



SIERRA NEVADA MEMORIAL HOSPITAL

COMMUNITY BENEFIT REPORT 2013 COMMUNITY BENEFIT IMPLEMENTATION PLAN 2014

A message from Katherine Medeiros, President and CEO of Sierra Nevada Memorial Hospital, and Don Coots, Chair of the Sierra Nevada Memorial Hospital Board of Directors

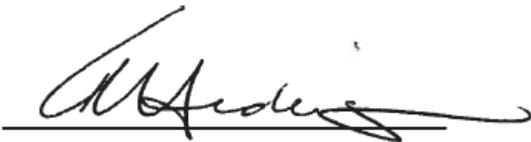
When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Sierra Nevada Memorial Hospital, we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Sierra Nevada Memorial Hospital, we share a commitment to optimize the health of our community. In fiscal year 2013 Sierra Nevada Memorial Hospital provided \$21,972,864 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Sierra Nevada Memorial Hospital Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 10, 2013 meeting.



Katherine A. Medeiros
President and CEO



Don Coots
Board Chair

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EXECUTIVE SUMMARY

Sierra Nevada Memorial Hospital (SNMH) has been meeting the health needs of residents in Nevada County for over 50 years. Situated in the rural County's western region, the Hospital has been carrying out its mission since 1958, contributing to the wellness of its community by offering quality services delivered in a compassionate and cost effective manner, and collaborating with others to improve quality of life.

The Hospital has 804 employees and offers 104 licensed acute care beds and 18 Emergency Department (ED) beds. Services have continued to expand over the years to meet the growing needs of the community. An Ambulatory Treatment Center was added in the 1990s to respond to patients with chronic illnesses and other ongoing outpatient care needs. In more recent years, the Hospital opened the Sierra Nevada Diagnostic Center. Its Cancer Center is nationally accredited by the Commission on Cancer of the American College of Surgeons as a Community Cancer Program, and a Primary Stroke Center has earned the Gold Seal of Approval from the Joint Commission for Primary Stroke Centers.

In this critical period of health reform, developing much needed safety net capacity to ensure access to care for the region's most vulnerable, and fostering collaboration to develop a coordinated continuum of care across multiple health and social service providers underscore the Hospital's community benefit efforts. These efforts are guided by the Community Health Needs Assessment (CHNA) process. Specifically, SNMH is focused on several priority issues that continue to impact health and quality of life within the community it serves:

- Access to primary care
- Access to preventative services
- Access to mental health and substance abuse treatment
- Access to specialty care
- Unintentional injury

This report highlights a number of new and existing initiatives that respond to these priorities. One new initiative in particular that addresses access to care is a new **Satellite Lab and X-Ray Clinic** located in Penn Valley in the vicinity of Rough and Ready, an area of the County identified in the CHNA as a Community of Concern where the population is more at risk. The difficulty in obtaining lab and x-ray services was voiced multiple times by community members when conducting the CHNA and the new clinic will significantly enhance access to these services.

The Hospital is also placing increased emphasis on **physician recruitment** efforts to help address the access to care issue. In addition to parts of the region that have a Medically Underserved Population designation, a large portion of the Hospital's service area is designated as a Health Professional Shortage Area for primary care and mental health.

The Hospital is one of the few providers in the region responding to a CHNA priority need for disease prevention education and self-management skills for chronic disease. Its best practice **Congestive Heart Active Management Program, (CHAMP®)** grew significantly in FY 2013, delivering positive outcomes that demonstrated participants in the program were able to avoid hospitalization and lead healthier, more active lives by improving their ability to manage heart disease. With a focus on underserved populations, CHAMP® provides clinical and educational support to individuals living with heart disease, and help with medication compliance.

A second evidence-based program offered by the Hospital is focused on the priority health issue of diabetes. Called **Diabetes: Take Control!**, the program follows Stanford University's Diabetes Self-Management Program, providing education, nutrition counseling, and skills to help individuals control this illness. The Hospital is working collaboratively with the region's Federally Qualified Health Center

(FQHC), Western Sierra Medical Clinic, to expand course offerings for diabetes and other Chronic Disease Self-Management Programs in FY 2014, particularly within the two communities of concern identified in the CHNA, where diabetes was found to be far more prevalent.

In response to priority CHNA issues surrounding mental health and substance abuse, the Hospital redesigned its **Dignity Health Community Grants Program** in FY 2013 to focus on building community capacity for the continuum of care often required to overcome these illnesses. Nonprofit community agencies were asked to work with each other and the Hospital to develop innovative new programs addressing mental health and substance abuse. One partnership program is co-locating medical, behavioral health and substance abuse services under one roof, and incorporating navigation and coaching services for clients served. A second partnership is creating a coordinated pre-teen/teen program, offering both prevention and intervention services to at risk girls residing in Communities of Concern who need emotional, social and educational support. As grant program work progresses in FY 2014, emphasis will be on working with agencies to develop methods for measuring outcomes and evaluating programs.

With an emphasis on stroke, a **Nurse Navigator** program at the Hospital has been created to address the priority need for access to specialty care. Stroke, specifically among the elderly male population in the region, was identified as a high-risk health issue in the CHNA. The Hospital is also developing a lung cancer screening program to respond to the growing prevalence of lung cancer, which was identified in the CHNA as an increasing concern.

More details on these, and other community benefit programs, can be found in the following pages. In total, SNMH's Fiscal Year 2013 community benefit investment in its community was \$4,727,471, which excludes \$17,245,393 in unpaid Medicare costs.

MISSION STATEMENT

We share the mission of Dignity Health:

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.

ORGANIZATIONAL COMMITMENT

The clearest demonstration of Sierra Nevada Memorial Hospital's (SNMH) commitment to community is the support of and engagement in the community benefit planning and budgeting process by Leadership, and the active role both Leadership and employees at multiple levels play in serving the community. Annually, the Hospital President and members of the Executive Management Team review priority community health needs and refine objectives, programs and budget accordingly. Community benefit oversight is provided by the SNMH Board of Directors. Board members provide input into the annual Community Benefit Report and Plan, and approve the final document. Members of the Board also receive community benefit updates on core strategic programs on a bi-annual basis (see Appendix A for a roster of the SNMH Board of Directors). Other responsibilities of the Board include:

- Ensure services and programs align with the mission and values of Dignity Health and are guided by five core principles:
 - Focus on disproportionate unmet health and health-related needs
 - Emphasize prevention
 - Contribute to a seamless continuum of care
 - Build community capacity
 - Demonstrate collaborative governance
- Ensure the Hospital abides by uniform methods of accounting community benefit activities and expenses
- Review community benefit budget and expenses
- Review program design and outcomes

Day to day community benefit programs and services are managed by the Hospital's Wellness Department, working with the Dignity Health Sacramento Service Area Community Benefit Department. Community benefit orientation and training programs are conducted during the year at various hospital departmental meetings.

The Community Health Needs Assessment (CHNA) provides insight into the health of the community and identifies gaps in care that require attention. It serves as the foundation for determining the Hospital's priority areas of focus for strategic community benefit investment. The Hospital is directly involved in the development of the CHNA, in partnership with numerous community leaders and nonprofit providers. Hospital Leadership, Board Directors, and Community Benefit staff review assessment findings, evaluate and compare priority health issues against existing community benefit programs and services to ensure they are aligned, and make recommendations regarding new initiatives. Core community benefit initiatives, such as the Hospital's Chronic Disease Self-Management Program, are incorporated into the Hospital's strategic plan and tied to specific goals and measurable outcomes.

Operating in a rural region with medically underserved areas, high levels of poverty, and a growing elderly population at risk of being isolated¹, the Hospital also recognizes that good health is dependent upon organizations working together to build safety net capacity, and is committed to engaging the community through collaboration. The annual Dignity Health Community Grants Program is one of the ways the Hospital is fostering collaboration. Grant applicants in FY 2013 were asked to partner on joint projects that offer a full continuum of care needed by specific underserved target populations living within communities of concern identified through the CHNA. Partner organizations were also asked to develop improved processes for information sharing, program and care coordination, joint planning and joint program evaluation. Working with Western Sierra Medical Clinic, a Federally Qualified Health Center, is another example of how the Hospital collaborates to extend access to vulnerable residents in the region.

¹ Nevada County 2009-2010 Economic & Demographic Profile, produced by the Center for Economic Development, CSU, Chico Research Foundation

Non-Quantifiable Benefits

SNMH understands that improving the health of the community is dependent upon engaging with the community to develop shared strategies and goals. Beyond the level of programs and services offered, the Hospital is committed to working with public health and other government agencies, the nonprofit health and social service sectors, civic leaders and constituents - to bring about long-term change in health care quality and delivery. Members of the Leadership Team at SNMH serve on the boards of key community organizations, including the Western Sierra Medical Clinic, Grass Valley Chamber of Commerce, Grass Valley Rotary Club, and the Nevada Economic Resource Council. They lend expertise and advocate for change that will positively impact health, quality of life and economic well-being.

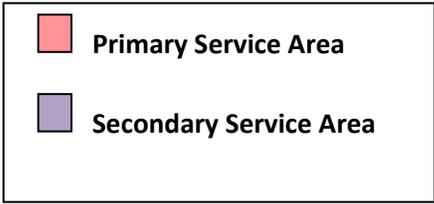
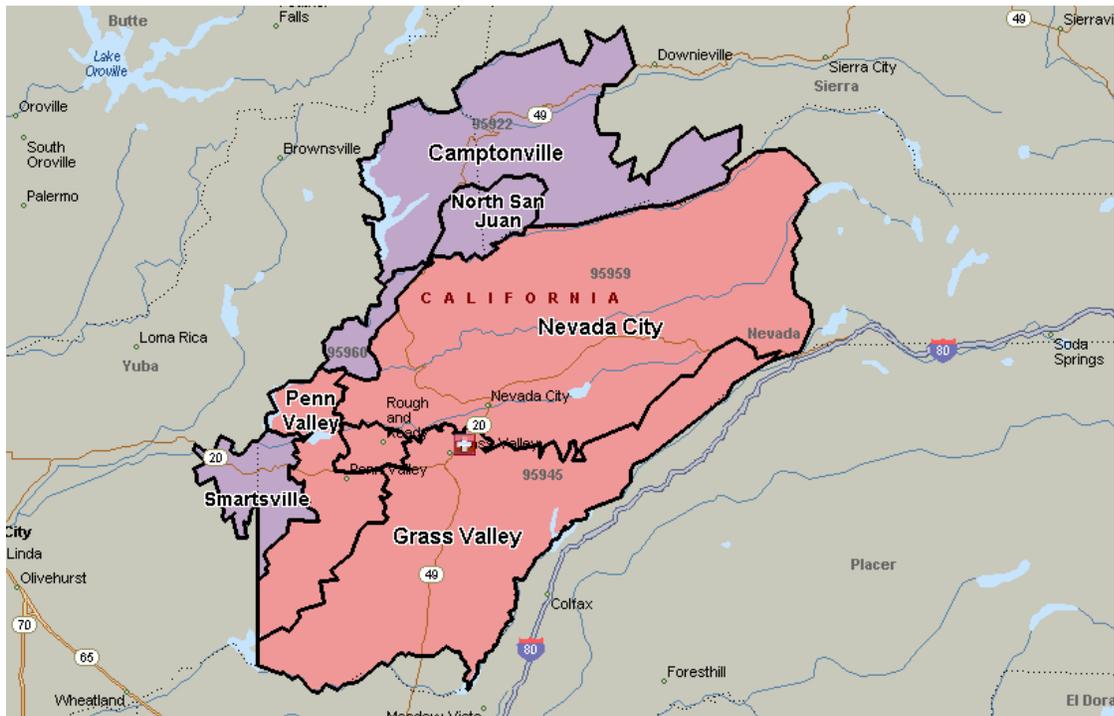
Employees at all levels also participate in the community in many ways, providing clinical expertise and leadership. For example, SNMH Case Managers and Social Workers can be found volunteering time to support local nonprofit health and health-related organizations, like the Care Crisis Nursery. Volunteer educators travel to remote areas of the community where exposure is limited to speak at forums in an effort to increase awareness about the importance of prevention and early detection of disease.

COMMUNITY

Definition of Community

Sierra Nevada Memorial Hospital's community, or primary service area, in Nevada County is defined as the geographic area which it serves and determined by analyzing patient discharge data. The Hospital's primary and secondary service areas are shown on the map below and encompass six zip codes in the communities of Grass Valley, Penn Valley and Nevada City (95949, 95945, 95959, 95975, 95922, and 95960).

Sierra Nevada Memorial Hospital Primary Service Area



Description of Community

Nevada City, Grass Valley, Truckee and nine other unincorporated cities make up Nevada County. With almost 179,000 acres of national forest and over 15,000 acres of state park land, the region is known for its open space, rural atmosphere and small-town style of life. Forest and parks comprise 63 percent of all land. Nevada County ranks 36th among the most populated counties in California. Agriculture, forestry and fishing companies represent the largest business sectors in Nevada County, with small businesses comprised of one to four employees most representative of the economy.

Nevada County is home to over 74,000 residents; a large percentage who are retired. Persons 65 or older comprise a higher percentage in Nevada County (18.7%) than in California as a whole (11.2%), indicating a greater need for specialty medical services. Transportation for this large senior population is a challenge within this rural region. While Telecare vans help meet the need of seniors requiring transportation, there is limited public transportation. Over 88% of county residents depend on their own vehicles for commuting.²

Parts of Nevada County are also considered Medically Underserved Population (MUP) areas by the California Healthcare Workforce Policy Commission. Large portions of the Hospital's service area are designated Health Professional Shortage Areas for primary care and mental health services.

Community Demographics

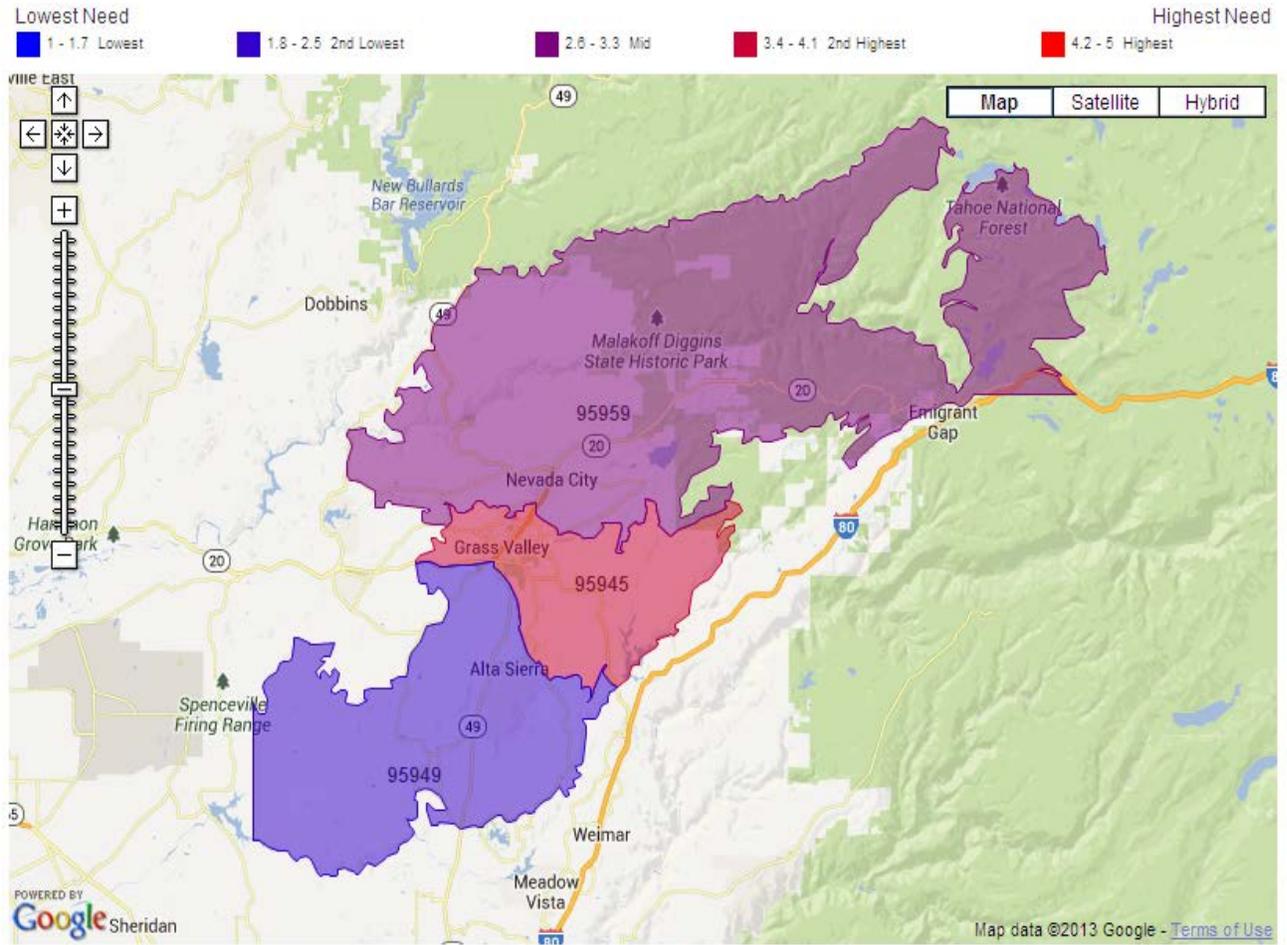
- **Population:** 74,223
 - Under 18 = 18.7%
 - 18-44 = 25.77%
 - 45-65 = 34.98%
 - 65+ = 20.55%
- **Diversity**
 - Caucasian: 87.6%
 - Hispanic: 7%
 - Asian: 1.3%
 - African American: 0.4%
 - American Indian/Alaska Native & Other: 3.7%
- **Average Income:** \$61,832
- **Uninsured:** 18.8%
- **Unemployment:** 9.4%
- **No High School Diploma:** 5.7%
- **Renters:** 25.1%
- **Community Needs Index (CNI) Score:** 2.7
- **Medicaid Patients:** 12.2%
- **Other Area Hospitals:** Tahoe Forest Hospital in Truckee, CA, (critical access)

Sierra Nevada Memorial Hospital Community Needs Index Data

The Hospital's CNI Score of 2.7 score falls in the median range. The CNI highlights by zip code the areas of greatest risk for preventable hospitalizations (see CNI map below). The data is derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and validated by Hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).

² Nevada County 2009-2010 Economic & Demographic Profile, produced by the Center for Economic Development, CSU, Chico Research Foundation.

Sierra Nevada Memorial Hospital Community Needs Index (CNI) Map: Median CNI Score: 2.7



Mean(zipcode): 2.6 / Mean(person): 2.7

CNI Score Median: 3.4

CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
95945	3.4	24049	Grass Valley	Nevada	California
95949	1.8	19803	Alta Sierra	Nevada	California
95959	2.6	17775	Nevada City	Nevada	California

COMMUNITY BENEFIT PLANNING PROCESS

A. COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Sierra Nevada Memorial Hospital's (SNMH) recently completed 2013 Community Health Needs Assessment (CHNA) was conducted in partnership with community stakeholders and Valley Vision, a nonprofit community research and service organization. A team of experts from multiple sectors within the Hospital's service area was assembled to conduct the assessment, including: 1) a local public health expert with over a decade of experience in conducting CHNAs; 2) a geographer with expertise in using GIS technology to map health-related characteristics of populations across large geographic areas, and 3) local public health practitioners and consultants to collect and analyze data.

The assessment followed a community-based participatory research approach, led by a workgroup that was comprised of community benefit staff, other health systems, and Sierra Health Foundation. Various health and community experts involved in the process included the Nevada County Public Health Officer, Nevada County School District Superintendent, and physicians and leaders of community health and social service organizations.

The CHNA was guided by the following objective: *In order to provide necessary information for the Sierra Nevada Memorial Hospital community health improvement plan, identify communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.*

The World Health Organization defines *health needs* as “objectively determined deficiencies in health that require health care, from promotion to palliation.” Building from this, the CHNA used the following definitions for health *need* and *driver*:

Health Need: A poor health outcome and its associated driver.

Health Driver: A behavioral, environmental, and/or clinical factor, as well as more upstream social economic factors that impact health

Methodology

The assessment used a mixed methods data collection approach that included primary data such as key informant interviews, community focus groups, and a community assets assessment. Secondary data included health outcomes, demographic data, behavioral data, and environmental data.

Unit of analysis and study area

The study area of the assessment included SNMH's service area, as previously described. A key focus was to show specific communities (defined geographically) experiencing disparities as they related to chronic disease and mental health. Zip code boundaries were selected as the unit-of-analysis for most indicators. This level of analysis allowed for examination of health outcomes at the community level that are often hidden when data are aggregated at the county level. Some indicators (demographic, behavioral, and environmental in nature) were included in the assessment at the census tract, census block, or point prevalence level, which allowed for deeper community level examination.

Selection of data criteria

Criteria were established to help identify and determine all data to be included for the study. Data were included only if they met three standards: 1) all data were to be sourced from credible and reputable sources; 2) data must be consistently collected and organized in the same way to allow for future trending, and; 3) data must be available at the zip code level or smaller.

County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity. All rates are reported per 10,000 of population. Health outcome indicator data were adjusted using Empirical Bayes Smoothing, where possible, to increase the stability of estimates by reducing the impact of the small number problem. To provide relative comparison across zip codes, rates of ED visits and hospitalization for heart disease, diabetes, hypertension, and stroke were age adjusted to reduce the influence of age.

Primary data – the voice of the community

Primary data collection included qualitative data gathered in four ways: 1) input from the Dignity Health community benefit team; 2) key informant interviews with area health and community experts; 3) focus groups with area community members, and; 4) community health asset collection via phone interviews and website analyses.

Key informants are health and community experts familiar with populations and geographic areas residing within SNMH's service area. To gain a deeper understanding of the health issues pertaining to chronic disease and populations living in more vulnerable communities, seven key informants participated in the CHNA process. Interviews were conducted with these informants using a theoretically grounded interview guide. Each interview was recorded and content analysis was conducted to identify key themes and important points pertaining to each geographic area. Findings from these interviews were also used to help identify communities most appropriate for focus groups.

Members of the community representing subgroups, defined as groups with unique attributes (race and ethnicity, age, sex, culture, lifestyle, or residents of a particular neighborhood within the service area), were recruited to participate in a focus group. A standard protocol was used for the focus group in order to better understand the experiences of these community members as they relate to health disparities and chronic disease. Content analysis was performed on the focus group interview notes to identify salient health issues affecting these community residents.

Secondary Quantitative Data

Secondary quantitative data used in the assessment are listed below in Tables 1 and 2.

Table 1: ED visits, hospitalization, and mortality

ED and Hospitalization		Mortality	
Accidents	Hypertension*	All-Cause Mortality*	Infant Mortality
Asthma	Mental Health	Alzheimer's Disease	Injuries
Assault	Substance Abuse	Cancer	Life Expectancy
Cancer	Stroke*	Chronic Lower Respiratory Disease	Liver Disease
Chronic Obstructive Pulmonary Disease	Unintentional Injuries	Diabetes	Renal Disease
Diabetes*	Self-inflicted injury	Heart Disease	Stroke
Heart Disease*		Hypertension	Suicide

*Age adjusted by 2010 California standard population

Table 2: Socio-demographic, behavioral, and environmental data profiles used in the CHNA

Socio-Demographic	
Total Population	Limited English Proficiency
Family Make-up	Percent Uninsured
Poverty Level	Percent over 25 with No High School Diploma
Age	Percent Unemployed
Race/Ethnicity	Percent Renting
Behavioral and Environmental Profiles	
Safety Profile <ul style="list-style-type: none"> Major Crime Assault Unintentional Injury Fatal Traffic Accidents Accidents 	Food Environment Profile <ul style="list-style-type: none"> Percent Obese/Percent Overweight Fruit and Vegetable Consumption (≥ 5/day) Farmers Markets Food Deserts Modified Retail Food Environment Index (mRFEI)
Active Living Profile <ul style="list-style-type: none"> Park Access 	Physical Wellbeing Profile <ul style="list-style-type: none"> Age-adjusted Overall Mortality Life Expectancy Infant Mortality Health Care Professional Shortage Areas Health Assets

Data Analysis - Identifying Vulnerable Communities

Socio-demographics were examined to identify neighborhoods within the service area with high vulnerability to chronic disease disparities and poor mental health outcomes. Race/ethnicity, household make-up, income, and age variables were combined into a *vulnerability index* that described the level of vulnerability of each census tract. This index was then mapped for the entire service area. A tract was considered more vulnerable, or more likely to have higher unwanted health outcomes than others, if it had higher: 1) percent Hispanic or non-White population; 2) percent single parent headed households; 3) percent below 125% of the poverty level; 4) percent under five years old; and 5) percent 65 years of age or older living in the census tract. This information was used in combination with input from the CHNA workgroup to identify prioritized areas for which key informants would be sought. See the vulnerability index below.



Focus Group Selection

The selection for the focus group was determined by feedback from key informants and analysis of health outcome indicators (ED visits, hospitalization, and mortality rates). Key informants were asked to identify populations that were most at risk for health disparities and mental health issues. In addition, analysis of health outcome indicators by zip code, race and ethnicity, age, and sex, revealed communities with high rates that exceeded established benchmarks of the state and county, as well as Healthy People 2020 targets. This information was compiled to determine the location of focus groups within the service area.

Communities of Concern

To identify Communities of Concern, primary data from key informant interviews, detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. Zip code communities with rates that exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, or mortality were considered. The health outcome data analysis was triangulated with primary data and socio-demographic data to identify specific Communities of Concern.

Data on socio-demographics of residents living in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing status, employment status, and health insurance status, were examined. Area health needs were determined via in depth analysis of qualitative and quantitative data, and then confirmed by socio-demographic data.

Health Needs Identified: Assessment Findings

Analysis of data revealed two Communities of Concern listed in Table 3.

Table 3: Identified Communities of Concern for Sierra Nevada Memorial Hospital Service Area

Zip	Community Name	County	2010 Population*
95945	Grass Valley	Nevada	25,199
95975	Rough and Ready	Nevada	1,769
Total population			26,968

(*Source: 2010 Census data)

These two Communities of Concern are home to nearly 27,000 residents living in the communities of Grass Valley and Rough and Ready. Both zip codes displayed rates for unemployment that surpassed state and national rates, and both were higher than national benchmarks for poverty. More residents in these zip codes had no health insurance as compared to state and national benchmarks. Higher rates of chronic illness were identified within both zip codes. There were more than double the number of ED visits and hospitalizations in these two zip codes as compared to zip codes in the service area due to diabetes and heart disease. Stroke, hypertension, COPD and asthma were also greater concerns for residents in these two communities. Mental health illness in these two zip codes was significantly higher, with cases that nearly twice exceeded county and state benchmarks. The problems of substance abuse, self-inflicted injury, and suicide were also greater.

Priority Health Needs

Multiple priority health needs were identified through the analysis of both quantitative and qualitative data. These were prioritized according to the degree of support in the findings. All needs are noted as a “health driver,” or a condition or situation that contributed to a poor health outcome:

- Lack of access to primary care and preventive services
- Lack of integration of behavioral health and primary care
- Transportation issues and limitations
- Limited access to healthy foods, food security
- Lack of access to specialty care
- Lack of dental care
- Lack of access to mental health services

- Eligibility requirements for Medi-Cal and other social services
- Lack of access to outdoor and recreational activities
- Lack of access to physical therapy

Communicating the Results

Results of the assessment are being widely disseminated. Forums to examine the findings are planned within the Hospital. Copies of the assessment were made available to local government officials and all of the nonprofit community-based organizations. The assessment is posted on the Hospital website as well as on the Dignity Health Website, www.DignityHealth.org. (See Attachment 1 for the full CHNA report.)

B. ASSETS ASSESSMENT

Communities require resources in order to maintain and improve their health. These include health related assets, including health care professionals and community-based nonprofit organizations. An assessment of these resources revealed nearly 40 assets that could potentially provide opportunities for partnership. SNMH has established partnerships with a number of these agencies. The Hospital works closely with the only Federally Qualified Health Center, Western Sierra Medical Clinic, and other community-based nonprofit organizations through the Dignity Health Community Grants Program. (A listing of health assets can be found at the back of the CHNA in Attachment 1.)

C. DEVELOPING THE HOSPITAL’S IMPLEMENTATION PLAN

Process for Prioritization

A Hospital Leadership team worked with CHNA partners, and community benefit staff to prioritize health needs to be addressed in FY 2014. The following criteria were applied for the needs prioritization:

- An assessment identified the issue as significant and important to a diverse group of community stakeholders
- The issue affects a large number of individuals
- The issue is linked to high Hospital ED and inpatient utilization
- The problem is not currently being addressed in the community
- There are currently significant community resources focused on the issue
- The potential for collaboration with community partners exists
- CHNA trending over time reflects the issue is becoming more serious
- The issue is likely to grow worse if left unaddressed
- SNMH has the required expertise and human/financial resources to respond in a way that is impactful

Results of the planning process determined that SNMH would build upon existing programs and services that are already addressing priority health needs, and implement new initiatives to address unmet healthcare needs in the community, with a focus on four overarching priority health areas:



Through the planning process, it was also determined that special emphasis for programs and services addressing these four priority areas will be on:

- Communities of Concern to ensure residents can access, and benefit from, services and programs
- Collaboration within the community's safety net to increase access to care
- Community outreach to ensure awareness of, and increase participation in, chronic disease prevention and self-management educational offerings, particularly diabetes and heart disease

Implementation Strategies/Action Plans

1. Access to Primary Care

SNMH has a leadership role on the board of FQHC, Western Sierra Medical Clinic. The Hospital financially subsidizes this center's current efforts to serve as a primary health care home to the underserved. In order to expand the reach of Clinic services (a need identified in the CHNA), the Hospital has enabled the Clinic to utilize hospital-owned facilities in Grass Valley for additional capacity at a reduced rate. The Hospital also ensures patients in need of a primary care provider are given timely referrals to the Clinic prior to discharge from the ED.

Satellite Lab and X-Ray Clinic

The Hospital opened a new satellite lab and x-ray clinic in Penn Valley, in the vicinity of Rough and Ready, one of the Communities of Concern identified in the CHNA. This outpatient facility will significantly enhance access to medical services for underserved populations. Key informants in the CHNA voiced the difficulties many residents within these part of the region have obtaining lab and x-ray tests.

2. Access to Preventative Services

The Hospital is one of the few providers in the region addressing the need for health education that focuses on disease prevention and management of chronic illness. Through the Hospital's Wellness Education department, thousands of residents have been served over the past 15 years, receiving the necessary resources and skills to control health conditions and lead healthier lives. In addition, the Hospital provides blood screenings on a regular basis. The Hospital will continue to provide these priority services, and focus on outreach efforts to increase awareness and participation in chronic diseases program offerings among residents within the two Communities of Concern identified in the CHNA. Specific emphasis by the Hospital is placed on diabetes, hypertension and heart disease as key problem conditions that were consistently raised in the CHNA. These conditions are being addressed through several core programs:

CHAMP® (Congestive Heart Active Management Program)

This best practice health intervention model provides assistance and support to those with heart disease. The Hospital implemented CHAMP® when heart disease was determined to be a health priority in the region some years ago. Heart conditions are also a major cause for hospitalization. CHAMP® provides ongoing educational and clinical support to residents with heart failure, and provides medication monitoring. It aims to help individuals with heart disease live healthier, more active lives, and reduce avoidable hospital admissions.

Cardiac Rehabilitation

Complementary to CHAMP®, the Hospital offers cardiac rehabilitation programs and classes specifically focused on the underserved who would not otherwise have access to such services.

Diabetes: Take Control!

This active and growing program provides education and nutrition counseling to enable residents to better manage their diabetes, maintain good health and avoid hospitalizations for uncontrolled symptoms. Workshops follow the evidence-based Stanford University Diabetes Self-Management Program. The Hospital has 12 facilitators now trained to lead workshops.

Better Breather, Pulmonary Rehabilitation, and Smoking Cessation

In response to the high prevalence identified in the CHNA for Chronic Obstructive Pulmonary Disease and asthma, the Hospital offers ongoing Better Breather, Pulmonary Rehabilitation, and Smoking Cessation classes.

Building Capacity for Preventative Services

Collaborative efforts are underway by the Hospital and Western Sierra Medical Clinic to increase access to preventative services, particularly within Communities of Concern. The Hospital is training key members of the Clinic's staff as facilitators for the Chronic Disease Self-Management Program workshops, in order to extend the reach of course offerings to communities in need.

3. Access to Mental Health and Substance Abuse Treatment

Sierra Nevada Memorial Hospital recognizes the major gap in services for mental health care, and the high substance abuse problem in the region, and is responding through collaborative measures that build capacity in the community for services addressing these needs. Specifically, the Hospital has redesigned its annual Dignity Health Community Grants Program to focus on creating strategic partnership programs within the nonprofit community that target underserved individuals in need of mental health care and/or substance abuse treatment. One new partnership program being established in FY 2014 involves Community Recovery Resources (CORR), Western Sierra Medical Clinic, and FREED Center for Independent Living. These nonprofit community based organizations are collaborating with the Hospital to coordinate a continuum of care for individuals dealing with mental illness and substance abuse problems.

The initiative is designed to provide improved access to primary care, substance abuse, behavioral health, and preventative services for individuals living in Nevada County, with particular focus on individuals who have been hospitalized and are at risk of readmission, and/or individuals who utilize the ED for care related to substance abuse or conditions that could be managed more efficiently in a primary care or substance abuse treatment environment. Through collaboration, the initiative will integrate a number of preventative services, including intervention, care transition, case management and navigation. Western Sierra Medical Clinic will be co-locating primary care services at CORR's drug and alcohol residential treatment facility. FREED will bring care transitioning and coaching to the partnership, working directly with the Hospital to identify high-risk underserved patients with complex health needs.

The collaboration will focus on streamlining access to care and services through a "no wrong door" model. Each organization will cross-train staff on services, eligibility, warm hand-offs, and areas of expertise including substance abuse, chronic disease, and disability awareness. Key indicators to measure progress will include number of cross-referrals; number of warm-handoffs; number of patients successfully served; and case studies of shared clients. Monthly meetings, scheduled trainings, and quarterly data/progress reports will be our primary methods of evaluating and measuring progress.

4. Access to Specialty Care

The Hospital continues to expand its Nurse Navigator and peer support programs, particularly for stroke victims. Stroke is an area of expertise for the Hospital, and was identified as a high-risk health issue in the CHNA, specifically among the large elderly male population in the region. The Hospital is also developing a lung cancer screening program to respond to the growing prevalence of lung cancer, which was indicated in the CHNA as an increasing concern.

5. Unintentional Injury

Quantitative data from the CHNA reflected that ED visits for unintentional injury is far greater within the Hospital's service area when compared to state rates. A significant contributing factor for this high rate is due to falls among the large elderly population in the region. In response, the Hospital offers falls prevention classes, and is involved in the Falls Prevention Coalition of Nevada County, an organization dedicated to reducing the risk of falls through education.

The Hospital will continue to provide core community benefit services that are directly responding to other priority health needs, including:

1. **Transportation and Medication.** The Hospital assesses and provides transportation for those with no means to travel, and provides medications to patients who cannot afford to purchase them.
2. **Professional Health Education.** The Hospital provides educational training opportunities for future workforce expansion needed to expand access to care in the region. Student nurses work with preceptors in the Hospital's inpatient unit on a continuous basis.
3. **Cancer and Traumatic Brain Injury Support Groups.** Support groups offered by the Hospital provide education, and help those in the community and their family members cope with cancer and brain injuries.
4. **Alzheimer's Outreach Program.** In response to a growing need to assist patients, their families and caregivers with Alzheimer's, SNMH's Home Care Department provides an Alzheimer's Outreach Program that serves as a community education, resource and support center. Alzheimer's is particularly prevalent among the growing elderly residents within Nevada County. A licensed Social Worker is dedicated to the program, which offers a variety of services, including ongoing "Yes I Can" courses that teach caregivers and families how to provide quality care for those with Alzheimer's still living at home, and Caregiver Support Groups. The program provides education and caregiver support via home visits and through consultations and serves to link those in need to important resources and assisted living/care centers.

Needs Not Prioritized

The Hospital responds to priority health needs in many ways, and in times that are critical for patients in crisis. In addition to charity care, indigent care, and un-funded care for Medi-Cal patients, a significant number of programs and services offered address the priority needs identified in the 2013 CHNA. The needs of Nevada County are monumental, and as the sole hospital serving this expansive rural region, Sierra Nevada Memorial Hospital does not have the resources available to develop and/or duplicate initiatives to meet every priority need identified, which makes collaboration with community assets critical. The Hospital is not addressing lack of access to healthy foods as the City of Grass Valley and Nevada City provide weekly farmers markets that offer fresh foods available at affordable costs. The Hospital does not have the expertise or means to offer dental care. Chapa-De provides dental services to the underserved population in Nevada County.

6. PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION

Sierra Nevada Memorial Hospital strives to ensure that the needs of the uninsured and underinsured patient population are addressed. No one should go without health care and the Hospital is committed to treating patients who have financial needs with the same dignity, compassion and respect that is extended to all patients. The Hospital considers each patient's ability to pay for his or her medical care, and follows the Dignity Health Patient Payment Assistance Policy, which makes free or discounted care available to uninsured individuals with incomes up to 500 percent of the federal poverty level (see Appendix B for a summary of the Dignity Health Patient Payment Assistance Policy).

Continued education to stay current on the Financial Assistance Policy is required for Hospital Leadership and employees at all levels of the organization. Employees working in Admitting and Patient Financial Services are fully versed in the policy and dedicated to assisting patients that are in need of support. Any employee or member of the medical staff can refer patients for financial assistance. Family members, friends or associates of a patient may also make a request for financial assistance.

To ensure all patients are aware of the policy, financial assistance information is distributed in a number of ways. Notices in the primary languages spoken by the populations the Hospital serves are posted in the Hospital's emergency departments, in admitting and registration areas, and in the business and financial services office. Notices are also placed in all patient bills and include a toll-free contact number.

In addition to financial assistance, the Hospital further supports the specific needs of uninsured and underinsured patient populations by assisting them with government health insurance program enrollment and transportation. Information is also available on the Dignity Health Website: www.Dignityhealth.org.

Enrollment Assistance

Following medical treatment, the hospital provides assistance to help uninsured patients enroll in government sponsored health insurance programs. In FY 2013, 450 uninsured patients received this free assistance. Hospital-sponsored expense for this assistance was \$10,705.

Transportation

Taxi transportation is available for patients who do not have, or cannot afford their own transportation home upon discharge from the hospital. There were 250 patients who received this service in FY 2013 at a community benefit expense of nearly \$5,000.

PLAN REPORT AND UPDATE

INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives – FY 2013

Key community benefit initiatives and community-based programs directly provided, or substantially supported, by Sierra Nevada Memorial Hospital in FY 2013 are summarized below. These initiatives and programs are mapped to align with the five priority health areas and are guided by five core principles:

1. Focus on disproportionate unmet health-related needs.
2. Emphasize prevention.
3. Contribute to a seamless continuum of care.
4. Build community capacity.
5. Demonstrate collaborative governance.

Initiative I: Access to Primary Care

- Financial assistance
- Western Sierra Medical Clinic (FQHC) support and collaboration
- Satellite Lab and X-Ray Clinic (new in FY 2014)
- Physician recruitment (new program identified for FY 2014)
- Enrollment assistance
- Transportation
- Health screenings (blood pressure, cholesterol, mammograms, etc)
- Alzheimer's Outreach program

Initiative II: Access to Preventative Services

- Congestive Heart Active Management Program (CHAMP®)
- Cardiac Rehabilitation
- Diabetes – Take Control!
- Western Sierra Medical Clinic collaboration (new in FY 2014)
- Heart Smart Education
- Wellness Education
 - Pre-diabetes and Diabetes Management
 - Chronic Disease Self-Management
 - Asthma
 - Smoking Cessation
 - Exercise for Strength and Fitness
 - Aging
 - Nutrition and Healthy Cooking
 - Prenatal Care
- Nutrition Assessments and Counseling for Cancer
- Cancer Center Comfort Cuisine
- Cancer Screenings
- Cancer Support Group

Initiative III: Access to Mental Health and Substance Abuse Treatment

- Dignity Health Community Grants Program (redesigned 2013-2014)

Initiative IV: Access to Specialty Care

- Nurse Navigator program (new in FY 2014)
- Lung cancer screening program (new in FY 2014)

Initiative V: Unintentional Injury

- Falls Prevention Education
- Falls Prevention Coalition of Nevada County

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The SNMH Board of Directors and Executive Leadership, and Dignity Health (formerly Catholic Healthcare West) receive quarterly updates on program performance and news. The following Program Digests highlight a few key programs that address one or more of the initiatives listed above.

PROGRAM DIGESTS

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®) AND CARDIAC REHABILITATION	
Hospital CB Priority Areas	<p>Access to Care</p> <ul style="list-style-type: none"> ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	As identified in the CHNA, heart failure is a priority issue in Nevada County, particularly prevalent because of a large and growing senior population.
Program Description	CHAMP® is open to all eligible with a diagnosis of congestive heart failure at no cost. The program improves the health status of heart failure patients by providing a vital link to the medical world through regular phone interaction and educational discussion. The goal is to improve patient understanding and management of CHF to reduce Hospital admissions/readmissions. The program monitors patient symptoms or complications, and provides recommendations on diet changes, medicine modifications, daily weights and physician visits. The Hospital also provides a Cardiac Rehab program to complement CHAMP®, where participants receive appropriate and monitored exercise therapy. Cardiac Rehab targets the underserved, but is also open to all at no cost.
FY 2013	
Goal FY 2013	Improve the health and quality of life for those that suffer from heart disease, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2013 Objective Measure/Indicator of Success	Increase number of participants with emphasis on underserved. Avoid Hospital or emergency department admissions among 60% or greater of participants.
Baseline	Heart failure is a priority health issue for Nevada County, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Team; outreach to increase enrollment; improvements in methodology for program outcome measurement.
Result FY 2013	533 total active participants; exceeded metric goal for avoiding Hospital admissions among participants. Over 90% of those participants enrolled did not admit to the Hospital.
Hospital's Contribution / Program Expense	CHAMP® - \$30,968. Cardiac Rehabilitation - \$61,622
FY 2014	
Goal 2014	Improve the health and quality of life for those that suffer from heart disease, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Avoid Hospital or ED admissions among 60% of participants; enhance outreach to Communities of Concern identified in the CHNA.
Baseline	Heart failure is a priority health issue for Nevada County, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Team; more outreach to continue to increase enrollment; focus on improvements in program outcome evaluation.
Community Benefit Category	A2-e Community Based Clinical Services – Ancillary/Other Clinical Services.

DIABETES: TAKE CONTROL!	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Diabetes has been identified in the CHNA as a growing health issue in Nevada County, due to an aging population, and a high level of risk behaviors, like obesity, which can lead to this disease. Also high Hospital inpatient and ED utilization rate due to diabetes and related symptoms.
Program Description	Following the evidence-based Stanford University model, the program includes a number of components - diabetes facts and nutrition, diabetes self management, and nutritional counseling. Target population is underserved, but the program is open to all in the community. Program participants are tracked 3 and 6 months post intervention to determine program outcomes.
FY 2013	
Goal FY 2013	Improve the health and quality of life for those that suffer from diabetes, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the Hospital.
2013 Objective Measure/Indicator of Success	Increase awareness of, and enrollment in, Diabetes: Take Control! Program, through enhanced community outreach efforts. Track and evaluate Hospital admissions six months post intervention. Meet or exceed metric goal to avoid Hospital or ED admissions among 60% of program participants.
Baseline	The program addresses a priority CHNA health issue in the community. Diabetes cases also represent high utilization of inpatient and ED admits.
Intervention Strategy for Achieving Goal	Regular evaluation of Diabetes: Take Control! Program to align with needs of community; hospital admissions avoided, and feedback from group participants.
Result FY 2013	197 new participants in FY 2013, Hospital readmissions avoided among 98% of the participants.
Hospital's Contribution / Program Expense	\$3,415
FY 2014	
Goal 2014	Improve the health and quality of life for those that suffer from Diabetes, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Increase awareness of Diabetes: Take Control! Program throughout the community to grow program workshop offerings, numbers of lay facilitators, and participants. Collaborate with Western Sierra Medical Clinic to expand reach of the program into Communities of Concern. Achieve or exceed metric goal.
Baseline	The program addresses a priority CHNA health issue in the community. Diabetes cases also represent high utilization of inpatient and ED admits.
Intervention Strategy for Achieving Goal	Regular evaluation of Diabetes: Take Control! Program to align with needs of community; Hospital admissions avoided, and feedback from group participants. Increased outreach in the community, particularly in Communities of Concern.
Community Benefit Category	A1-e Community Health Education – Self-help.

ALZHEIMER'S OUTREACH PROGRAM (AOP)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety ✓ Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	The presence of Alzheimer's in Nevada County is significant and growing due to an aging population within the community. AOP responds to this need.
Program Description	Offered by the hospital's Home Care group, the Alzheimer's Outreach Program offers a series of classes and support groups designed to assist and empower care givers with knowledge and skills to help them prevent the mental and physical distresses involved in caring for those with Alzheimer's and other forms of dementia. The program teaches care givers and family members how to provide quality care for Alzheimer's patients still living at home. Home visits, telephone consultations and a resource website are important components of the program.
FY 2013	
Goal FY 2013	Improve quality of care and quality of life for those with Alzheimer's and other forms of dementia by providing assistance, education, training and resources to care givers and families, and support the mental and physical needs of care givers involved in this difficult and stressful field of care.
2013 Objective Measure/Indicator of Success	Expand "Yes I Can" class series to meet new demand (currently have waiting list). Consider instituting four new course offerings for professional caregivers based on interest and need expressed by program participants (Behavior and Communications; Incontinence; Personal Care; Body Mechanics).
Baseline	The presence of Alzheimer's in Nevada County is significant and growing due to an aging population within the community. AOP responds to this need.
Intervention Strategy for Achieving Goal	Ongoing evaluation of programs to align with and meet needs of community. Continued outreach to community to create awareness of available services.
Result FY 2013	286 participants in the program; nearly double FY 2012.
Hospital's Contribution / Program Expense	\$15,642
FY 2014	
Goal 2014	Improve quality of care and quality of life for those with Alzheimer's and other forms of dementia by providing assistance, education, training and resources to care givers and families, and support the mental and physical needs of care givers involved in this difficult and stressful field of care.
2014 Objective Measure/Indicator of Success	Increase budget and/or obtain grant funding to enable new course offerings. Ongoing evaluation of programs to align with and meet needs of community. Continued outreach to community to create awareness of available services.
Baseline	The presence of Alzheimer's in Nevada County is significant and growing due to an aging population within the community. AOP responds to this need.
Intervention Strategy for Achieving Goal	Ongoing evaluation of programs to align with and meet needs of the community. Continued outreach to community to create awareness of available services.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

WELLNESS EDUCATION	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	Education on health and well-being is not offered elsewhere in the community. The hospital's program fulfills this need, which is a priority in a region where chronic disease is a major health issue, evidenced in the CHNA and utilization rates of the Hospital.
Program Description	Wellness Education offers a broad range of free or discounted classes including diabetes, which is an identified priority health issue in the community; asthma; management skills for other chronic diseases; smoking cessation; aging; nutrition and healthy cooking, and prenatal care. The Wellness program also works with other partners in the community to conduct outreach at Health Fairs, Job Fairs and other community events.
FY 2013	
Goal FY 2013	Enhance the self-awareness and responsibility of individuals to develop and maintain healthy lifestyles and provide the education, tools and skills to prevent and manage illness and disease.
2013 Objective Measure/Indicator of Success	Increase awareness of Wellness program offering in the community demonstrated by an increased number of program participants.
Baseline	Responds to lack of education and prevention offerings in the community, and the need for them as identified in the CHNA, as well as in high Hospital utilization rates for chronic illnesses.
Intervention Strategy for Achieving Goal	Regular evaluation of Wellness programs to align with needs of community; feedback from group participants.
Result FY 2013	The number of participants enrolled in various Wellness classes grew significantly in FY 2013 – 46% increase - due to increased outreach efforts;
Hospital's Contribution / Program Expense	\$15,642.
FY 2014	
Goal 2014	Enhance the self-awareness and responsibility of individuals to develop and maintain healthy lifestyles and provide the education, tools and skills to prevent and manage illness and disease.
2014 Objective Measure/Indicator of Success	Increase awareness of Wellness program offering in the community demonstrated by an increased number of program participants.
Baseline	Responds to lack of education and prevention offerings in the community, and the need for them as identified in the CHNA, as well as in high Hospital utilization rates for chronic illnesses.
Intervention Strategy for Achieving Goal	Regular evaluation of Wellness programs to align with needs of community; feedback from group participants; continued outreach to community, specifically Communities of Concern.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshop.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the hospital should then refocus its limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

Report – Classified Summary of Un-sponsored Community Benefit Expense (For Period From 7/1/2012 Through 6/30/2013). Community benefit expenses were calculated using a cost accounting methodology.

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<u>Benefits for Living in Poverty</u>						
Financial Assistance	3,485	1,399,740	0	1,399,740	1.1	1.1
Medicaid	20,588	17,446,054	18,161,511	(715,457)	(0.5)	(0.5)
Means-Tested Programs	6,151	5,487,105	2,872,363	2,614,742	2.0	2.0
Community Services						
Community Benefit Operations	0	27,192	0	27,192	0.0	0.0
Community Building Activities	0	113	0	113	0.0	0.0
Community Health Improvement Services	1,225	90,113	0	90,113	0.1	0.1
Financial and In-Kind Contributions	9	655,276	0	655,276	0.5	0.5
Totals for Community Services	1,234	772,694	0	772,694	0.6	0.6
Totals for Living in Poverty	31,458	25,105,593	21,033,874	4,071,719	3.1	3.1
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	27	0	0	0	0.0	0.0
Community Health Improvement Services	3,916	66,415	0	66,415	0.1	0.1
Financial and In-Kind Contributions	858	588,325	0	588,325	0.5	0.4
Health Professions Education	4	1,012	0	1,012	0.0	0.0
Totals for Community Services	4,805	655,752	0	655,752	0.5	0.5
Totals for Broader Community	4,805	655,752	0	655,752	0.5	0.5
Totals - Community Benefit	36,263	25,761,345	21,033,874	4,727,471	3.6	3.6
Unpaid Cost of Medicare	83,503	62,419,155	45,173,762	17,245,393	13.2	13.2
Totals with Medicare	119,766	88,180,500	66,207,636	21,972,864	16.8	16.8
Grand Totals	119,766	88,180,500	66,207,636	21,972,864	16.8	16.8

Telling the Story

Effectively telling the community benefit story is essential to create an environment of awareness, understanding and interest in the priority health issues challenging the region and importantly, to inform the public about the ways in which these issues are being addressed by Sierra Nevada Memorial Hospital. The 2013 Community Benefit Report and 2014 Plan will be distributed to members of the Board of Directors, and Hospital Leadership, as well as to employees engaged in community benefit activities. It serves as a valuable tool for ongoing community benefit awareness and training.

The document will also be more broadly distributed within the organization to all departments, and outside of the organization to community leaders, government and health officials, partners and other agencies and businesses throughout the region. It can be found, along with the 2013 Community Health Needs Assessment under “Community Health” in the “Who We Are” section on Dignity Health’s Website: www.DignityHealth.org.

APPENDIX A

Sierra Nevada Memorial Hospital Board of Directors Roster

Position	Board of Director	Occupation
Chairman	Don Coots	Retired from Executive Management in Mortgage Finance Industry
Vice Chairman	Michele White	Retired from business, primarily in Human Resources management and consulting.
Secretary	Ed Sylvester	Retired from private practice as CEO of Engineering firm
Director	Leo Granucci	Retired executive from pharmaceutical business
Director	Sarah Woerner, M.D.	Pediatrician in local group practice, just retired
Director	Kevin Vaziri	President and CEO, Woodland Healthcare
Director	Andrew Chang, MD	Gastroenterologist in local group practice
Director	Dale Creighton	President, SCO Planning and Engineering
Director	Stacy Fore, DDS	Dentist in local group practice
President & CEO	Katherine A. Medeiros	Sierra Nevada Memorial Hospital

APPENDIX B

Dignity Health Summary of Patient Payment Assistance Policy

DIGNITY HEALTH SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY (June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.

- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, dignity health management and dignity health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

ATTACHMENT 1

2013 Community Health Needs Assessment