Dignity Health
Woodland Memorial Hospital

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Community Benefit 2018 Report and 2019 Plan

Dignity Health
Woodland Memorial Hospital

A message from

Kevin Vaziri, president and CEO of Woodland Memorial Hospital and Mike Chandler, Chair of the Dignity Health Woodland Memorial Hospital Community Board.

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

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

In fiscal year 2018 (FY18), Woodland Memorial provided $8,675,491 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $13,706,663 in unreimbursed costs of caring for patients covered by Medicare.

Woodland Memorial's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its September 25th, 2018 meeting.

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

Kevin Vaziri
President/CEO

Mike Chandler
Chairperson, Community Board

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At-a-Glance Summary

Community Served	Woodland Memorial is situated in Yolo County, located at 1325 Cottonwood Street in Woodland, CA. The general acute care hospital is a part of Dignity Health and has 720 employees, 108 licensed acute care beds, 17 emergency department beds and 31 inpatient mental health beds. The hospital provides compassionate, high quality health care and services to the residents of Woodland, Davis and the surrounding communities. Less than half of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison and Knights Landing.
Economic Value of Community Benefit	$8,675,491 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $13,706,663 in unreimbursed costs of caring for patients covered by Medicare.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are: 1) Active Living and Healthy Eating 2) Access to Behavioral Health Services 3) Disease Prevention, Management and Treatment 4) Safe, Crime and Violence Free Communities 5) Access to High Quality Health Care and Services 6) Basic Needs (Food Security, Housing, Economic Security, and Education)
FY18 Actions to Address Needs	• Enhanced Mental Health Crisis & Follow-Up: This strategic partnership addresses the limited access to behavioral health services by improving communication and collaboration abilities of the nonprofit agencies involved through direct referrals to lower levels of care which increases the number of individuals served and decrease delays in service. • Congestive Heart Active Management Program (CHAMP®): Establishes a relationship with patients who have heart disease after discharge from the hospital through regular phone interaction to support and education to help manage this disease and monitoring of symptoms or complications. • Resource Connection & Patient Navigator Program: Serves as an access point for vulnerable individuals and families to be connected to primary care/community health and social services, receive case management, education, and enrollment support • Haven House Interim Care Program: Medical respite transitional program that utilizes a four bed house and offers respite for homeless individuals upon discharge from the hospital • Oncology Nurse Navigator: Offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards including patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options.

	• Yolo Adult Day Health Center: Addresses specialty health care and support needs of the elderly and disabled populations by offering a high touch interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. • Human Trafficking Response Program: Focuses on educating staff to identify and respond to victims within the hospital; Provide victim-centered, trauma-informed care; and Collaborate with community agencies to improve quality of care.
Planned Actions for FY19	For FY19, the hospital plans to build upon many of the FY18 initiatives and explore new partnership opportunities with Yolo County, health plans and community organizations. Efforts to enhance patient navigation services in partnership with Empower Yolo will continue while adding additional organizations including health plans, community clinics, and other community resources. Hospital ED staff will work in collaboration with Empower Yolo to identify individuals that need assistance with establishing a medical home and understanding their health coverage and benefits. Woodland Memorial will play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including the launching of a medical respite program in partnership with Yolo Community Care Continuum and Sutter Health. The hospital will continue to focus on access to behavioral health services through the Mental Health Continuum of Care Partnership and in partnership with Yolo County and other community partners.

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

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

MISSION, VISION AND VALUES

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

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

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

Our Vision

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

Our Values

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

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

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

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

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

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About Woodland Memorial Hospital

Woodland Memorial is situated in Yolo County, located at 1325 Cottonwood Street in Woodland, CA. The general acute care hospital is a part of Dignity Health and has 720 employees, 108 licensed acute care beds, 17 emergency department beds and 31 inpatient mental health beds. A wide range of the hospital's medical services have received numerous local and national recognitions and accreditations. Woodland Memorial holds Quality Oncology Practice Initiative certification, is recognized as a Certified Primary Stroke Center by the Joint Commission, and received a Get with the Guidelines® Stroke Gold Plus Quality Achievement award by the American Heart Association/American Stroke Association. The hospital was also recognized as a "Baby Friendly Hospital" by the World Health Organization and the United Nations Children's Fund.

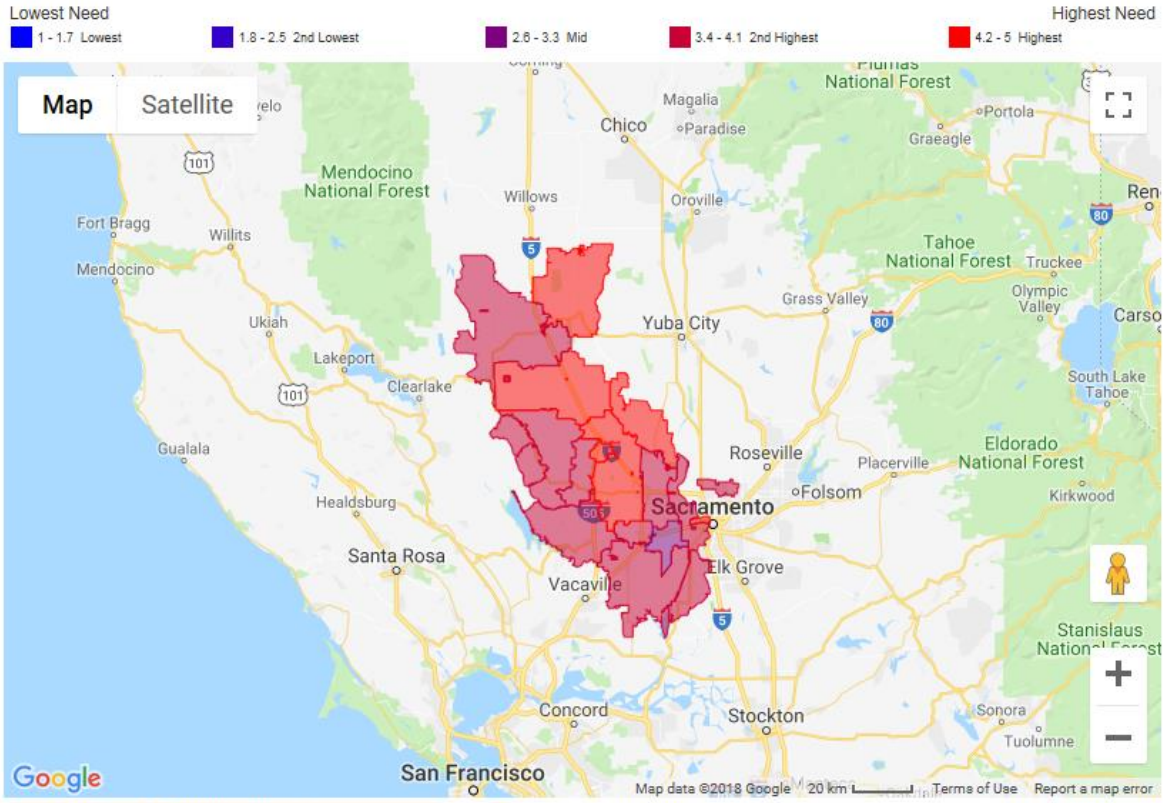
Description of the Community Served

The City of Woodland has a strong historic heritage and serves as the primary support community for agricultural services. Davis is a unique university community internationally known for its commitment to environmental awareness and progressive and socially innovative programs. West Sacramento sits across the Sacramento River and is home to the Port of Sacramento, which ships over a million tons of agricultural products to worldwide markets. Less than half of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison and Knights Landing. Arbuckle and portions of Dixon are designated as Health Professional Shortage Areas by the U.S. government's Health Resources and Services Administration.

Woodland Memorial serves the residents of Woodland, Davis, West Sacramento and the surrounding communities. The community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives 80% of discharges. The hospital's primary service area is comprised of 21 zip codes. A summary description of the community is below, and additional details can be found in the CHNA report online.

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

- Total Population: 280,018
- Hispanic or Latino: 34.7%
- Race: 46.3% White, 2.3% Black/African American, 12.1% Asian/Pacific Islander, 4.6% All Other.
- Median Income: $66,316
- Uninsured: 9.9%
- Unemployment: 4.9%
- No HS Diploma: 15.5%
- CNI Score: 3.8
- Medicaid Population: 27.2%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes



Mean(zipcode): 3.9 / Mean(person): 3.9 CNI Score Median: 3.8 CNI Score Mode: 3.6

Zip Code	CNI Score	Population	City	County	State
95605	4.4	15434	West Sacramento	Yolo	California
95606	3.6	340	Brooks	Yolo	California
95607	3.4	310	Capay	Yolo	California
95612	4	1275	Clarksburg	Yolo	California
95616	3.6	51338	Davis	Yolo	California
95618	3.2	29827	Davis	Yolo	California
95620	4	22444	Dixon	Solano	California
95627	4	4173	Esparto	Yolo	California
95637	3.6	242	Guinda	Yolo	California
95645	4.6	1598	Knights Landing	Sutter	California
95653	3.6	490	Madison	Yolo	California
95673	3.8	15988	Rio Linda	Sacramento	California
95679	3.6	29	Rumsey	Yolo	California
95691	3.8	39875	West Sacramento	Yolo	California
95694	3.8	9653	Winters	Yolo	California
95695	4.2	39985	Woodland	Yolo	California
95698	4.2	333	Zamora	Yolo	California
95776	3.8	25146	Woodland	Yolo	California
95912	4.4	5210	Arbuckle	Colusa	California
95932	4.8	7802	Colusa	Colusa	California
95987	4	6570	Williams	Colusa	California

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

COMMUNITY ASSESSMENT AND PLANNING PROCESS

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

Community Health Needs Assessment

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

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

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

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

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

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

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

Woodland Memorial does not have the capacity or resources to address all priority health issues identified in Yolo County, although the hospital continues to seek opportunities that respond to the needs that have not been selected as priorities. The hospital is not addressing affordable and accessible transportation and pollution-free living and working environments, as these priorities are beyond the capacity and expertise of Woodland Memorial.

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

Creating the Community Benefit Plan

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

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

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

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

The planning and development of each initiative also involves research on best practices to identify existing evidence-based programs and interventions, and relationship strengthening with community-based providers that serve target populations for intended initiatives. Once identified, community-based partners become part of the hospital's core project team. Core project teams for all initiatives meet quarterly, or as needed, to evaluate program progress and outcomes, and to make program changes and/or improvements. When target populations and priority health issues are shared by other Dignity

Health hospitals in the Greater Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

2018 REPORT AND 2019 PLAN

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

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

Report and Plan Summary

Health Need: Active Living and Healthy Eating			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Yolo Food Bank	Woodland Memorial has been a longstanding partner of the food bank and their efforts to coordinate the storage and distribution of over 4 million pounds of food to 19,000 households annually.	☒	☒
Farmer's Market	Working with multiple agencies and local farmers, the hospital hosts a weekly farmers market that offers inexpensive fresh foods.	☒	☒
Nutritional Education and Counseling	The hospital takes advantage of its farmers market as a forum to offer nutrition education and counseling.	☒	☒
Commit2Fit	In partnership with the City of Woodland, a year-round fitness challenge is offered to anyone who lives, works or spends time in Woodland. This free program offers a variety of promotions for gym memberships, health classes, and fitness activities throughout the year for those that register. With a growing participation rate, this collaboration has won the statewide Helen Putnam Award for Excellence in Health and Wellness.	☒	☒
Anticipated Impact: The anticipated result is to increase access to healthy foods and safe activity and improve the knowledge of the community about the importance of living a healthy and active lifestyle.			

Health Need: Access to Behavioral Health Services			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Inpatient Mental Health Services	Yolo County is dependent upon Woodland Memorial as the only source of inpatient mental health treatment in the community. There were over 600 vulnerable and at-risk	☒	☒

	indigent and Medi-Cal insured residents receiving acute psychiatric care in FY18, who otherwise would not have had access to care. The community benefit investment to care for these individuals was nearly $5 million.		
Enhanced Mental Health Crisis & Follow-Up	Evolving through the Community Grants Program, this partnership was developed by the hospital and is focused on building a continuum of care in the community for mental health care working with Suicide Prevention of Yolo County and Yolo Community Care Continuum which operates the Safe Harbor crisis residential treatment facility. In the first half of FY18, Yolo Family Service Agency (YFSA) served as the third partner in the collaboration. As part of the FY18 cycle, Davis Community Meals was added in replacement of YFSA to address additional needs identified by the partners and community. The primary goal of the program is to link individuals who admit to the hospital and do not need inpatient mental health treatment to crisis residential treatment services at Safe Harbor and/or follow-up outpatient mental health care in a community setting. Significant partnership enhancements are being made in FY19 to respond to the ongoing need for case management in the community setting and provide additional services for those experiencing homelessness.	☒	☒
Prevention Wraparound and Peer Parent Partner Services	Yolo Crisis Nursery in collaboration with Stanford Youth Solutions and Yolo County Children's Alliance will provide access to wrap-around and peer parent partner services to families at risk of child abuse or neglect and involvement with the child welfare system. In partnership with the Birth Center at Woodland Memorial Hospital, the community organizations will also provide services to families in areas of highest need to keep them healthy and whole. Through Community Grants, this program also addresses the Active Living and Healthy Eating priority.	☒	☒
Baby & Me	Free support group for primary caregivers of infants from 0 to 9 months. Led by a Dignity Health educator, the group aims to empower parents, minimize post-partum depression, create friendships, and act as a safety net for individuals navigating the first months of a child's life. This program addresses a variety of priority health needs in addition to behavioral health services.	☒	☒
Anticipated Impact: The hospital's initiative to address access to behavioral health services are anticipated to result in: improve patient linkages to outpatient behavioral health services; provide a seamless transition of care; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.			

Health Need: Disease Prevention, Management and Treatment			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Healthy Lives (Vida Sana)	The hospital offers this six week course, which is based on the Stanford Chronic Disease Self-Management Program, to residents who have, or are at risk of diabetes, with an emphasis on outreach to the Hispanic community in partnership with Holy Rosary Church. The program is taught in Spanish and in English and engages participants in learning to recognize the signs and symptoms of diabetes. Participants are also taught proper nutrition, healthy eating habits, and medication management.	☒	☒
Diabetes Care Management Program	This program takes Woodland Memorial's focus on diabetes to the next level. High risk individuals with uncontrolled diabetes are involved in bimonthly diabetes group medical appointments, and monitored closely via phone by case managers. They also receive more in-depth individual counseling from a nurse certified diabetic educator, primary care case manager, or registered dietitian, who work closely with primary care providers.	☒	☒
Congestive Heart Active Management Program (CHAMP®)	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits. In FY18, the program received a Mercy Foundation grant for the purchase of scales, blood pressure cuffs and oximeter to better evaluate patients during phone consultations.	☒	☒
Mercy Faith and Health Partnership	This interfaith community outreach program supports the development of health ministry programs including healthcare professionals, clergy and other interested members who have a desire to focus on health promotion and disease prevention programs within their congregations. Providing education, advocacy and referrals for available resources within the congregation, health ministry teams do not duplicate available services, such as nursing or medical care, but seek to creatively bridge gaps in healthcare.	☒	☒
Multiple Sclerosis Support Group	Education and support are offered monthly to those affected by multiple sclerosis. Average group attendance varies between 10 and 15.	☒	☒

Migrant Center Visits	The hospital sends a health educator to various centers to do a health screening and counseling for their residents. A follow-up visit is done three months later to track the status and offer additional support.	☒	☒
Healthy Living Outreach & Screenings	Collaborating with various community organizations, the hospital participates in 20+ health fairs each fiscal year where a plethora of screenings are offer dependent on the target audience.	☒	☒
Anticipated Impact: The initiative to address this health need by the hospital is anticipated to result in: reduction of hospital admissions for chronic disease related; improve the health and quality of life for those who suffer from chronic illness; enable participants to better manage their disease; and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.			

Health Need: Safe, Crime and Violence Free Communities			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Human Trafficking Response Program	The Human Trafficking Response Program initiative focuses on: • Educating staff to identify and respond to victims within the hospital; • Provide victim-centered, trauma-informed care; • Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration.	☒	☒
Empower Yolo	Empower Yolo provides twenty-four hour crisis intervention, emergency shelter, confidential counseling, training, legal assistance, and other services for individuals and families persons affected by domestic violence, sexual assault, stalking, human trafficking, and child abuse. The hospital is partnering with the organization to ensure victims of domestic assault and human trafficking are connected to appropriate community resources. Empower Yolo is also assisting in training hospital staff of available services when a victim is identified.	☒	☒
Anticipated Impact: The initiative to address safe, crime, and violence free communities are anticipated to result in: prevent unsafe environments; improve safety for the patient population served; provide education to all hospital staff on trauma informed care; increase the awareness of services available; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.			

Health Need: Access to High Quality Health Care and Services			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Yolo Adult Day Health Center	The hospital is the primary provider in Yolo County that addresses specialty health care and support needs of the elderly and disabled populations through the Adult Day Health Center. The Center offers a high touch interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. The Center specializes in high touch chronic disease management with the added components of caregiver respite, transportation, nutrition, education, and socialization.	☒	☒
Yolo Healthy Aging Alliance	The hospital is collaborating with the Yolo Healthy Aging Alliance to increase awareness and care intervention skills for those dealing with persons suffering from dementia and to develop a referral and care planning program engaging community resources. Training has been provided to hospital staff and ongoing efforts will continue to provide education on community resources. The alliance has conducted cross training, bringing providers and community-based organizations together to begin building relationships and share information on services and referral processes.	☒	☒
CommuniCare Capacity Building	The hospital has made a five year commitment to help this Federally Qualified Health Center build a new full-service clinic in Woodland, which is providing much needed new capacity for primary, behavioral and dental health care, health education and patient support services for underserved populations.	☒	☐
Resource Connection & Patient Navigator Program	The hospital partners with community nonprofit, Empower Yolo, to offer this resource, which serves as an access point for vulnerable individuals and families to be connected to community health and social services, receive case management, education, and enrollment support. In May of 2018, services were expanded to include Emergency Department Navigation services which will continue to be the main emphasis of the program. The focus will be on connecting individuals to primary care providers in the community and assisting in establishing a medical home and follow up care post emergency department visit.	☒	☒
Oncology Nurse Navigator	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology	☒	☒

	navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.		
Anticipated Impact: The hospital's initiatives to address access to high quality health care and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; and improve collaborative efforts between all health care providers.			

Health Need: Basic Needs (Food Security, Housing, Economic Security and Education)			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Haven's House	A partnership between Woodland Memorial, Sutter Davis, and the Yolo Community Care Continuum, Haven House is a medical respite transitional program that utilizes a four bed house and offers respite for homeless individuals upon discharge from the hospital. In Fy19, the program will provide temporary shelter as well as linkage to supportive services to patients who have been cleared from a local hospital, yet remain medically fragile and do not have a safe place to go. Woodland Memorial committed $65,000 in FY18 to launch the program.	☐	☒
Anticipated Impact: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option.			

Community Grants Program

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

In FY18, the hospital awarded two grants totaling $82,717. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	**Project Name**	**Amount**
Yolo Crisis Nursery	Prevention Wrap Around and Peer Parent Partner Services	$32,717

Yolo Community Care Continuum	Enhanced Mental Health Crisis Partnership and Follow-up	$50,000

Anticipated Impact

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

Planned Collaboration

Human Trafficking Response Program

Since initiative launch in FY15, nearly 9,500 employees within the service area have received education on red flag and response protocols to identify and connect vulnerable patients with qualified community resources. FY19 will continue to expand this education along with implementing advanced training on victim-centered and trauma-informed care within emergency department, family birth center, care coordination, and spiritual care staff. The hospital will continue to strengthen meaningful collaboration with community stakeholders that focus on recovery, prevention and reintegration. Partners include:

- Empower Yolo
- Opening Doors
- WEAVE
- Yolo County District Attorney's Office

Homeless Initiatives

Woodland Memorial, in collaboration with a variety of partners including Yolo County, County and City elected officials, Sutter Davis Hospital and many community service providers, are working together to address the issue of homelessness and develop innovative solutions to enhance the continuum of care. This includes assessing the current services and collaborative meetings taking place while identifying the areas in which the county is experiencing the most challenges. Woodland Memorial is a very active participant in the effort and continues to be engaged in several conversations. Such initiatives include:

1) Woodland Multidisciplinary Team (MDT): In partnership with Yolo County Health and Human Services Agency, the focus of the MDT is to coordinate interventions and support, share resources, and decrease duplication efforts among the partner agencies assisting individuals and families living homeless in Yolo. The meetings have expanded to including individual community members to be present and participate in developing their own care plans. Partners include:
    - City of Woodland Police Department
    - Yolo County HHSA

- Yolo County District Attorney
- Yolo County Public Defender's Office
- Yolo County Sheriff
- Yolo County Housing
- Yolo Community Care Continuum
- CommuniCare Health Center
- Fourth and Hope
- Sutter Davis Hospital

2) Haven's House Interim Care Program: Through multi-agency collaboration, Haven House was developed in late FY18 with services starting in early FY19. The medical respite transitional program utilizes a four bed house to offer respite and recuperative services for homeless individuals upon discharge from the hospital. The program will provide temporary shelter as well as linkages to supportive services to patients who have been cleared from a local hospital, yet remain medically fragile and do not have a safe place to go. Outreach efforts continue to leverage additional partnerships based on the needs of the guests served. Original partners include Yolo Community Care Continuum and Sutter Davis Hospital.

Promotores Conference

The Yolo County Promotores/Community Health Workers (CHW) is a group aimed to advance the work of Promotores and CHWs to reach underserved populations and decrease health disparities. The annual conference brings this group together to network and provide education facilitating communication, providing added skills, provide a forum to collaborate and build capacity. Professional development is also provided through an assortment of relevant and timely workshops. Partners include:

- Communicare Health Center
- Winters Healthcare
- Yolo County Children's Alliance
- Empower Yolo
- Vison y Compromiso

Road to Healthy Moms

The partnership seeks to develop a system of care that develops and strengthens a community – clinical partnership to improve clinical and social outcomes for women along their perinatal life course, regardless of where they present for care. The program promotes patient, family and community involvement in strategic planning and improvement activities and is focused on low income women who receive or can receive perinatal care (preconception and inter-conception) through Dignity Health Services. The plan is to pilot the project in Yolo County with the goal of scaling to other local health jurisdictions in California. Through collaboration between Dignity Health/Woodland Healthcare and the local public health program, leveraging the AHRQ Community Clinical Linkages, the goal is to demonstrate that any state or county that has a hospital/healthcare system and a public health department can join forces to create a system of care that is coordinated and continuous for women during their child bearing years. The initial partners include Yolo County Public Health and Woodland Memorial but additional organizations will be added with the focus of forming and sustain partnerships and relationships among hospital, clinical, community and public health organizations to fill the gaps that exist in addressing maternal mental health and wellness.

Financial Assistance for Medically Necessary Care

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

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

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

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

Program Digests

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

Congestive Heart Active Management Program (CHAMP®)	
Significant Health Needs Addressed	☐ Active Living and Healthy Eating ☐ Access to Behavioral Health Services ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ✓ Access to High Quality Health Care and Services
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through: - Regular phone interaction to support and education to help manage this disease. - Monitoring of symptoms or complications
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.
FY 2018 Report	
Program Goal / Anticipated Impact	Improve the health and quality of life for those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
Measurable Objective(s) with Indicator(s)	Increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Establish collaboration between CHAMP®, the new Patient Navigator Program and the hospital's Readmission team to increase referrals. Provide ongoing education to community clinics about available services.
Intervention Actions for Achieving Goal	Regular meetings with the CHAMP® Team and continued partnership building with Federally Qualified Health Centers to connect heart failure patients to a medical home with assistance from the patient navigators as needed.
Planned Collaboration	CHAMP® currently works with the care coordinators at the hospitals, patient navigators, and community clinics.
Program Performance / Outcome	436 participants enrolled in the program and only 6% readmitted to the hospital 30 days post intervention.
Hospital's Contribution / Program Expense	$42,979
FY 2019 Plan	
Program Goal / Anticipated Impact	Improve the health and quality of life for those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
Measurable Objective(s) with Indicator(s)	Continue to increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Strengthen collaboration between CHAMP®, the Patient Navigator Program and the hospital's Readmission team to increase referrals. Provide ongoing education to community clinics about available services and improve communication between CHAMP staff and primary care providers.
Intervention Actions for Achieving Goal	Regular meetings with the CHAMP® Team and continued partnership building with Federally Qualified Health Centers to connect heart failure patients to a medical home with assistance from the patient navigators as needed.
Planned Collaboration	CHAMP® currently works with the care coordinators at the hospitals, patient navigators, and community clinics.

Oncology Nurse Navigator	
Significant Health Needs Addressed	✓ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ✓ Access to High Quality Health Care and Services
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit around their diagnosis and treatment options. The program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.
FY 2018 Report	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and improve patient/doctor relationships.
Measurable Objective(s) with Indicator(s)	Increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners. Continue to provide education within the community setting.
Intervention Actions for Achieving Goal	Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with the Resource Connection staff and community clinics who serve the underserved.
Planned Collaboration	Oncology nurse navigators work with a variety of community partners in terms of finding available services as well as receiving referrals for patients who need assistance
Program Performance / Outcome	3,365 persons served -- shared by Dignity Health hospitals in Sacramento and Yolo Counties.
Hospital's Contribution / Program Expense	$60,692 which is a shared by Dignity Health hospitals in Sacramento and Yolo Counties.
FY 2019 Plan	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and improve patient/doctor relationships.
Measurable Objective(s) with Indicator(s)	Continue to build awareness to increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.
Intervention Actions for Achieving Goal	Continue to promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with the Resource Connection staff operated by Empower Yolo and community clinics who serve the underserved.
Planned Collaboration	Oncology nurse navigators work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance.

Resource Connection & Patient Navigator Program	
Significant Health Needs Addressed	✓ Active Living and Healthy Eating ☐ Access to Behavioral Health Services ☐ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ✓ Access to High Quality Health Care and Services
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Located on the hospital's campus, a Resource Connection center provides a one stop access point for community services and health education in both Spanish and English including linkages to primary care, health insurance enrollment assistance, health education, case management and community referrals. In the second half of FY18, major emphasis was placed on emergency department navigation.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2018 Report	
Program Goal / Anticipated Impact	Increase access to healthcare services and other social support services for underserved populations; develop a more comprehensive referral system to ensure patients utilizing the emergency department are being connected with community resources.
Measurable Objective(s) with Indicator(s)	Increase numbers served by 10% or greater. Improve methods of outcomes measurement including referral sources and follow-up of services received. Look to build capacity and make program more visible for potentially referring patients utilizing the emergency department for non-urgent care to a clinic or provider.
Intervention Actions for Achieving Goal	Continue to build relationship between the Resource Center and case management, emergency department and other staff at the hospital.
Planned Collaboration	The Resource Connection is a partnership between the hospital and community nonprofit, Empower Yolo.
Program Performance / Outcome	182 unique individuals served and connected to a variety of community resources including primary care.
Hospital's Contribution / Program Expense	$48,888
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to increase access to community healthcare services by focusing on emergency department navigation. Empower Yolo will work closely with the ED staff to ensure individuals utilizing the ED for non-urgent care needs are assisted with establishing a medical home and follow up appointment in a more appropriate setting.
Measurable Objective(s) with Indicator(s)	Program will be measured by improved access for patients in the community setting; reduced emergency department primary care visits; increased linkages to additional community resources; and reduced costs.
Intervention Actions for Achieving Goal	Focus on strengthening relationship between the patient navigators and case management, emergency department, other staff at the hospital. Build relationships with community clinics and local health plans to ensure access is available.
Planned Collaboration	The Resource Connection is a partnership between the hospital and community nonprofit, Empower Yolo. The Resource Connection will continue to focus on implementing services and partnerships into the ED in FY19. This will include increasing hospital staff engagement, building on existing partnerships and also creating new, community-based partners such as federally qualified health centers, service providers and managed Medi-Cal health plans.

Yolo Adult Day Health Center (YADHC)	
Significant Health Needs Addressed	☐ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ✓ Access to High Quality Health Care and Services
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Yolo Adult Day Health Center (YADHC), operated by the hospital, targets adults at high risk of hospitalizations due to complex chronic conditions impacting independent living. A strong medical, social and rehabilitation interdisciplinary service approach is offered to promote the well-being, dignity and self-esteem of individuals, and their caregivers.
Community Benefit Category	C3-Hospital Outpatient Services
FY 2018 Report	
Program Goal / Anticipated Impact	Provide comprehensive interdisciplinary support for a growing vulnerable elderly and disabled population that otherwise would go without adequate community-based interventions to minimize need to transition to a higher level of care. Care model addresses medication management, care coordination, functional issues, psycho-social needs and caregiver stress.
Measurable Objective(s) with Indicator(s)	Focused outreach and educational efforts that target underserved in the community, and enhance collaborative community partnerships to ensure resources are available. Programmatically, ADHC support reduces hospitalization and ED use by 23%.
Intervention Actions for Achieving Goal	Outreach in community and among physicians to increase awareness of, and access to, center services for elderly in need.
Planned Collaboration	YADHC works collaboratively with the others that focus on the same target population such as the Yolo Healthy Aging Alliance, Yolo Hospice, Yolo County Health Council, Yolo County Adult and aging Commission, Senior Link of Yolo County and others.
Program Performance / Outcome	YADHC currently serve 88 families with an average daily attendance of 55 and the waiting list is at 54.
Hospital's Contribution / Program Expense	$563,673 total contribution into Yolo Adult Day Care Center.
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to provide care for a growing vulnerable elderly and disabled. To address growing wait list, Dignity Health is actively working to identify an expanded program space as well as piloting a community-based nurse navigation program in collaboration with occupational therapy support.
Measurable Objective(s) with Indicator(s)	Focused outreach and educational efforts that target underserved in the community, and enhance collaborative community partnerships to ensure community members have access to a variety of resources. Continue measuring outcomes associated with the prevention of hospital admissions. Collaborate with Yolo County to increase capacity.
Intervention Actions for Achieving Goal	Continue outreach in community and among physicians to increase awareness of, and access to, center services for elderly and disabled individuals in need. Explore the possibility of moving physical location to increase capacity.
Planned Collaboration	YADHC works collaboratively with the hospital, community partners, Yolo County, and coalitions that focus on the same target population such as the Yolo Healthy Aging Alliance, Yolo Hospice, Yolo County Health Council, Yolo County Adult and aging Commission, Senior Link of Yolo County and others.

Enhanced Mental Health Crisis & Follow-up	
Significant Health Needs Addressed	☐ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management, and Treatment ✓ Safe, Crime and Violence Free Communities ☐ Access to High Quality Health Care and Services
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	This strategic partnership addresses the limited access to behavioral health services by improving communication and collaboration abilities of the nonprofit agencies involved. The project facilitates direct referrals to lower levels of care which increases the number of individuals served and decreases delays in service; moreover, it improves the quality of services by providing comprehensive follow-up services designed to increase the efficacy of treatment and decrease recidivism due to a recurrence of symptoms.
Community Benefit Category	E2-a Grants - Program grants
FY 2018 Report	
Program Goal / Anticipated Impact	All individuals served by the project will experience greater access to non-crisis resources and will not present for mental health emergency services for at least 6 months post involvement in the project.
Measurable Objective(s) with Indicator(s)	The program will improve access to mental health treatment for residents who have not been served in the traditional mental health system by addressing the current gap in after-hours resources for individuals living in high need areas of our community.
Intervention Actions for Achieving Goal	Expand access to mental health care by providing telephone support and referrals, crisis residential services and resource coordination, and follow up counseling services to identified individuals.
Planned Collaboration	This is a partnership between the hospital, Suicide Prevention Yolo County, Yolo Community Care Continuum and a new partner, Davis Community Meals, which was added in the second half of FY 18 and replaced Yolo Family Service Agency.
Program Performance / Outcome	Across all three partners, 63 persons received services which included 17 crisis residential referrals to YCCC Safe Harbor and 46 successful follow-up contacts.
Hospital's Contribution / Program Expense	$50,000
FY 2019 Plan	
Program Goal / Anticipated Impact	All individuals served by the project will experience greater access to non-crisis resources and follow up support and services enhancing the continuum of care.
Measurable Objective(s) with Indicator(s)	Improve access to mental health treatment for our most vulnerable residents who have not been served in the traditional mental health system by addressing the current gap in after-hours resources for individuals living in high need areas of our community. The efforts will result in the reduction of hospital services required by individuals served.
Intervention Actions for Achieving Goal	This collaborative program will continue to expand access to mental health care by providing telephone support and referrals, crisis residential services and resource coordination, and follow up counseling services to identified individuals. By facilitating lower levels of care through comprehensive follow-up, the program partners will be able to increase the efficacy of treatment and decrease recidivism through ongoing symptom management.
Planned Collaboration	This is a partnership between the hospital, Suicide Prevention Yolo County, Yolo Community Care Continuum and new partner, Davis Community Meals.

ECONOMIC VALUE OF COMMUNITY BENEFIT

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

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Living in Poverty			
Financial Assistance	**1,104**	**1,959,717**	**1.1**
Medicaid *	**21,858**	**5,019,878**	**2.8**
Means-Tested Programs	**90**	**47,360**	**0.0**
Community Services			
A - Community Health Improvement Services	1,342	196,255	0.1
E - Cash and In-Kind Contributions	1,668	465,489	0.3
F - Community Building Activities	0	4,808	0.0
G - Community Benefit Operations	0	153,506	0.1
Totals for Community Services	**3,010**	**820,058**	**0.5**
Totals for Living in Poverty	**26,062**	**7,847,013**	**4.4**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	2,702	49,661	0.0
B - Health Professions Education	484	173,508	0.1
C - Subsidized Health Services	357	563,673	0.3
E - Cash and In-Kind Contributions	13,264	30,975	0.0
F - Community Building Activities	1,450	10,661	0.0
Totals for Community Services	**18,257**	**828,478**	**0.5**
Totals for Broader Community	**18,257**	**828,478**	**0.5**
Totals - Community Benefit	**44,319**	**8,675,491**	**4.9**
Medicare	**20,589**	**13,706,663**	**7.7**
Totals with Medicare	**64,908**	**22,382,154**	**12.6**

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

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $8,494,387.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Woodland Healthcare Community Board Roster

Mike Chandler, Chair Retired Yocha Dehe Fire Chief	Roger Clarkson, Vice Chair Retired Yolo County Health Department
Lori Aldrete, Secretary President, Aldrete Communications	Tim Bernard, DPM Woodland Clinic Medical Group
Calvin Handy Retired UC Davis Police Chief	Eric Mitchel, MD Mercy Medical Group
Betsy Marchand, Retired Yolo County Board of Supervisors	Rafael Rodriguez, MD Diagnostic Pathology Medical Group
Justin Chatten-Brown, MD Woodland Emergency Group Emergency Services Medical Director	Michelle Ing, PA Woodland Clinic Medical Group
Kevin Vaziri Woodland Memorial President	Laurie Harting Dignity Health Senior Vice President, Operations

Woodland Memorial Community Health Advisory Committee Roster

Betsy Marchand, Chair Retired Yolo County Supervisor	Heidi Mazeres Manager, Education Woodland Memorial Hospital
Janlee Wong Executive Director California Chapter of the National Association of Social Workers	Gina Daleiden Executive Director First 5 Yolo
Tico Zendejas Executive Director, RISE, Inc.	Tandy Burton Director of Behavioral Health Services Woodland Memorial Hospital
Calvin Handy Retired UC Davis Police Chief	Rachel Raymond Deputy District Attorney Yolo County District Attorney's Office
Dr. Sarada Mylavarapu Chief Medical Officer Woodland Memorial Hospital	Ashley Brand Director, Community Health and Outreach Dignity Health Sacramento Service Area
Liza Kirkland Manager, Community Health and Outreach Dignity Health Sacramento Service Area	Katie Curran Manager, Community Relations Woodland Memorial Hospital
Diana Landeros Community Health Specialist Dignity Health Sacramento Service Area	

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

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

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

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

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

- Doula Program – Woodland Memorial implemented the doula program that offers free doula services to any mother who is delivering at the hospital. In addition, the hospital provides the environment to train doula's which then makes them eligible to become a certified doula through the International Childbirth Association (ICEA). Training includes: 16 hours of classroom training (fulfills the ICEA Doula Training and Support Workshop requirement); labor support experience; required childbirth classes; and mentorship from seasoned doulas and nurses as individuals work through the certification process.

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

- Yolo County Health Council – This committee serves as a liaison between the Yolo County Board of Supervisors and health systems. It establishes and maintains the area-wide health planning and activities identifying health goals and needs of Yolo County. The council aims to develop and improve health services in the county.

- Healthy Yolo Coalition – The hospital participates in this collaborative initiative led by Yolo County Public Health Department which is focused on engaging and mobilizing the community in addressing public health issues and identifying strategies to improve the quality of life.

- Davis Movies in the Park – Woodland Memorial serves as the presenting sponsor which brings hundreds of families to each movie showing, providing a free, safe, family friendly activity in a local park. The hospital allowed for this activity to remain through their support after other funding sources were discontinued.

Additionally, members of the hospital's leadership and management teams volunteer time and expertise as board members and/or volunteers of nonprofit health care organizations and civic and service agencies, such as the Woodland Chamber of Commerce, Davis Chamber of Commerce, Empower Yolo, Woodland Community College Foundation and Partnership Health Plan of California. Annual sponsorships support multiple programs, services and fund-raising events of organizations; among them, CommuniCare Health Center, Yolo Health Aging Alliance, Yolo Community Care Continuum, Yolo Family Service Agency, Yolo Crisis Nursery and American Heart Association.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

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

Free Care

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

Discounted Care

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

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

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

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

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

Woodland Memorial Hospital 1325 Cottonwood St, Woodland, CA 95695 | Financial Counseling 530-662-3961 ext. 4559 **Patient Financial Services** 888-488-7667
https://dignityhealth.box.com/s/pc4wm268paz3oyfc5kg7gd81p4mfrnoa]