **2,345** | **369,103** | **0.2** |
| **Totals - Community Benefit** | **27,740** | **3,048,154** | **1.8** |
| **Medicare** | **59,289** | **27,829,957** | **16.3** |
| **Totals with Medicare** | **87,029** | **30,878,111** | **18.1** |

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. This resulted in the hospital receiving more Medicaid revenue than expense incurred, and thus $0 net benefit. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $1,845,559.

# APPENDIX A: BOARD OF DIRECTORS

| |
|---|
| Edward B Sylvester<br>Retired CEO Engineering<br>Community Representative |
| Alison Lehman<br>County Executive Officer<br>Community Representative |
| Dale Creighton<br>President, SCO Planning and Engineering<br>Community Representative |
| Stacy Fore, DDS<br>Local General Dentist |
| Alex Klistoff, MD<br>Retired Physician |
| Nancy Guerland<br>Retired Home Health Executive<br>Community Representative |
| Scott Robertson<br>CEO, Emerald Cove Marina at Bullard's Bar<br>Community Representative |
| Monty East<br>Retired Utilities District Manager<br>Current Real Estate Agent |
| Michael Korpiel<br>President and CEO<br>Mercy San Juan Medical Center |
| Alan Wong, MD<br>Urologist |
| Katherine A. Medeiros<br>President and CEO<br>Sierra Nevada Memorial Hospital |

# APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- Northern California Community Loan Fund (NCCLF)
  Dignity Health has partnered with NCCLF since 1992, and was one of Dignity Health's first community investment. This CDFI has invested more than $254 million in projects throughout Northern and Central California, promoting economic justice and alleviating poverty by increasing the financial resilience and sustainability of community-based nonprofits and enterprises. In 2016 and 2017 Dignity Health approved two 7-year $1,000,000 loans respectively—the first as lending capital for NCCLF's many projects, and the second as lending capital in a "FreshWorks" Fund supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts").

- Rural Community Assistance Corporation (RCAC)
  In June 2017 Dignity Health approved a 7-year $500,000 loan to RCAC for projects in rural California, Nevada and Arizona. RCAC assists rural communities in building social capital, environmental infrastructure, and affordable housing. It also provides nonprofit organizations with access to financing. RCAC financing creates employment opportunities, affordable housing, safe and reliable environmental infrastructure, and much-needed community facilities and services. RCAC operates in rural California, Nevada and Arizona, and several other states west of the Rockies.

- Enrollment Assistance – Hospital and Nevada County employees provide enrollment assistance at the hospital to low income patients, in an effort to get coverage in Medi-Cal and other government assistance programs.

- Health Professions Education - The hospital regularly sponsors seminars and training for medical students, physicians, nurses, and other students in the health care field. Hundreds of hours each year are committed to providing internships for nurses, paramedics, therapists, and clinical laboratory technicians.

- Transitional Housing and Lodging - When there are no available alternatives, Sierra Nevada Memorial subsidizes payments for room and board in the community for patients unable to pay when they are discharged from the hospital.

Additionally, members of the hospital's leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies, such as the Western Sierra Medical Clinic, Nevada County Economic Resource Council, BriarPatch Community Market and Hospice of the Foothill. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them, Community Recovery Resources (CoRR), Nevada County Arts Council, Nevada City Chamber of Commerce, American Heart Association, and others.

# APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

**Free Care**

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

**Discounted Care**

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

**Traducción disponible:** You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

**Sierra Nevada Memorial Hospital** 155 Glasson Way, Grass Valley, CA 95945 | Financial Counseling 530-274-6758 **Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp