

Sierra Nevada Memorial Hospital

Community Benefit Report 2014
Community Benefit Implementation Plan 2015



A Message From:

**Katherine Medeiros, President and CEO of Sierra Nevada Memorial Hospital, and Sarah Woerner, M.D.,
Chair of the Sierra Nevada Memorial Hospital Board of Directors**

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health, the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

Sierra Nevada Memorial Hospital, a part of the Dignity Health Greater Sacramento Service Area, shares a commitment to improve the health of our community and offers programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done for nearly 50 years to better the health of the communities we serve.

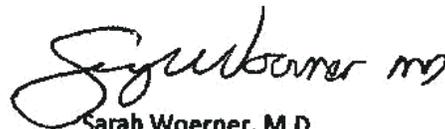
In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report community benefit efforts and measurable objectives as well as plans for the coming year. Encouraged and mandated by its governing body, Dignity Health complies with both mandates at all of its facilities, including hospitals in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Sierra Nevada Memorial Hospital provided \$9,000,080 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, total expense was \$24,881,854.

The Sierra Nevada Memorial Hospital Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 14, 2014 meeting. Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 916 851-2731.



Katherine Medeiros
President and Chief Executive Officer
Sierra Nevada Memorial Hospital



Sarah Woerner, M.D.
Chair, Sierra Nevada Memorial Hospital
Board of Directors

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EXECUTIVE SUMMARY

Sierra Nevada Memorial Hospital'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 Hospital opened its doors in 1958.

Located at 155 Glasson Way in Grass Valley, CA, Sierra Nevada Memorial Hospital has expanded in numerous ways since its early days to meet the growing needs of the community. Today, the hospital has 804 employees and offers 104 licensed acute care beds and 18 emergency department beds. Additions have included an Ambulatory Treatment Center, a Community Cancer Center that is nationally accredited by the Commission on Cancer of the American College of Surgeons, state-of-the-art Diagnostic Imaging Center, Wound Care Healing & Hyperbaric Medicine Center, and Wellness Center. The hospital has also earned the Gold Seal of Approval from the Joint Commission as a Primary Stroke Center.

As the only full service acute care hospital serving Nevada County, Sierra Nevada Memorial 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 severely limited. The region's safety net is challenged by a lack of access to both primary and mental health care and minimal health prevention and education options for underserved and at-risk populations. These challenges are reflected in alarming hospital utilization trends and through assessments of the community, and serve as the basis for community benefit planning and programming. In FY 2014, the hospital further advanced a number of core community benefit programs in partnership with others in the community that respond to these priority health issues, and laid the groundwork for new initiatives in FY 2015. Highlights include:

Mental Health Crisis Support Partnership

FY 2014 marked the beginning of a unique collaboration between the hospital and Nevada County to address the lack of access to mental health care and to improve quality of care and timeliness of care for patients in crisis. It is estimated that 10% of all residents in Nevada County suffer from mental illness and 40% of these individuals go without care¹. Partners in this new program anticipate these statistics to change significantly. During the first phase of the program, implemented in February 2014, the County placed a licensed psychotherapist in the hospital's emergency department, and engaged specially trained on-call peer counselors to be available at the hospital around the clock to support patients in crisis. In the second phase of the program, planned for FY 2015, a four-bed crisis stabilization unit will be established on the hospital campus. Overall goals are to expand and enhance psychiatric emergency services for the community, reduce the need for transferring patients to inpatient psychiatric facilities by providing patients a less restrictive level of care, improve follow-up care for released patients and reduce readmissions.

Integrated Care Coordination for Family Wellness

The Integrated Care Coordination for Family Wellness program was launched late in FY 2014 after several

¹ 2013 Mental Health Advisory Board Annual Report to the Board of Supervisors.

months of planning, and is a partnership between the hospital, FREED Center for Independent Living, Community Recovery Resources and Western Sierra Medical Clinic. The program responds to priority health issues surrounding access to primary, mental and preventative health care services and the need to integrate and coordinate these services for vulnerable populations. FREED Center for Independent Living brings expertise in case management, coaching and navigation, as well as a keen knowledge of community resources to the partnership. Community Recovery Resources has been improving lives in the community through mental health and substance abuse treatment services for decades. Western Sierra Medical Clinic is the region's primary Federally Qualified Health Center providing medical, dental, maternal and behavioral health services to thousands of residents in need. Early in the program, partners underwent cross-training to understand each other's services and developed a process for seamless referrals. Western Sierra Medical Clinic has also established a clinic co-located at Community Recovery Resources. During the startup phase of the program, over 100 residents received one or more partner services, and numbers are expected to increase significantly in FY 2015 as the program expands. As part of the expansion, a FREED navigator will be stationed on the hospital campus to work directly with hospital case managers.

Cancer Nurse Navigator

A new Cancer Nurse Navigator program was introduced by the hospital in FY 2014 to increase access to care for patients with breast cancer. The program is designed to help patients navigate the maze of options related to breast 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. The hospital provides similar navigator services to individuals with lung cancer, and for stroke victims. Breast and lung cancer, and stroke are leading causes of death in Nevada County.

Heart Failure Program

Heart disease is also among the top causes of death in Nevada County, yet the region lacks services to support those who suffer from this illness. The need for preventative health services and education for heart disease was identified as a priority issue in the Community Health Needs Assessment, and the hospital is responding to this need through a best practice Heart Failure Program.

Diabetes: Take Control!

Diabetes: Take Control! responds to the need for health prevention and educational services for Nevada County residents struggling with diabetes. Diabetes was identified through assessment as a major health concern, particularly in the communities of Grass Valley and Rough and Ready. The program offers education and self-management skills to help individuals control their diabetes and live healthier and more active lives. The hospital is working collaboratively with the Western Sierra Medical Clinic to expand diabetes workshops to the communities of Grass Valley and Rough and Ready where the need is greatest.

Alzheimer's Outreach

Hundreds of vulnerable elderly residents and their families and caregivers benefited from the hospital's Alzheimer's Outreach Program in FY 2014. Offered through the hospital's Home Care department, the program provides education, caregiver support, personalized consultations, and home visits. Individuals are also linked to community resources. Alzheimer's is among the leading causes of death in Nevada County, particularly for females.

Details on these programs, new initiatives in development, and other community benefit investments by Sierra Nevada Memorial Hospital are documented in more detail in this report. The total value of community benefit for FY 2014 was \$9,000,080, which excludes \$15,881,774 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

A commitment to improving the health of the community has been an essential part of Sierra Nevada Memorial Hospital's mission for over 50 years. The hospital is proud of its history of investing in community health programs and partnering with others to identify and address urgent health needs in the community it serves.

Every three years, the hospital conducts a Community Health Needs Assessment (CHNA) that brings administrative and clinical leadership together with public health experts, nonprofit providers, representatives of medically underserved populations and other stakeholders to understand community needs and resources. The assessment process is used to guide the hospital in developing health improvement strategies and making investments that are aligned with priority health issues. It also strengthens relationships among participating organizations.

As in past years, the priorities for community health improvement efforts continue to focus on three broad areas of need specifically for underserved populations:

- Access to primary, mental and specialty health care
- Access to preventative health services and education
- Access to health care and social support services for the elderly

Initiatives that respond to these priority needs are conducted in collaboration with community partners to leverage resources and areas of expertise for higher impact, create a community-wide system of care and foster long-term sustainable change. Initiatives, like the Integrated Care Coordination for Family Wellness Program, the evolving Mental Health Crisis Stabilization Partnership with the County, and programs that address chronic disease, are incorporated into the hospital's strategic plan and tied to specific goals and measurable outcomes. Hospital leadership works with community benefit staff to plan, evaluate and budget for these initiatives each year.

Sierra Nevada Memorial Hospital's commitment to the health of its community is reflected through other key programs. Offered each year since 1990, the Dignity Health Community Grants Program is a way for the hospital to support the work of other nonprofit organizations that share the same mission to improve the health and lives of underserved populations. The grants program maintains a focus on the priority areas of need and further encourages collaboration by requiring organizations to partner on programs in order to provide a greater continuum of care. In the 2014 grants cycle, for example, the Domestic Violence and Sexual Assault Coalition teamed with The Friendship Club to create a pre-teen/teen program that offered prevention and intervention to at-risk youth exposed to abuse, drug use, mental illness, or an incarcerated parent. Over 700 youth were served through this "Building Bridges to a Healthy Future" program.

In addition, the Dignity Health Community Investment Program helps build community capacity by providing loans at below-market rate interest to nonprofit organizations that are working to increase access to health care, create jobs, develop low-income housing, and enhance educational opportunities for underserved populations.

Governance

Oversight for community benefit is provided by the Sierra Nevada Memorial Hospital Board of Directors.

Members help guide the hospital's community benefit practices, ensuring that programs and services address the unmet health needs of the community and promote the broader health of the region (see Appendix A for the Sierra Nevada Memorial Hospital Board of Directors roster). Specific roles and responsibilities of the Board and hospital leadership are to:

- Ensure services and programs align with the mission and values of Dignity Health and are in keeping with 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 follows uniform methods of accounting for community benefit activities and expenses
- Review and approve the Community Health Needs Assessment and ensure alignment of programs and services with priority health issues
- Evaluate and approve the community benefit budget
- Evaluate community benefit program design and content
- Monitor and evaluate program progress, and determine program continuation or termination

Day to day community benefit programs and services are managed through the hospital's Wellness Department, working with the Dignity Health Sacramento Service Area Community Benefit Department. Quarterly reports are provided to the Board of Directors, and community benefit orientation and training programs are conducted each year for various departments of the hospital.

Non-Quantifiable Benefits

Recognizing that true health improvement requires shared ownership of strategies and goals, Sierra Nevada Memorial Hospital makes it a responsibility to engage with the community in many ways that are hard to measure and go beyond financial and programmatic investments. Whether serving on coalitions, boards or committees, members of the hospital's leadership and management teams volunteer significant time and expertise to help develop and implement strategies for long-term positive change in the health, wellbeing and economic vitality of the region. Leadership in the community by the hospital extends to multiple organizations; from the region's Federally Qualified Health Center, Western Sierra Medical Clinic, where joint efforts are focused on capacity building, to the Falls Prevention Coalition, which is preventing injury among Nevada County's elderly population through outreach and education.

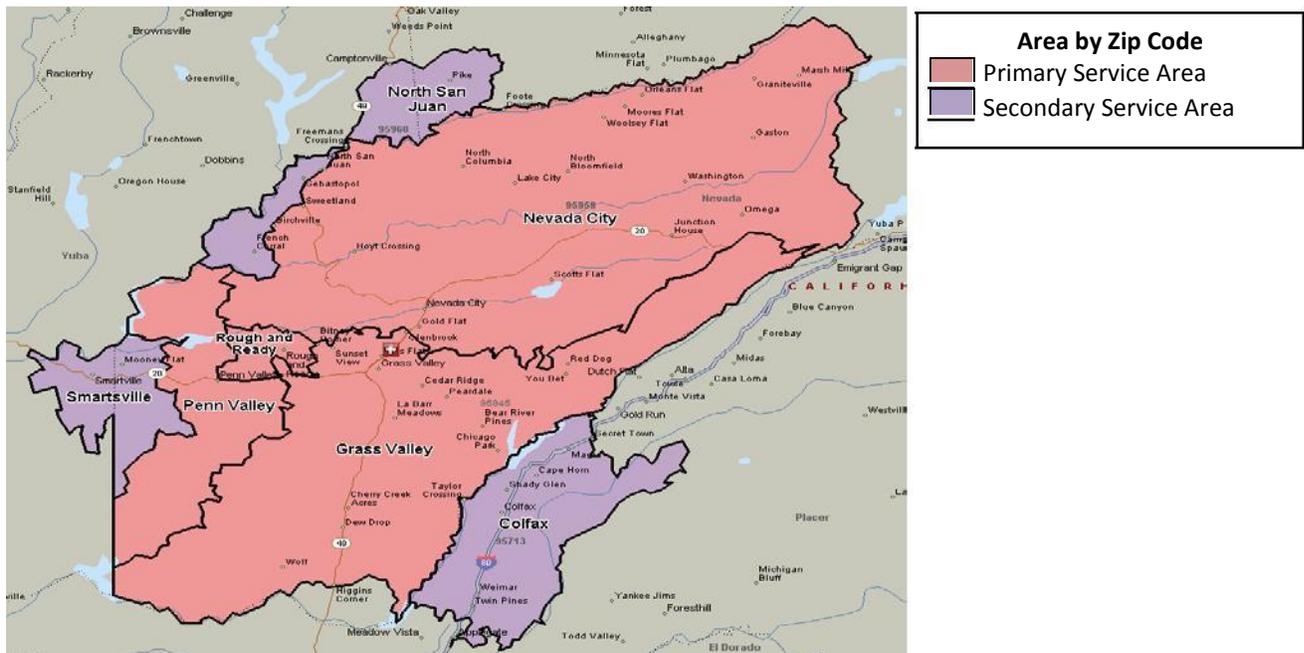
The hospital provides leadership expertise on the boards of numerous other organizations, including the Nevada County Center for the Arts, Nevada County Economic Resource Council, Hospice of the Foothills, BriarPatch Community Market Cooperative, and the Greater Grass Valley Chamber of Commerce.

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 service area is shown on the map below and encompasses five zip codes in the communities of Grass Valley, Penn Valley, Rough and Ready and Nevada City (95949, 95945, 95959, 95975, and 95946). Grass Valley (95945), and Nevada City (95959) are designated Medically Underserved Areas by the Health Resources and Services Administration. The Administration has also designated these two communities, as well as Penn Valley (95946) and Rough and Ready (95975) as Health Professional Shortage Areas.

Sierra Nevada Memorial Hospital Service Area



Description of the Community

Located 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 has experienced a dramatic transformation of its landscape. Following the Gold Rush, open-range cattle grazing, orchards, timber production and deep, hard-rock gold mining became 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 and its salary base includes primarily local service-sector employment and businesses².

² Walker, P., Marvin, S., & Fortman, L. (2003). Landscape changes in Nevada County. *California Agriculture*, 57(4).

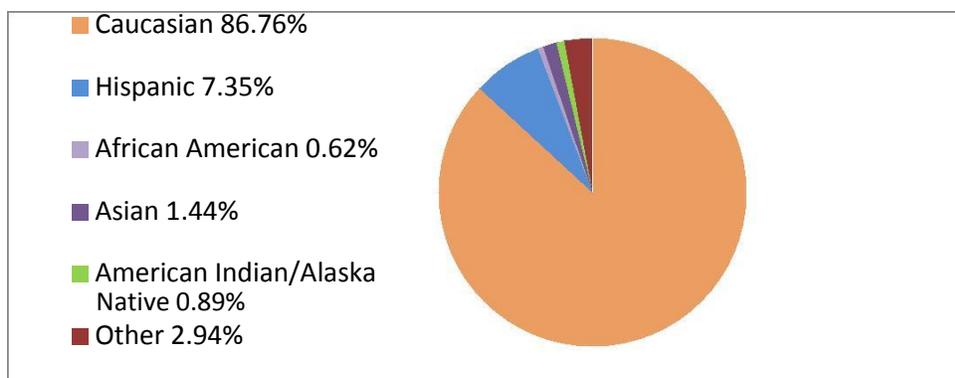
With almost 179,000 acres of national forest and over 15,000 acres of state park land, Nevada County is known for its open space, rural atmosphere and small-town style of life. While a number of health resources are available within its more populated communities, Nevada County’s rural environment contributes to barriers in accessing health care and health-related services for individuals and families living in the country.

While the 2013 Community Health Needs Assessment reflects a substantial list of priority health issues in Nevada County, one of the most significant is the growing concern surrounding the needs of the mentally ill, and the lack of adequate options for care. Another significant factor is the large and growing number of older adults and the challenges they have in finding available resources to help them make difficult transitions in life. In addition to the hospital’s assessment, access to mental health care and the needs of an aging population come to light as major concerns in health status reports issued by the Nevada County Health and Human Service Agency, and other agency reports. Addressing both these concerns are priorities for Sierra Nevada Memorial Hospital.

Demographics of the Community

Nevada County ranks only 36th among the most populated counties in California, and there are 74,069 residents living within the hospital’s primary service area. Other demographics include:

Diversity

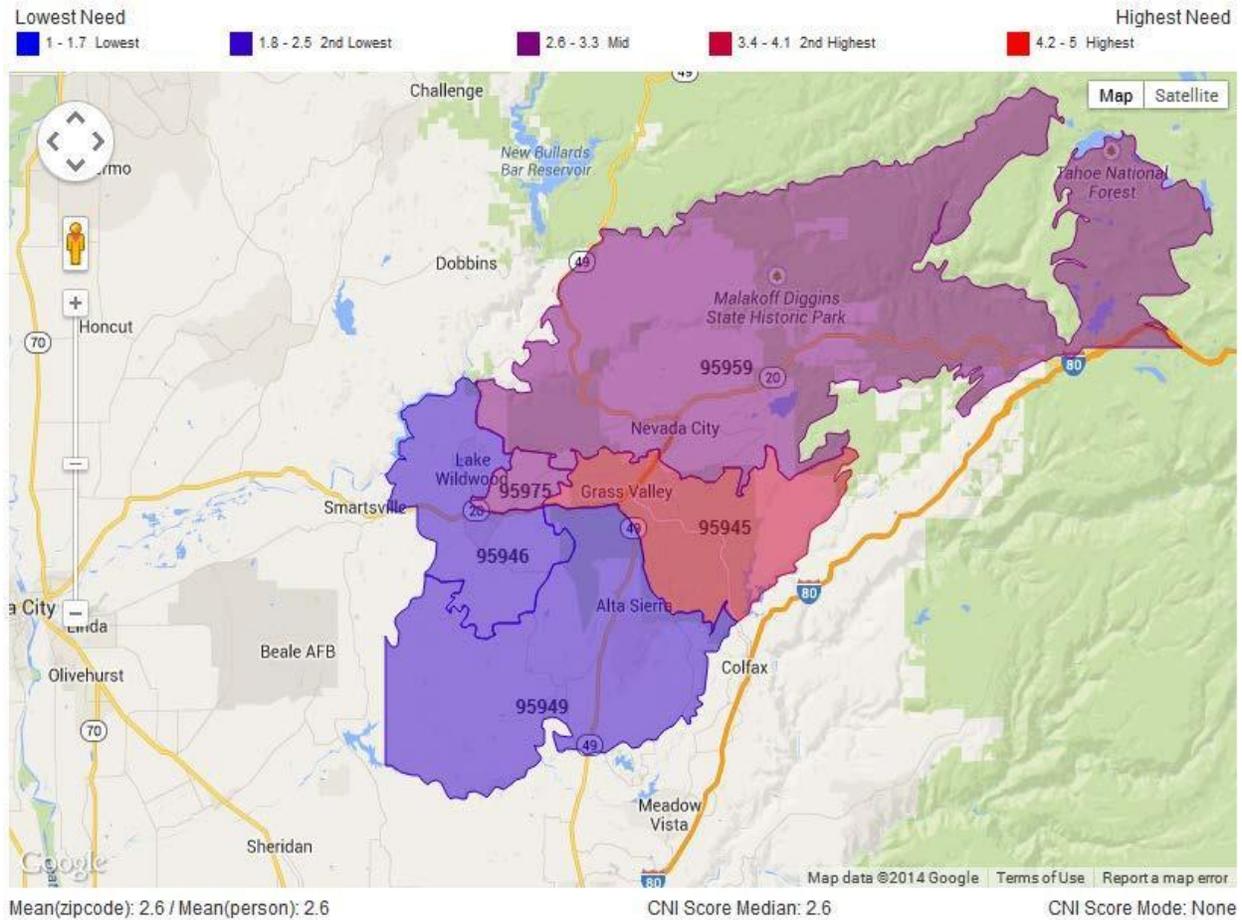


- **Median Income:** \$54,405
- **Uninsured:** 12.91%
- **Unemployment:** 9.4%
- **No High School Diploma:** 5.7%
- **Renters:** 25.1%
- **Community Needs Index Score:** 2.6
- **Medicaid Patients:** 12.2%
- **Other Area Hospitals:**
 - Tahoe Forest Hospital in Truckee, CA (critical access only)
- **Medically Underserved Areas:**
 - Grass Valley – 95945
 - Nevada City - 95959
- **Health Professional Shortage Areas:**
 - Grass Valley – 95945
 - Nevada City - 95959
 - Penn Valley - 95946
 - Rough and Ready - 95975

Sierra Nevada Memorial Hospital Community Needs Index (CNI) Data

The hospital's CNI Score of 2.6 score falls in the middle 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).

Sierra Nevada Memorial Hospital Community Needs Index (CNI) Map: Median CNI Score: 2.6



Zip Code	CNI Score	Population	City	County	State
95945	3.4	24049	Grass Valley	Nevada	California
95946	2	9096	Lake Wildwood	Nevada	California
95949	1.8	19803	Alta Sierra	Nevada	California
95959	2.6	17775	Nevada City	Nevada	California
95975	3.2	1726	Nevada County	Nevada	California

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

Sierra Nevada Memorial Hospital completed its most recent Community Health Needs Assessment in spring of 2013, in partnership with nonprofit research organization, Valley Vision, regional health systems, public health experts, Sierra Health Foundation, and California State University, Sacramento. The process engaged multiple community stakeholders over a nine-month period, that in addition to residents, included school district officials, physicians, leaders of community health and social service organizations.

Study area for the assessment included the hospital’s primary service area. Zip code boundaries were selected as the unit-of-analysis for most indicators to allow for closer examination of health outcomes at the community level, which are often hidden when viewed 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 again, allowed for deeper community level examination. A specific objective was to identify within the hospital’s primary service area, those communities experiencing disparities related to chronic disease and mental health.

The assessment used a mixed methods research approach. Primary qualitative data was obtained from interviews with hospital clinical and community benefit staff members and key informants (area health and community experts). A focus group consisting of 12 community members was conducted with area residents, and phone interviews and website analyses were conducted to assess community health assets. Secondary quantitative data was collected on health, demographic, behavioral, and environmental factors. County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity of health issues. Secondary data collected included information on the specific factors shown in Tables 1 and 2.

Table 1: Emergency Department Visits, Hospitalization, Mortality

Emergency Department 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

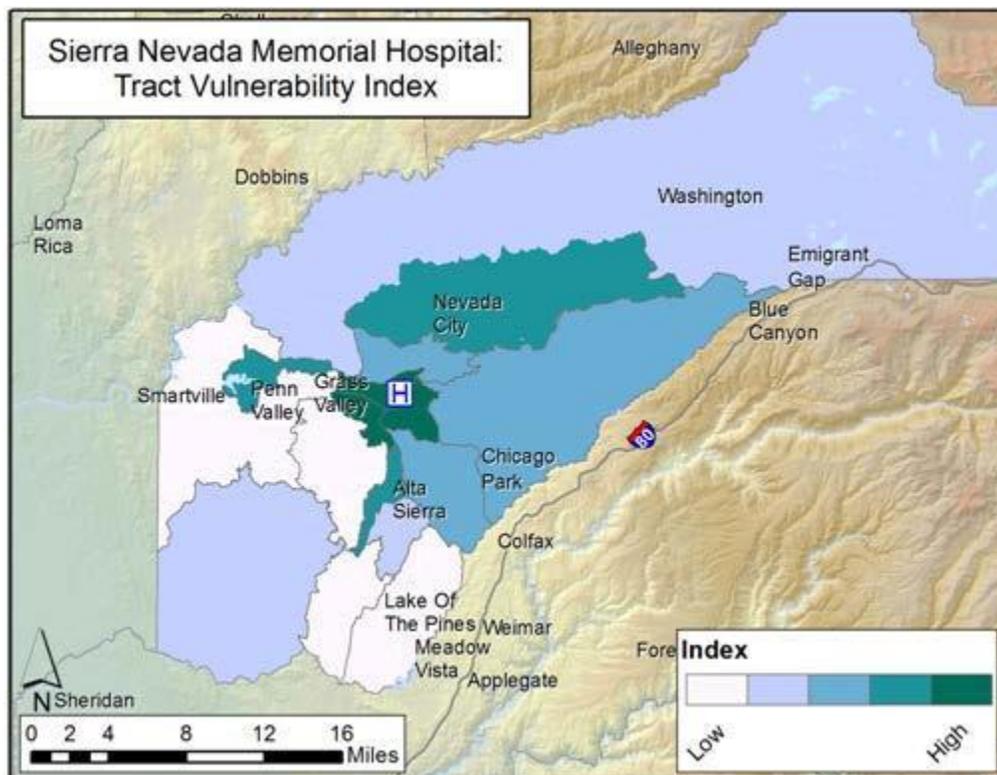
*Age adjusted by 2010 California standard population

Table 2: Socio-Demographic, Behavioral, and Environmental

Socio-Demographic		Behavioral and Environment	
Total Population	Limited English Proficiency	Major Crime	Percent Obese/Overweight
Family Make-up	Percent Uninsured	Assault	Fruit/Vegetable Consumption
Poverty Level	Percent over 25 No High School	Unintentional Injury	Farmers Markets
Age	Percent Unemployed	Fatal Traffic Accidents	Food Deserts
Race/Ethnicity	Percent Renting	Park Access	Retail Food
Physical Wellbeing Profile			
		Age-Adjusted Mortality	Life Expectancy
		Infant Mortality	Health Care Professional Shortage
		Health Assets	

Identifying Vulnerable Communities

Socio-demographics were examined to identify neighborhoods in the hospital's service area with high vulnerability to chronic disease and mental health issues. Race/ethnicity, household make-up, income, and age variables were combined into a vulnerability index that described the level of vulnerability within each census tract. This index was then mapped for the entire service area. A tract was considered more vulnerable, or more likely to have poor health outcomes than others, if it had a 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 of individuals 65 years of age or older. This information helped identify areas that required a greater level of examination and discussion with key informants. The vulnerability index for the hospital's service area is shown below.



Focus Group Selection

Areas selected for the focus group were determined from key informant feedback and through the analysis of health outcome indicators (emergency department 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, an analysis of health outcome indicators by zip code, race and ethnicity, age, and sex revealed communities with high rates that exceeded state and county benchmarks and Healthy People 2020 targets.

Communities of Concern

To identify communities of concern, primary data from key informant interviews, and detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined, as well as rates within zip codes that exceeded county, state, or Healthy People 2020 benchmarks for emergency department utilization, hospitalization, and mortality.

Analysis of data revealed two communities of concern - Grass Valley (95945) and Rough and Ready (95975). These two areas of concern are home to more than 27,000 residents who are highly diverse, have high rates of poverty, low educational attainment, high levels of unemployment, and rent versus own their homes. In Rough and Ready (95975), there are more families in poverty with children and elderly residents 65 years of age or older living in poverty than the national average.

Priority Health Needs

The assessment identified significant priority health issues across the hospital's primary service area. These health issues were seen in greater magnitude within the two communities of concern:

- 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

In particular, lack of access to mental health care and lack of access to preventative health services for chronic illness were consistently mentioned in the qualitative phase of the assessment as conditions affecting many area residents.

Communicating the Results

Results of the assessment have been widely disseminated. Forums to examine the findings were conducted with members of the hospital's Board of Directors, and for departments within the hospital, and copies of the assessment were made available to local government officials and nonprofit community-based organizations across the region. The assessment is posted on the Dignity Health Website, www.DignityHealth.org (see Attachment 1 for the full report), and also available on the Healthy Living Website (www.healthylivingmap.com), a site developed and provided to the public by Sierra Nevada Memorial Hospital and other health system partners.

Assets Assessment

With the hospital's emphasis on collaborating with partners for more impactful health improvement efforts, gaining a more in-depth understanding of the available resources in the community was an important consideration in the assessment process. Nearly 40 community resources were identified and evaluated. The hospital is currently working with a number of these resources, such as local Federally Qualified Health Center, Western Sierra Medical Clinic, FREED Center for Independence, Domestic Violence and Sexual Assault Coalition, and The Friendship Club on initiatives that improve access to care, prevent domestic violence, support troubled teens, and address chronic illness. Through other evolving partnership programs, such as the Integrated Care Coordination for Family Wellness program, and the Mental Health Crisis Stabilization Partnership with Nevada County, the hospital continues to develop strong collaborative relationships in the community.

Implementation Plan Development

In participation with assessment partners and stakeholders, Sierra Nevada Memorial Hospital used the following criteria to evaluate and prioritize community health issues:

1. Magnitude/scale of the problem. The health need emerged consistently through the assessment process as significant and important to a large diverse group of community stakeholders.
2. Severity of the problem. The health need leads to serious effects (co-morbid conditions, mortality and/or economic burden for those affected and the community).
3. Problem linked to high utilization rates. The health need is evidenced by high emergency department and inpatient admissions that could be prevented if adequate resources were available in the community.
4. Internal assets. Sierra Nevada Memorial Hospital has the ability to make a meaningful contribution to respond to the problem through clinical expertise and/or financial resources.
5. Disproportionate impact. The problem disproportionately impacts the health of underserved and vulnerable populations.
6. Evidence-based approaches. There are demonstrated evidence-based practices available that can be applied to effectively address the problem.
7. Assessment trends. The problem consistently emerges as a priority in past assessments.
8. Leveraging resources. There is consensus among stakeholders that the problem is a priority, and there is opportunity to collaborate with others to address the problem.

Through this process of evaluation, three priority health issues were selected from the broader list of priorities identified in the Community Health Needs Assessment as specific areas of focus for the hospital. These include: 1) access to primary, mental and specialty health care; 2) access to preventative health services and education and; 3) access to health care and social support services for the elderly. Initiatives that address these priorities will target vulnerable and at-risk populations, with emphasis on identified communities of concern and collaboration with community partners to maximize efforts and have a greater region-wide impact. Initiatives will also require methodologies be developed to measure and demonstrate health improvement outcomes. Sierra Nevada Memorial Hospital will continue to work with its partners to refine goals and strategies over time to ensure they effectively address the needs identified.

Implementation Strategies/Actions

1. Access to Primary, Mental and Specialty Health Care

The Community Health Needs Assessment determined that many underserved adults in the region do not routinely access health care services, including primary, mental and specialty care, and in many cases do not have a health care home or identified primary care provider. When ill, individuals are more apt to visit the emergency department for conditions that could be effectively treated on an outpatient basis. In other cases, many individuals do not seek health care until conditions have exacerbated into an urgent situation. Several barriers to accessing care came to light in the assessment. While the foothills provide for open space, the rural environment impacts proximity to services. Clinics in the region lack space, and there are not enough physicians who accept Medi-Cal insurance. In fact, nearly all of Nevada County is designated as a Health Professional Shortage Area. Initiatives by the hospital to address access to care take these barriers into consideration, including an active recruitment effort underway to attract physicians to the community.

Western Sierra Medical Clinic Collaboration

Sierra Nevada Memorial Hospital works closely with the region's Federally Qualified Health Center, Western Sierra Medical Clinic, to increase access to care. The clinic is able to operate a second site by

utilizing hospital-owned facilities in the community of Grass Valley at a significantly reduced cost. In FY 2014, the hospital financially supported the clinic's recruitment activities to add OB/GYN services; much needed to address the significant lack of access to prenatal care for underserved women in the region. In Nevada County, 23% of births were identified as having late or no prenatal care, in comparison to 17.2% in California as a whole³. The hospital and clinic also continue to work closely to coordinate the care of patients. The positive impact of this relationship was highlighted by participants in the 2013 Community Health Needs Assessment who noted they received follow-up primary care appointments at the clinic within 72 hours of being released from the hospital or emergency department.

Penn Valley Satellite Lab and X-Ray Clinic

Nearly 300 Medi-Cal-insured and indigent residents received services in FY 2014 at the hospital's Satellite Lab and X-Ray Clinic located in the underserved area of Penn Valley/Rough and Ready. FY 2014 was the first full year of operation for this outpatient facility, which fills a major gap in services in this part of the region.

Mental Health Crisis Support Partnership

A unique partnership continues to evolve between Sierra Nevada Memorial Hospital and Nevada County to address the urgent need for mental health services and the steady increase in residents admitting to the emergency department in crisis. The first phase of the program launched in February of FY 2014 with the placement by the County of a licensed psychotherapist in the hospital's emergency department to support patients in crisis. Specially trained on-call peer counselors are also available at the hospital to support patient needs around the clock. These services are resulting in more timely quality care for patients with acute psychiatric issues; 95 patients on average each month receive treatment. The second phase of the program will be implemented in FY 2015 when the County will establish a four-bed crisis stabilization unit on the hospital campus.

Tele-Psychiatric Care

Sierra Nevada Memorial Hospital has also implemented the use of tele-psychiatry in its emergency department to allow patients to access psychiatric services during a crisis day or night. Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care.

Cancer Nurse Navigator

Nurse navigators at the hospital are effectively supporting the need for specialized care for individuals with breast and lung cancer, and victims of stroke. Introduced by the hospital in FY 2013, the navigation program expanded in FY 2014 to meet a growing demand for services. Patients receive education on treatment options, as well as referrals for follow-up care and education. Navigation services target underserved populations that otherwise would not have access to care.

Integrated Care Coordination for Family Wellness

The hospital is working in partnership with the FREED Center for Independent Living, Community Recovery Resources and Western Sierra Medical Clinic to respond to priority health issues surrounding access to primary, mental and preventative health care and the need to integrate and coordinate these services for vulnerable populations. Integration of services was consistently reported to be an important need by participants in the 2013 Community Health Needs Assessment. Partners in this program underwent cross-

³ 2013 Nevada County Health Status Report. Health and Human Services Agency. Nevada County Public Health Department

training in FY 2014 to understand each other's services and developed a process for seamless referrals. Western Sierra Medical Clinic also established a clinic co-located at Community Recovery Resources. During the startup phase of the program, over 100 residents received one or more partner services, and numbers are expected to increase significantly in FY 2015 as the program expands. As part of the expansion, a FREED navigator will be stationed on the hospital campus to work directly with hospital case managers.

Dignity Health Community Grants Program

Conducted annually by the hospital, the Dignity Health Community Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to care, and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.

2. Access to Preventative Health Services and Education

Chronic disease was consistently mentioned in the 2013 Community Health Needs Assessment as a condition affecting a large number of residents, and has been identified as such in all past assessments. Assessment participants described the lack of available education and support services as major barriers to staying healthy, leading normal lives, and keeping their costs for health care in check. An inability for individuals to manage their chronic disease is also a cause for high emergency department readmission rates. Sierra Nevada Memorial Hospital is one of the few providers in the region addressing the need for health education that focuses on disease prevention and the management of chronic illness. Through the hospital's Wellness Education Department, thousands of residents receive the necessary resources and skills to control health conditions and lead healthier lives. The hospital is expanding these program offerings and specifically targeting underserved residents in more depressed areas of the County through a partnership with Federally Qualified Health Center, Western Sierra Medical Clinic.

Heart Failure Program

A best practice heart disease intervention model at the hospital provides assistance and support to individuals suffering from heart disease. Heart disease is among the top causes of death in Nevada County, and a major cause for hospitalization. The program offers 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 the Heart Failure Program, the hospital offers cardiac rehabilitation programs and classes specifically focused on underserved individuals who lack access to such services.

Diabetes: Take Control!

The active and growing Diabetes: Take Control! program provides education and nutrition counseling to enable residents to better manage diabetes, maintain good health and avoid hospitalization for uncontrolled symptoms. Program workshops follow the evidence-based Stanford University Diabetes Self-Management Program curriculum. The hospital has over 12 facilitators trained to lead workshops, and has trained new program leaders at Western Sierra Medical Clinic to extend the reach of the program.

Better Breather, Pulmonary Rehabilitation, and Smoking Cessation Classes

In response to the high prevalence of Chronic Obstructive Pulmonary Disease and asthma in Nevada County, the hospital offers ongoing Better Breather, Pulmonary Rehabilitation, and Smoking Cessation classes, which are open to all at a reduced cost.

Support Groups

The 2013 CHNA identified several diseases and injuries that cause high levels of stress for patients and family members who provide their care. Hospital-sponsored support groups for cancer, brain injury, stroke and asthma provide complementary resources for medical treatment, and are an opportunity for patients and family members to share their concerns while learning methods for handling difficult situations. Groups are conducted by a trained hospital staff member, and bring people together facing similar issues to share experiences and advice. Benefits include reduced stress, anxiety, loneliness and isolation, improved coping skills and an enhanced understanding of conditions and treatment options.

3. Access to Health Care and Social Support Services for the Elderly

The need for services among older adults represents a significant health factor in Nevada County. One-third of all people residing in the County are over the age of 55, and those who are 65 years of age and older comprise a higher percentage in Nevada County (18.65) than in California as a whole (11.2%)⁴. An aging population living within a rural environment presents unique health challenges, including greater risks for being isolated and depressed, higher rates of injury, chronic illness and physical disabilities (mobility, vision), and difficulties accessing health care and in finding caregivers. Data from the 2013 Community Health Needs Assessment also reflects that emergency department visits for unintentional injury are far greater in Nevada County when compared to state rates, and the majority of injuries are related to falls among the region's growing elderly population. Falls are among the top five reasons for fatal injuries in the County, and also account for 57% of the County's non-fatal hospitalized injuries. Over 75% of injuries due to falls occur in individuals 65 years of age and older⁵. Sierra Nevada Memorial Hospital is addressing the needs of elderly residents in the community in several ways.

Alzheimer's Outreach Program

The hospital's Home Care Department offers an Alzheimer's Outreach Program that serves as a community education, resource and support center. A licensed social worker is dedicated to the program, which offers services, including a "Yes I Can" course that teaches caregivers and families how to provide quality care for those with Alzheimer's who are still living at home and a Caregiver Support Group. The program also 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. Nearly 300 elderly residents benefited from the program in FY 2014.

Falls Prevention Program

Sierra Nevada Memorial Hospital is fulfilling an important need in the community through its Falls Prevention Program. The program is offered at the hospital and in the community to capture a larger number of participants, and consists of education about fall risk factors and prevention strategies for older adults and caregivers. Participants also learn appropriate exercises for enhanced balance and strength. Over 400 residents benefited from this falls prevention program in FY 2014.

Needs Not Prioritized

Sierra Nevada Memorial Hospital responds to the health needs of its community in many ways, and in times that are critical for those in crisis. In addition to providing financial assistance, indigent care and un-

⁴ 2013 Nevada County Health Status Report. Health and Human Services Agency. Nevada County Public Health Department.

⁵ 2013 Nevada County Health Status Report. Health and Human Services Agency. Nevada County Public Health Department.

funded Medi-Cal care, a significant investment is being made to address the three priority health needs outlined in this report. While Sierra Nevada Memorial Hospital has focused on these priority areas, this report is not exhaustive of everything the hospital does to enhance the health of its community. However, the needs in Nevada County are significant and as a small community hospital, Sierra Nevada Memorial Hospital does not have the available resources to develop and/or duplicate efforts to meet them all. The hospital is not directly addressing the lack of county-wide transportation. The Transit Services Division of the Nevada County Department of Public works provides public transit and paratransit services in western Nevada County. The hospital does, however, ensure patients without the means for travel receive transportation. Although not directly addressing the need for access to healthy foods, the hospital participates in the BriarPatch Community Market Cooperative, which is focused on developing healthy food strategies. The City of Grass Valley and Nevada City also provide weekly farmers' markets that offer fresh foods at affordable costs. The hospital does not have the resources or expertise to address the need for dental care, although dental emergencies by patients admitting to the emergency department receive treatment. Chapa-De provides dental services to the underserved population in Nevada County. Sierra Nevada Memorial Hospital has, and will continue, to provide support to enhance these efforts. The hospital will also continue to seek collaborative opportunities that address needs that have not been selected where it can appropriately contribute to addressing those needs.

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% 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 emergency department, 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 providing transportation for those with no means for travel, and provides medications to patients who cannot afford to purchase them. For a number of years, the hospital has provided enrollment assistance for the underserved. These efforts were enhanced in FY 2014 to support implementation of the Affordable Care Act. The hospital hosted enrollment activities in the community and in partnership with Nevada County to provide assistance and education during open enrollment to those seeking coverage through the Health Benefit Exchange and Medicaid expansion.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives

Key community benefit initiatives and community-based programs directly provided, or substantially supported, by Sierra Nevada Memorial Hospital in FY 2014 are summarized below. These initiatives and programs are mapped to align with the three priority health areas selected through the Community Health Needs Assessment process, 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, Mental and Specialty Health Care

- Financial assistance
- Western Sierra Medical Clinic Collaboration
- Penn Valley Satellite Lab and X-Ray Clinic (new in FY 2014)
- Integrated Care Coordination for Family Wellness Program (new in FY 2014, with plans for expansion in FY 2015)
- Mental Health Crisis Support Partnership (new in FY 2014, with plans for expansion in FY 2015)
- Tele-Psychiatric Care for Mental Health (new in FY 2014)
- Cancer and Stroke Nurse Navigation (expanded services in FY 2014)
- Dignity Health Community Grants program
- Physician Recruitment (new in FY 2014)
- Enrollment assistance
- Transportation
- Health screenings (blood pressure, cholesterol, mammograms)

Initiative II: Access to Preventative Health Services and Education

- Heart Failure Program
- Cardiac Rehabilitation
- Diabetes: Take Control!
- Better Breather, Pulmonary Rehabilitation, and Smoking Cessation Classes
- Cancer, Traumatic Brain Injury, Stroke and Asthma Support Groups
- Heart Smart Education
- Variety of Wellness Education Programs:
 - Exercise for Strength and Fitness
 - Nutrition and Healthy Cooking
 - Prenatal Care
- Nutrition Assessments and Counseling

Initiative III: Access to Health Care and Social Support Services for the Elderly

- Alzheimer's Outreach Program
- Falls Prevention Program
- Aging Education (through the Wellness Department)
- Participation in the Falls Prevention Coalition

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Sierra Nevada Memorial Hospital Board of Directors, hospital leadership, and Dignity Health receive updates on program activities and outcomes. The following pages include Program Digests for key programs that address one or more of the initiatives listed above.

DESCRIPTION OF KEY PROGRAMS AND INITIATIVES - PROGRAM DIGESTS

HEART FAILURE PROGRAM

Hospital Priority Areas	<ul style="list-style-type: none"> <input type="checkbox"/> Access to Primary, Mental and Specialty Health Care <input checked="" type="checkbox"/> Access to Preventative Health services and Education <input type="checkbox"/> Access to Health Care and Support Services for the Elderly
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	As identified in the Community Health Needs Assessment, heart failure is a priority health issue in Nevada County and among the leading causes of death. Heart failure is particularly prevalent among the elderly.
Program Description	The program is open to all residents 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 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 Rehabilitation program to complement the Heart Failure Program where participants receive appropriate exercise therapy.

FY 2014

Goal FY 2014	Improve the health and quality of life for those that suffer from heart disease by providing education and skills to better manage their illness and reduce the need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Avoid hospital or emergency department admissions among 60% of participants and enhance the awareness of the program in underserved communities.
Baseline	Heart failure is a priority health issue for Nevada County, identified in past and current Community Health Needs Assessments. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Conduct regular meetings with the program team and expand outreach to increase enrollment.
Result FY 2014	649 participants were served in this program. Less than 15% of the participants readmitted to the hospital 3 months post-intervention.
Hospital's Contribution / Program Expense	\$80,711

FY 2015

Goal 2015	Improve the health and quality of life for those that suffer from heart disease by providing education and skills to better manage their illness and reduce the need to be admitted or readmitted to the hospital.
2015 Objective Measure/Indicator of Success	Avoid hospital or emergency department admissions among 60% of participants; enhance outreach individuals living in underserved parts of the region.
Baseline	Heart failure is a priority health issue for Nevada County, identified in past and current Community Health Needs Assessments. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Conduct regular meetings with the program team and expand outreach to increase enrollment. Focus on improvements in program outcome evaluation.
Community Benefit Category	A3-g Health Care Support Services - Case management post-discharge

CANCER NURSE NAVIGATOR

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Primary, Mental and Specialty Health Care ✓ Access to Preventative Health services and Education ☐ Access to Health Care and Support Services for the Elderly
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 CHNA Vulnerable Population	Breast and lung cancer are leading causes of death in Nevada County. The navigation program demonstrates improvements in the health of participants while offering services free of cost that would not otherwise be accessible.

Program Description The Cancer 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. The hospital provides similar navigator services for stroke victims.

FY 2014

Goal FY 2014	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.
2014 Objective Measure/Indicator of Success	Continue to increase number of underserved assisted through outreach and community collaboration and build awareness of the program within the community.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority need in Community Health Needs Assessments. The program offers necessary resources that would otherwise not be accessible for Medi-Cal and uninsured populations.
Intervention Strategy for Achieving Goal	Promote services in the community and work with establish relationships with partners to increase awareness of services and available resources.
Result FY 2014	1,735 persons served
Hospital's Contribution / Program Expense	\$102,276

FY 2015

Goal 2015	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.
2015 Objective Measure/Indicator of Success	Continue to increase number of underserved assisted through outreach and community collaboration and build awareness of program within the community.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority need in Community Health Needs Assessments. The program offers necessary resources that would otherwise not be accessible for Medi-Cal and uninsured populations.
Intervention Strategy for Achieving Goal	Promote services in the community and work with establish relationships with partners to increase awareness of services and available resources.
Community Benefit Category	A3-g Health Care Support Services - Case management post-discharge

DIABETES – TAKE CONTROL!

Hospital Priority Areas	<input type="checkbox"/> Access to Primary, Mental and Specialty Health Care <input checked="" type="checkbox"/> Access to Preventative Health services and Education <input type="checkbox"/> Access to Health Care and Support Services for the Elderly
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	Diabetes is a significant health issue in Nevada County, and the hospital experiences high numbers of inpatient and emergency department admissions by residents who are unable to control symptoms associated with the disease.
Program Description	The program offers diabetes education and nutritional counseling to help residents better manage this chronic condition, avoid uncontrolled symptoms and hospitalization, and lead healthier, more productive lives. The program focuses on diabetes facts and nutrition and self-management tools and skills, and also offers nutrition consultations.

FY 2014

Goal FY 2014	Improve the health and quality of life for individuals suffering from diabetes by enabling them to manage the symptoms of this chronic illness, providing needed education, and reducing their need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Increase awareness of the program in the community and expand the number of lay leaders necessary to increase workshop offerings to reach a greater number of participants. Specifically, achieve and/or exceed target metric goal – 70% of all participants avoid hospital admission three months post intervention.
Baseline	Diabetes is an identified health issue within the hospital’s community. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regularly evaluate the program for effectiveness, including feedback from participants, and increase outreach to the community and with partners to reach underserved populations.
Result FY 2014	215 participants were served in FY14 and less than 2% were readmitted to the hospital when measured at three month post-intervention intervals.
Hospital’s Contribution / Program Expense	\$19,252

FY 2015

Goal 2015	Improve the health and quality of life for individuals suffering from diabetes by enabling them to manage the symptoms of this chronic illness, providing needed education, and reducing their need to be admitted or readmitted to the hospital.
2015 Objective Measure/Indicator of Success	Increase awareness of the program in the community and expand the number of lay leaders necessary to increase workshop offerings to reach a greater number of participants. Specifically, achieve and/or exceed target metric goal – 70% of all participants avoid hospital admission three months post intervention.
Baseline	Diabetes is an identified health issue within the hospital’s community. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Regularly evaluate the program for effectiveness, including feedback from participants, and increase outreach to the community and with partners to reach underserved populations.
Community Benefit Category	A1-e Community Health Education - Self-help

ALZHEIMER'S OUTREACH PROGRAM

Hospital Priority Areas	<ul style="list-style-type: none"> <input type="checkbox"/> Access to Primary, Mental and Specialty Health Care <input checked="" type="checkbox"/> Access to Preventative Health services and Education <input checked="" type="checkbox"/> Access to Health Care and Support Services for the Elderly
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance

Link to CHNA Vulnerable Population The Alzheimer's Outreach Program addresses a significant and growing health issue due to an aging population within the community, and lack of access to services. Alzheimer's is among the leading causes of death in Nevada County, particularly for females.

Program Description Offered by the hospital's Home Care group, the Alzheimer's Outreach Program offers a series of classes and support groups designed to assist and empower caregivers with knowledge and skills to help them prevent the mental and physical challenges involved in caring for those with Alzheimer's and other forms of dementia. The program teaches caregivers 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 2014

Goal FY 2014 Improve the quality of care and quality of life for those with Alzheimer's and other forms of dementia, and support the special needs of caregivers and family members by providing assistance, education, training and resources.

2014 Objective Measure/Indicator of Success Continue to evaluate the program to align with the needs of the community, and enhance outreach and collaboration in the community to create awareness of this available service.

Baseline The Alzheimer's Outreach Program provides this much needed specialty service that is not available elsewhere in the community. Alzheimer's is among the leading causes of death in Nevada County, particularly for females.

Intervention Strategy for Achieving Goal Continued outreach to the community to create awareness of available services.

Result FY 2014 293 participants served

Hospital's Contribution / Program Expense \$4,102

FY 2015

Goal 2015 Improve the quality of care and quality of life for those with Alzheimer's and other forms of dementia, and support the special needs of caregivers and family members by providing assistance, education, training and resources.

2015 Objective Measure/Indicator of Success Continue to evaluate the program to align with the needs of the community, and enhance outreach and collaboration in the community to create awareness of this available service.

Baseline The Alzheimer's Outreach Program provides this much needed specialty service that is not available elsewhere in the community. Alzheimer's is among the leading causes of death in Nevada County, particularly for females.

Intervention Strategy for Achieving Goal Continued outreach to the community to create awareness of available services.

Community Benefit Category A1-a Community Health Education - Lectures/Workshops

FALLS PREVENTION

Hospital Priority Areas	<input type="checkbox"/> Access to Primary, Mental and Specialty Health Care <input checked="" type="checkbox"/> Access to Preventative Health services and Education <input checked="" type="checkbox"/> Access to Health Care and Support Services for the Elderly
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	The 2013 Community Health Needs Assessment reflects that emergency department visits for unintentional injury are far greater in Nevada County when compared to state rates, and the majority of injuries are related to falls among the growing elderly population in the region. Falls are among the top five reasons for fatal injuries in the County, specifically among the elderly population.
Program Description	The Falls Prevention Program is offered at the hospital and in the community and consists of education about fall risk factors and prevention strategies for older adults and their caregivers. Participants also learn appropriate exercises for enhanced balance and strength. The hospital is also an active participant in the Falls Prevention Coalition of Nevada County.

FY 2014

Goal FY 2014	Reduce the risk of injury by falls through education and prevention strategies for older adults and their caregivers.
2014 Objective Measure/Indicator of Success	Increase awareness about the program through outreach to the community and to health care providers. Through work with the Falls Prevention Coalition, engage additional community partners.
Baseline	Injury and death due to falls, primarily among the elderly population, is a growing concern in Nevada County.
Intervention Strategy for Achieving Goal	Build awareness about the program through outreach to the community to increase participation.
Result FY 2014	428 persons served
Hospital's Contribution / Program Expense	\$2,835

FY 2015

Goal 2015	Reduce the risk of injury by falls through education and prevention strategies for older adults and their caregivers
2015 Objective Measure/Indicator of Success	Increase awareness about the program through outreach to the community and to health care providers. Through work with the Falls Prevention Coalition, engage additional community partners.
Baseline	Injury and death due to falls, primarily among the elderly population, is a growing concern in Nevada County.
Intervention Strategy for Achieving Goal	Build awareness about the program through outreach to the community to increase participation.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops

SUPPORT GROUPS

Hospital Priority Areas	<input type="checkbox"/> Access to Primary, Mental and Specialty Health Care <input checked="" type="checkbox"/> Access to Preventative Health services and Education <input type="checkbox"/> Access to Health Care and Support Services for the Elderly
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to CHNA Vulnerable Population	Several diseases and injuries that cause high stress for patients and family members providing their care were identified in the 2013 Community Health Needs Assessment. Hospital-sponsored support groups address this issue by providing a resource that brings individuals and families together to share experiences and offer emotional support and practical solutions to difficult situations. Support groups are available to all.
Program Description	Support groups are offered for individuals with cancer or brain injury, as well as those who have had a stroke or suffer from asthma, and their family members as an integral component of treatment plans. Groups are conducted by a trained hospital staff member, and bring people together facing similar issues to share experiences and advice. Benefits include reduced stress, anxiety, loneliness and isolation, improved coping skills, control and enhanced education about conditions and treatment options.

FY 2014

Goal FY 2014	Teach individuals and their family members how to cope and adapt to lifestyles that are dictated by their illnesses through group therapy, team building, education and other resources.
2014 Objective Measure/Indicator of Success	Increase awareness of available support groups, focusing specifically on underserved populations who have no access to such services.
Baseline	The program responds to the lack of services in Nevada County that complement medical diagnoses and treatments and provide peer support, mentoring and education.
Intervention Strategy for Achieving Goal	Evaluate effectiveness of the different support groups through participant feedback, and continue to assess the need for these resources.
Result FY 2014	3,435 participants served including patients and their families.
Hospital's Contribution / Program Expense	\$23,302

FY 2015

Goal 2015	Teach individuals and their family members how to cope and adapt to lifestyles that are dictated by their illnesses through group therapy, team building, education and other resources.
2015 Objective Measure/Indicator of Success	Evaluate effectiveness of the different support groups through participant feedback, and continue to assess the need for these resources.
Baseline	The program responds to the lack of services in Nevada County that complement medical diagnoses and treatments and provide peer support, mentoring and education.
Intervention Strategy for Achieving Goal	Continue to evaluate effectiveness of the different support groups through participant feedback, and continue to assess the need for these resources.
Community Benefit Category	A1-d Community Health Education - Support groups

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

The following FY 2014 (for period from 7/1/2013 through 6/30/2014) Classified Summary of Un-sponsored Community Benefit Expense for Sierra Nevada Memorial Hospital was calculated using a cost accounting methodology.

Benefits for Those Living In Poverty	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Financial Assistance	4,976	1,884,731	0	1,884,731	1.4	1.4
Medicaid Means-Tested Programs	25,404	21,003,147	17,187,424	3,815,723	2.9	2.9
Community Services						
Community Benefit Operations	0	60,516	0	60,516	0	0
Community Building Activities	0	16,797	0	16,797	0	0
Community Health Improvement Services	4,522	244,797	0	244,797	0.2	0.2
Financial and In-Kind Contributions	13	489,906	0	489,906	0.4	0.4
Totals for Community Services	4,535	812,016	0	812,016	0.6	0.6
Totals for Those Living In Poverty	38,216	27,013,539	18,675,067	8,338,472	6.3	6.2
Benefits for the Broader Community	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Community Services						
Community Building Activities	22	12,835	0	12,835	0	0
Community Health Improvement Services	6,745	64,911	0	64,911	0	0
Financial and In-Kind Contributions	1,131	583,862	0	583,862	0.4	0.4
Totals for Community Services	7,898	661,608	0	661,608	0.5	0.5
Totals for the Broader Community	7,898	661,608	0	661,608	0.5	0.5
Totals - Community Benefit	46,114	27,675,147	18,675,067	9,000,080	6.8	6.7
Unpaid Cost of Medicare	83,934	62,944,275	47,062,501	15,881,774	12.1	11.9
Totals with Medicare	130,048	90,619,422	65,737,568	24,881,854	18.9	18.6
Grand Totals	130,048	90,619,422	65,737,568	24,881,854	18.9	18.6

Telling the Story

Effectively telling the community benefit story is essential to creating 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 2014 Community Benefit Report and 2015 Implementation Plan will be distributed to hospital leadership, members of the Board of Directors, the hospital's management team, and 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 the Hospital website as well as Dignity Health's Website: www.DignityHealth.org, and on the public website, www.healthylivingmap.com, created by Sierra Nevada Memorial Hospital in partnership with other health systems.

APPENDIX A

Sierra Nevada Memorial Hospital Board of Directors

Sarah Woerner, M.D.
Ed Sylvester Retired CEO Engineering Community Representative
Michele White Retired Human Resources Management Community Representative
Kevin Vaziri President and CEO Woodland Healthcare
Stacy Fore, DDS
Dale Creighton President, SCO Planning and Engineering Community Representative
Andrew Chang, M.D.
Tom W. Brown Community Representative
Kathy Rappath Community Representative
Scott Robertson Community Representative
Katherine A. Medeiros President and CEO 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.