



# **WOODLAND HEALTHCARE**

## **COMMUNITY BENEFIT REPORT 2013 COMMUNITY BENEFIT IMPLEMENTATION PLAN 2014**

A message from Kevin Vaziri, President and CEO of Woodland Healthcare, and Marianne MacDonald, Chair of the Woodland Healthcare Community Board

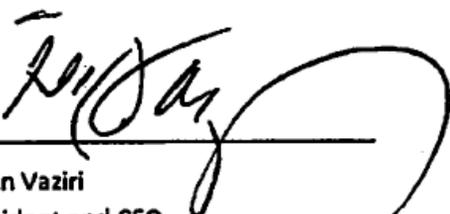
When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*.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

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

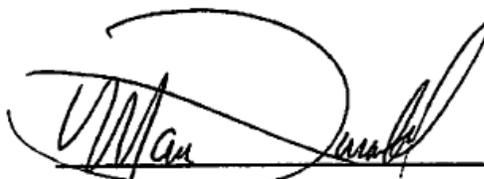
The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved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

At Woodland Healthcare, we share a commitment to optimize the health of our community. In fiscal year 2013 Woodland Healthcare provided \$18,391,572 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Woodland Healthcare Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 22, 2013 meeting.



**Kevin Vaziri**  
President and CEO



**Marianne MacDonald**  
Board Chair

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# EXECUTIVE SUMMARY

Woodland Healthcare has been meeting the health needs of residents in its Yolo County community for decades. The Hospital has a rich history in Yolo County that dates back to the opening of the Woodland Sanitarium in 1905. The Woodland Sanitarium grew to become the Woodland Clinic Hospital in the 1920s. In 1967, the Woodland Memorial Hospital and Woodland Clinic were completed with the help of the community. In 1992, Woodland Clinic and Woodland Memorial Hospital formed an affiliation to create Woodland Healthcare. The Hospital became a member of Dignity Health in 1996. Located at 1325 Cottonwood Street in Woodland, CA, the hospital has 108 licensed acute care beds, 17 Emergency Department (ED) beds, and 31 inpatient mental health beds. The hospital has 1,076 employees, including 125 providers, and an active medical staff of 135.

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

- Access to primary care
- Access to preventative services
- Access to mental health
- Access to healthy foods and nutrition education

This report highlights a number of new and existing initiatives that respond to these priorities. One in particular that addresses health issues surrounding access to care is the **Resource Connection** initiative in partnership with the Yolo Family Resource Center. Located on the campus of the Hospital, the Resource Connection serves as a community service hub, providing a one-stop access point for vulnerable individuals and families to be connected to key health and social services in the community. Enrollment services, case management, intervention and health education are also provided. Services, particularly with enrollment under the ACA will be expanded at the Resource Connection in FY 2014.

Woodland Healthcare is the only provider in Yolo County that fills a specialty need identified in the CHNA for access to care for a growing vulnerable elderly population. The Hospital operates the **Yolo Adult Day Health Center**, which offers a diverse program of health, social and rehabilitation services for adults struggling to function independently. The center's goal is to maximize independence, improve management of chronic symptoms, prevent hospitalization and/or premature nursing home placement and provide support and relief to caregivers.

Through a robust Chronic Disease Self-Management Program (CDSMP), the Hospital continues to expand its efforts to address the need for health prevention and education services. Utilizing the evidence-based Stanford University CDSMP model, the Hospital offers six-week workshops in both English and Spanish in various neighborhoods throughout Yolo County. The **Healthy Lives** workshop emphasizes diabetes, and provides education and skills to help those living with this chronic health problem better manage their illness and lead healthier and more productive lives. These program offerings will be expanding in FY 2014 through new partnerships involving Yolo County, Yolo Family Resource Center, First 5 Yolo Children and Families Commission and others, and the development of a new initiative focused on the priority health issue of obesity.

A **Diabetes Care Management Program** compliments Healthy Lives, targeting particularly high risk patients who have been recently hospitalized for uncontrolled diabetes due to marginal social environmental conditions or other system issues that affect treatment, such as access to care. Participants in this program are involved in bimonthly diabetes group medical appointments, and monitored closely via phone by case managers. Access to individual appointments with a nurse certified

diabetic educator, primary care case manager, or registered dietitian is also available. Case managers also ensure participants are linked to a primary care provider who is kept informed of the services they receive from the program.

Mental health continues to be a priority issue within the community served by Woodland Healthcare, and a top priority for the Hospital. The Hospital offers the only mental health residential treatment facility in Yolo County, and in FY 2013, provided inpatient psychiatric care to over 1,000 underserved residents who otherwise would not have had access to this critical care. Estimated community benefit expense during the year was over \$4.5 million. The facility offers a comfortable, home-like environment, where patients receive individualized care focused on their special needs, and support to ensure a smooth transition following treatment. Midway through the year, the Hospital undertook a significant expansion of the mental health facility to provide additional capacity to serve a greater number of residents in need. Moving into FY 2014, the Hospital is focused on building community capacity for outpatient mental health care through its redesigned **Dignity Health Community Grants Program**. Grant applicants were asked to collaborate to create partnership programs that target vulnerable individuals in need of mental health care and/or substance abuse treatment.

A **Farmers Market** hosted regularly by the Hospital responds to the need for fresh and affordable healthy food choices for local residents, and responds to a priority health issue identified in the CHNA. Residents have access to both health and nutrition education, and health screenings at these markets.

More details on these, and other core community benefit programs, can be found in the following pages. In total, Woodland Healthcare's Fiscal Year 2013 community benefit investment in its community was \$10,004,107, which excludes \$8,387,465 in unpaid Medicare costs.

# MISSION STATEMENT

We share the mission of Dignity Health:

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

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

## ORGANIZATIONAL COMMITMENT

The clearest demonstration of Woodland Healthcare's commitment to community is the support of and engagement in the community benefit strategic planning and budgeting process by Leadership, and the active role both Leadership and employees at multiple levels play in serving the community. Community benefit oversight and governance for the Hospital is provided by the Woodland Healthcare Community Board. A dedicated Community Benefit Advisory Committee – a standing committee of the Board – helps guide the Hospital's community benefit practices, ensuring that programs and services offered address the unmet health needs of the community it serves and promote the broader health of the region (See Appendix A for Woodland Healthcare Community Board and Community Benefit Advisory Committee Rosters). Specific roles and responsibilities of the Community Benefit Advisory Committee include:

- Ensure services and programs align with the mission and values of Dignity Health and focus on five core principles:
  - Disproportionate unmet health and health-related needs
  - Emphasize prevention
  - Contribute to a seamless continuum of care
  - Build community capacity
  - Demonstrate collaborative governance
- Ensure the Hospital abides by uniform methods of accounting community benefit activities and expenses
- Review and approve the Community Health Needs Assessment and ensure alignment of programs and services with priority health issues, with an emphasis on communities of concern
- Evaluate and approve budget
- Evaluate program design and content
- Monitor and evaluate program progress, and determine program continuation or termination

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

Operating in a region that struggles with a safety net characterized as fragmented and fragile<sup>1</sup>, Woodland Healthcare also recognizes that good health is dependent upon organizations working together to address issues, and is committed to engaging the community through collaboration. The annual Dignity Health Community Grants Program is one way the Hospital is fostering collaboration. Grant applicants in FY 2013 were asked to partner on joint projects that offer a full continuum of care needed by specific underserved target populations living within communities of concern identified through the CHNA. Partner organizations were also asked to develop improved processes for information sharing, program and care coordination, joint planning and joint program evaluation.

### Non-Quantifiable Benefits

Woodland Healthcare understands that true community health improvement cannot be achieved without collaboration and shared ownership of strategies and goals with others. Beyond the level of programs and services offered, the Hospital is committed to connecting with the community - working with public health

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<sup>1</sup> California HealthCare Foundation, 2009

and other government agencies, the nonprofit health and social service sectors, civic leaders and constituents - to bring about long-term change in health care quality and delivery. Hospital Leadership serves on the boards of key community organizations, including the Yolo County Health Council, Woodland, Davis and Dixon Chambers of Commerce, Woodland Rotary Club, and the Yolo County Mental Health Board. They lend expertise and advocate for change that will positively impact health, quality of life and economic well-being. For instance, Hospital Leadership is one of the health care leaders at the table of the Yolo County coalition, "Healthy Yolo: Our Community, Our Future." This new countywide strategic planning initiative aims to improve the health and wellbeing of residents. Over the next 18 months, the coalition will engage members of the community and strengthen the local public health system through a process where community members can come together to share and understand the specific health concerns and strengths of their community, prioritize public health issues, and determine goals and strategies for the future.

Strong partnerships are maintained in the community in many other ways. Hospital Case Managers and Social Workers can be found volunteering to support local nonprofit health and health-related organizations, like the American Red Cross, United Way and Food Bank. Volunteer educators travel to remote areas of the community where exposure is limited to speak at forums to increase awareness about the importance of prevention and early detection of disease.



## Description of Community

Yolo County is a middle-sized rural/suburban county with a strong commitment to the preservation of agriculture and open space. As of the 2010 census, the county had a population of 200,849. Of the total population, 88% live within cities in the county, with an estimated 97% of unincorporated land designated for agricultural use (603,544 acres). A significant portion of California's tomato industry is located within and surrounding Yolo County.

Nearly 21% of the population in Yolo County is estimated to be uninsured or underinsured. This represents the second highest rate of underserved residents in the region behind Sacramento County. A large part of the county is designated by the Federal Government as a Medically Underserved Area (MUA), which includes Dunnigan (95937), Knights Landing (95645), Zamora (95698), Madison (95653), Woodland (95776), and Davis (95616)<sup>2</sup>.

A large number of low-income residents in the western region of Yolo County are seen by Federally Qualified Health Centers (FQHC); there are three that exist within the county. At the same time, ED admission rates for Woodland Healthcare have continued to increase, and 40% of all emergency department visits were for non-emergent conditions that could have been treated in a primary care setting<sup>3</sup>.

## Community Demographics

- **Population:** 605,390
  - Under 18 = 23.92%
  - 18-44 = 42.19%
  - 45-64 = 23.03%
  - 65+ = 10.86%
- **Diversity**
  - Caucasian: 45.9%
  - Hispanic: 27.4%
  - Asian: 14.2%
  - African American: 7.6%
  - American Indian/Alaska Native & Other: 4.9%
- **Average Income:** \$64,496
- **Uninsured:** 20.7%
- **Unemployment:** 13.9%
- **No High School Diploma:** 17.5%
- **Renters:** 39.5%
- **Community Needs Index Score (CNI):** 4.2
- **Medicaid Patients:** 19.4%
- **Other Area Hospitals:**
  - Sutter Davis

## Woodland Healthcare Community Needs Index Data

The Hospital's CNI Score of 4.2 score falls in the median range. The CNI highlights by zip code the areas of greatest risk for preventable hospitalizations (see CNI map below). The data is derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).

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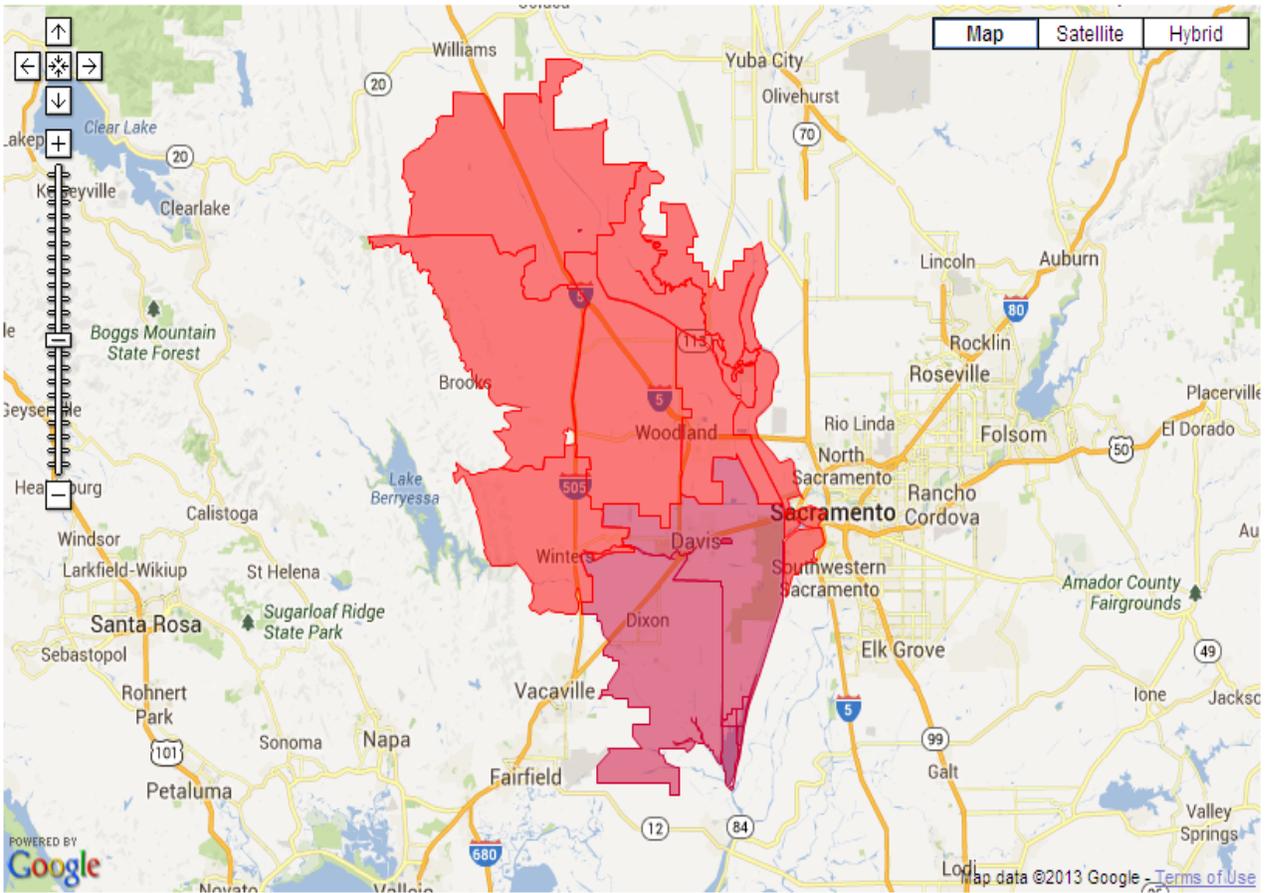
<sup>2</sup> Sacramento Region Health Care Partnership, Yolo County, Market Analysis Findings, 2012, February 24

<sup>3</sup> Sacramento Region Health Care Partnership, Yolo County, Market Analysis Findings, 2012, February 24

## Woodland Healthcare's Community Needs Index (CNI) Map: Median CNI Score: 4.2

Lowest Need Highest Need

■ 1 - 1.7 Lowest    
 ■ 1.8 - 2.5 2nd Lowest    
 ■ 2.6 - 3.3 Mid    
 ■ 3.4 - 4.1 2nd Highest    
 ■ 4.2 - 5 Highest



Mean(zipcode): 4.1 / Mean(person): 4

CNI Score Median: 4.2

CNI Score Mode: 4.2,4.4

| Zip Code | CNI Score | Population | City            | County | State      |
|----------|-----------|------------|-----------------|--------|------------|
| 95616    | 3.6       | 45984      | Yolo County     | Yolo   | California |
| 95618    | 3.4       | 26393      | Yolo County     | Yolo   | California |
| 95620    | 3.6       | 20066      | Solano County   | Solano | California |
| 95627    | 4.4       | 2726       | Esparto         | Yolo   | California |
| 95645    | 4.8       | 1770       | Sutter County   | Yolo   | California |
| 95691    | 4.4       | 35443      | West Sacramento | Yolo   | California |
| 95694    | 4.2       | 9335       | Winters         | Yolo   | California |
| 95695    | 4.2       | 40138      | Yolo County     | Yolo   | California |
| 95776    | 4.2       | 21823      | Yolo County     | Yolo   | California |
| 95912    | 4.4       | 5025       | Arbuckle        | Colusa | California |
| 95937    | 3.8       | 1127       | Colusa County   | Yolo   | California |

# COMMUNITY BENEFIT PLANNING PROCESS

## A. COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

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

The assessment followed a community-based participatory research approach, led by a workgroup that was comprised of Woodland Healthcare's community benefit staff, as well as representatives from Sutter, Kaiser, and UC Davis health systems, and Sierra Health Foundation. Various health and community experts involved in the process included the Yolo County Public Health Officer, Yolo County Supervisor (District 2), and physicians and leaders of community health and social service organizations.

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

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

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

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

### *Methodology*

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

### *Unit of analysis and study area*

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

### *Selection of data criteria*

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

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

*Primary data – the Voice of the Community*

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

Key informants are health and community experts familiar with populations and geographic areas residing within Woodland Healthcare’s core service area. To gain a deeper understanding of the health issues pertaining to chronic disease and populations living in more vulnerable communities, 13 key informants participated in the CHNA process. Interviews were conducted with these informants using a theoretically grounded interview guide. Each interview was recorded and content analysis was conducted to identify key themes and important points pertaining to each geographic area. Findings from these interviews were also used to help identify communities most appropriate for focus groups.

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

*Secondary Quantitative Data*

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

Table 1: ED visits, hospitalization, and mortality

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

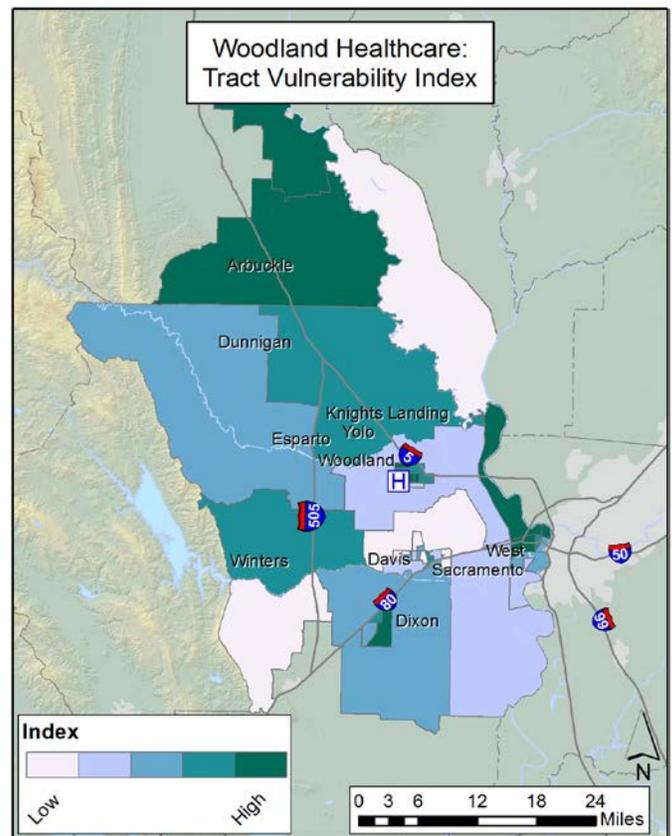
\*Age adjusted by 2010 California standard population

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

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

*Data Analysis - Identifying Vulnerable Communities*

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



### *Focus Group Selection*

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

### *Communities of Concern*

To identify Communities of Concern, primary data from key informant interviews, detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. Zip code communities with rates that exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, or mortality were considered. The health outcome data analysis was triangulated with primary data and socio-demographic data to identify specific Communities of Concern. Data on socio-demographics of residents living in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing status, employment status, and health insurance status, were examined. Area health needs were determined via in depth analysis of qualitative and quantitative data, and then confirmed by socio-demographic data.

### **Health Needs Identified: Assessment Findings**

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

Table 3: Identified Communities of Concern

| Zip  | Community Name  | County       | 2010 Population* |
|--|-----------------|--------------|------------------|
| 95605                                      | West Sacramento | Yolo         | 14,179           |
| 95645                                      | Knights Landing | Yolo, Sutter | 2,037            |
| 95691                                      | West Sacramento | Yolo         | 34,737           |
| 95695                                      | Woodland        | Yolo         | 37,946           |
| 95776                                      | Woodland        | Yolo         | 21,902           |
| Total Population in Communities of Concern |                 |              | 110,801          |

(\*Source: 2010 Census data)

The five Communities of Concern are home to more than 110,000 Yolo County residents. The zip codes include a diverse landscape - from the suburban city of West Sacramento with its active port, to the historic City of Woodland with its economic dependence on agriculture and manufacturing, to the small, rural agricultural community of Knights Landing. Data indicated that these areas are highly diverse, and characterized by high rates of poverty and unemployment, high rates of renting versus owning homes, and low educational attainment.

In four of the five zip codes, at least 50% of residents are Hispanic or non-White. The percentage of residents over the age of five with limited English proficiency ranged from 7.7% in zip code 95691 to 21.3% in 95605. Four of the Communities of Concern had a higher percentage of residents over the age 65 living in poverty compared to the national benchmark of 8.7%. Three of the zip codes had a percentage of families with children living in poverty higher than the national percent at 15.1%. Three of the five zip codes had a higher percentage of single female-headed households living in poverty than the national average of 31.2%.

All zip codes except for one had a higher percentage of residents over the age of 25 years without a high school diploma compared to the national average, with the highest being 47.5 % in 95645. Three of the zip codes had a higher percentage of unemployed residents as compared to the state rate of 9.8%. For

instance, 16.6% of the residents living in the 95605 zip code are unemployed. All but one of the zip codes had a higher percentage of uninsured residents compared to the national rate at 16.3%. In zip code 95605, 42.8% residents were uninsured.

### *Priority Health Needs*

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

- Access to primary care and preventative services
- Access to mental health and substance abuse services
- Access to specialty care
- Access to affordable healthy foods
- Improved transportation services
- Education on health and chronic disease management
- Nutrition education
- Access to dental care
- Access to affordable medical care and medications for all
- Safe places to be active

Diabetes was the most prevalent chronic disease. CHNA participants described difficulties in obtaining regular checkups, the high cost of necessary medications and equipment, and a lack of available diabetes education and support services. Heart disease was a common health problem, as were stroke and hypertension. Four of the five Communities of Concern had rates of ED visits related to mental health that exceeded the state benchmark. In zip code 95695, the rate of ED visits related to mental health was more than double the state benchmark. Three of the zip codes had rates of ED visits for self-injury that exceeded the state benchmark, with the rate for 95695 at nearly double the state benchmark. Four of the Communities of Concern had hospitalization rates for self-inflicted injury that exceeded state and county benchmarks. All five zip codes had rates of ED visits for substance abuse which exceeded both county and state benchmarks, and all had rates of ED visits for COPD, asthma, and bronchitis that were substantially above both county and state benchmarks. Many residents in these Communities of Concern felt unsafe spending time outdoors doing physical activity. When looking at the food environment, the Communities of Concern showed that approximately 24% of residents in each zip code are obese and approximately 34% of residents are overweight. Zip codes 95776, 95695, and 95645 in particular, contain areas within census tracts that have no access to healthy foods. Infant mortality was also an issue; all but one Community of Concern had rates exceeding the Yolo County benchmark of 3.6 deaths per 1,000 live births.

### **Communicating the Results**

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

### **B. ASSETS ASSESSMENT**

Communities require resources in order to maintain and improve their health. These include health related assets, including health care professionals and community-based nonprofit organizations. An assessment of these resources revealed nearly 40 assets that could potentially provide opportunities for partnership. Woodland Healthcare has established partnerships with a number of these agencies. The Hospital is linked through the Resource Connection to the Yolo Family Resource Center, and other

community-based nonprofit organizations through the Dignity Health Community Grants Program. (A listing of health assets can be found at the back of the CHNA in Attachment 1.)

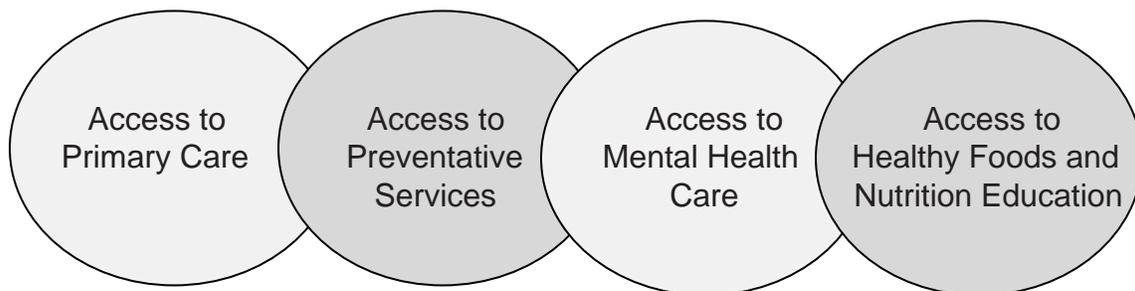
### C. DEVELOPING THE HOSPITAL'S IMPLEMENTATION PLAN

#### Process for Prioritization

Woodland Healthcare Leadership worked closely with the Woodland Healthcare Community Board, Community Benefit Advisory Committee of the Board and community benefit staff to prioritize health needs identified in the CHNA to be addressed in FY 2014. This ensured a well balanced planning process that included knowledge and expertise from community stakeholders. The following criteria were applied for the needs prioritization:

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

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



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

- Collaboration with community partners to build capacity
- Extension of programs and services and enhanced outreach in specific Communities of Concern identified through the CHNA
- Improved data collection by Hospital and partners to measure and demonstrate health improvements
- Strengthening the Community Benefit Advisory Committee membership to increase community representation and insight, particularly in Community of Concern areas

## Implementation Strategies/Action Plans

### 1. Access to Primary Care

The CHNA identified a number of barriers that contribute to poor access, including:

- Difficulties in obtaining referrals to providers
- Lack of insurance coverage
- Underinsured
- Cost of care, including medications
- Lack of services in rural locations

These contributors are also impacting ED operations at Woodland Healthcare, where 40 percent of all ED visits are for basic primary care as determined by discharge diagnoses. The Hospital is working in partnership with community-based nonprofit providers to address this priority health need in several ways.

#### *Nurse Navigation in the Emergency Department*

The Hospital has a Nurse Navigator program in place in its ED to connect those individuals and families who lack a primary care provider and the means to afford care with a primary care provider in the community.

- To enhance this effort in FY 2014, the Hospital will develop and implement a process for measuring successful patient outcomes that can be used as a method of evaluating program effectiveness and making improvements.

#### *Resource Connection*

Woodland Healthcare works in a collaborative partnership with the Yolo Family Resource Center to offer the Resource Connection on the Hospital campus. The Resource Connection serves as a community service hub, providing a one-stop access point for vulnerable individuals and families to be connected to key health and social services in the community. Enrollment services, case management, intervention and health education are also provided. This partnership is expanding in FY 2014 through:

- Increased outreach and enrollment services, particularly for the underserved living within Communities of Concern identified in the CHNA
- Development of an improved process for measuring program outcomes

#### *Yolo Adult Day Health Center*

The CHNA identified that a growing elderly population in Woodland Healthcare's was particularly vulnerable, and faced multiple issues including accessing care, transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric mental health issues. The Yolo Adult Day Health Center is specifically designed to respond to these issues. The center offers a diverse program of health, social and rehabilitation services that promote the well-being, dignity and self-esteem of an individual. The center's goal is to maximize independence, improve management of chronic symptoms, prevent hospitalization and/or premature nursing home placement and provide support and relief to caregivers. Special emphasis in FY 2014 will be on:

- Utilizing community outreach workers to extend caregiver training, education, and group support activities to individuals and families within identified Communities of Concern.

### 2. Access to Preventative Services

Key contributing factors leading to this priority issue include:

- Diabetes, as the most frequently cited issue (mentioned in nearly all key informant interviews and focus groups)
- The prevalence of other chronic diseases, including hypertension, heart disease, and high cholesterol
- Lack of available services and resources when trying to manage chronic conditions

- Being uninsured or underinsured makes it difficult to receive preventative care services
- Physicians often fail to discuss preventative health measures

Woodland Healthcare has several core initiatives in place to address the need for preventative services. The Hospital offers robust preventative education programs and Chronic Disease Self-Management workshops (following the evidence-based Stanford University model), in various neighborhoods throughout Yolo County. A key strategy in FY 2014 is to increase outreach to the five Communities of Concern. Programs include:

*Healthy Lives (Vida Sana)*

This six week course is offered to residents who have, or are at risk of, diabetes, with an emphasis on underserved populations. The program is taught in Spanish and in English. Participants learn to recognize the signs and symptoms of diabetes. Participants are also taught proper nutrition and healthy eating habits, as well as medication management. The program is a collaborative effort with other community agencies who offer an optional health cooking class and exercise component. A significant number of participants in Healthy Lives go on to participate in the complementary Chronic Disease Self-Management Program offered by the Hospital.

*Diabetes Care Management Program*

This program takes Woodland Healthcare’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.

*Your Life, Take Care (Tomando Control De Salud)*

This Chronic Disease Self-Management Program is six-weeks in duration and is offered to help people cope with ongoing health issues and a variety of chronic diseases, such as heart disease, cancer, arthritis, obesity, and depression. Classes are held in Spanish and English and focus on goal setting and problem solving, nutrition, communication skills, relaxation techniques, medication usage, community resources and partnering with primary care providers.

*Congestive Heart Active Management Program, CHAMP®*

CHAMP® serves as a unique model of health intervention, providing support and assistance for those who suffer from heart failure. The program responds to a priority health issue identified in the CHNA. CHAMP® serves as a vital link for patients to the medical world once they leave the hospital. It enables patients to manage their disease and maintain a high quality of life, and reduces the risk of being readmitted to the hospital.

*New FY 2014 Initiative to Expand Chronic Disease Self-Management Education*

Woodland Healthcare is working with the Yolo Family Resource Center to further expand preventative and chronic disease educational offerings at the community level. The Hospital will provide training to laypersons involved in the Center’s “Promotoras for Active Living” (PAL) project, which expressly targets the large Latino community in Yolo County.

*New FY 2014 Initiative to Address the Issue of Obesity*

Obesity was consistently identified as a significant health issue in the CHNA among both adults and children, with higher rates among the Latino population, leading to chronic illnesses like diabetes and heart disease. Working in partnership with the Yolo County Resource Center, Woodland Healthcare will provide pre and post health screenings including blood pressure, glucose levels, diabetes, and body mass index measurement for the Center’s new Dance into Fitness Program, which is part of the PAL project. The Hospital will also refer those with indications of diabetes, or pre-diabetes conditions to the program. Other partners in this growing effort include First 5 Yolo Children and Families Commission, Yolo Family Service Agency, and the Yolo County Public Health Department.

### **3. Access to Mental Health Care**

The Hospital offers the only mental health residential treatment facility in Yolo County, providing this service to both poor and broader communities. Inpatient psychiatric care is provided in a comfortable, home-like environment, where patients receive individualized care focused on their special needs. Upon admission, each patient is assigned to a registered nurse who coordinates that patient's care throughout his or her stay. This nurse also coordinates the patient's plans for discharge to assure a smooth transition. The inpatient program includes milieu therapy, one-to-one therapy and various group therapy modalities, as well as individualized activity programs. Because the mental health unit is located within the Hospital, patients have immediate access to a full range of medical services.

- The Hospital underwent a significant capacity expansion of its mental health inpatient facility in FY 2013, adding 11 new beds. The expansion was complete in August 2013.

#### *Building Community Capacity for Mental Health Care through Collaboration.*

The Hospital redesigned its Dignity Health Community Grants Program in FY 2014 to focus on creating strategic partnership programs among nonprofit providers that target vulnerable at-risk and homeless individuals in need of outpatient mental health care and/or substance abuse treatment. Through the grants program, agencies were asked to collaborate to ensure these critical services are available, especially for those living in Communities of Concern. Improved measures will also be incorporated to determine outcomes.

### **4. Access to Healthy Foods and Nutrition Education**

Targeting low-income residents, Woodland Healthcare has recently created an open Farmers Market on campus which is held regularly and offers affordable fresh healthy foods. An added component to the markets includes health education and health screenings.

Woodland Healthcare will continue its focus on other core community benefit services that are directly responding to priority health needs identified in the CHNA. These include:

1. **Access to Specialty Care.** Working with Yolo County, Woodland Healthcare is the primary provider of specialty care to indigent residents in the region.
2. **Enrollment Assistance.** Through its Enrollment Assistance program, the Hospital identifies patients without insurance and navigates them through this often confusing process. Hundreds of patients receive assistance each year.
3. **Transportation and Medications.** The Hospital assesses and provides transportation for those with no means to travel, and provides medications to patients who cannot afford to purchase them.

### **Needs Not Prioritized**

Woodland Healthcare responds to priority health needs in many ways, and at times that are critical for patients in crisis. As a small community hospital, Woodland Healthcare does not have the available resources to develop initiatives to meet every priority health need identified in the CHNA, which makes collaboration with community resources critical. The Hospital is not currently addressing the priority needs for access to dental care and safe places to be active; neither of these priorities is an area of specialty for the Hospital. Dental care in particular, is being addressed by community health centers in Yolo County.

### **5. PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION**

Woodland Healthcare strives to ensure that the needs of the uninsured and underinsured patient population are addressed. No one should go without health care and the Hospital is committed to treating patients who have financial needs with the same dignity, compassion and respect that is extended to all patients. The Hospital considers each patient's ability to pay for his or her medical care, and follows the

Dignity Health Patient Payment Assistance Policy, which makes free or discounted care available to uninsured individuals with incomes up to 500 percent of the federal poverty level (see Appendix B for a summary of the Dignity Health Patient Payment Assistance Policy).

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

To ensure all patients are aware of the policy, financial assistance information is distributed in a number of ways. Notices in the primary languages spoken by the populations the Hospital serves are posted in the hospital's emergency departments, admitting and registration areas, and in the Business and Financial Services office. Notices are also placed in all patient bills and include a toll-free contact number. In addition to financial assistance, the Hospital further supports the specific needs of uninsured and underinsured patient populations by assisting them with government health insurance program enrollment, free prescription medications and transportation.

#### *Enrollment Assistance*

Following medical treatment, the Hospital provides assistance to help uninsured patients enroll in government sponsored health insurance programs. In FY 2013, 1,420 uninsured patients received this free assistance. Hospital-sponsored expense for this assistance was \$301,412

#### *Prescription Medications*

Woodland Healthcare provides free prescription medications for those who lack the means to afford them. In FY 2013, over 300 underserved individuals received medications through community benefit. Expense was \$27,415.

#### *Transportation*

Taxi transportation is available for patients who do not have, or cannot afford their own transportation home upon discharge from the Hospital. There were 459 patients who received this service in FY 2013 at a community benefit expense of \$14,150.

# PLAN REPORT AND UPDATE

## INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

### Summary of Key Programs and Initiatives – FY 2013

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

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

#### **Initiative I: Access to Primary Care**

- Financial assistance
- ED Nurse Navigator Program
- Resource Connection Partnership
- Yolo Adult Day Health Center (outreach/education expansion planned in FY 2014)
- Enrollment assistance (expanding program in FY 2014)
- Dignity Health Community Grants Program
- Prescription medication program
- Health screenings
- Transportation

#### **Initiative II: Access to Preventative Services**

- Healthy Lives
- Diabetes Care Management Program
- Your Life, Take Care
- Congestive Heart Active Management Program, CHAMP®
- Promotoras for Active Living partnership (new in FY 2014)
- Obesity partnership (new in FY 2014)
- Mercy Faith and Health Partnership

#### **Initiative III: Access to Mental Health Care**

- Mental Health Residential Treatment
- Dignity Health Community Grants Program (redesigned in FY 2014)

#### **Initiative IV: Access to Healthy Foods and Nutrition Education**

- Farmers Market
- Nutrition and healthy eating education

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

## PROGRAM DIGESTS

| <b>RESOURCE CONNECTION</b>                         |   |
|--|---|
| <b>Hospital CB Priority Areas</b>                  | <ul style="list-style-type: none"> <li>✓ Access to Care</li> <li>Chronic Disease Prevention, Education and Management</li> <li>Continuum of Care to End Homelessness</li> <li>Women's and Children's Health and Safety</li> <li>✓ Community Health and Well-Being</li> </ul>  |
| <b>Program Emphasis</b>                            | <ul style="list-style-type: none"> <li>✓ Disproportionate Unmet Health-Related Needs</li> <li>Primary Prevention</li> <li>✓ Seamless Continuum of Care</li> <li>✓ Build Community Capacity</li> <li>✓ Collaborative Governance</li> </ul>   |
| <b>Link to Community Health Needs Assessment</b>   | Access to primary care for uninsured and low-income populations identified as a top CHNA priority. Need also evident in increased ED admissions for non-urgent care by target population and lack of financial resources to pay for services. The Resource Connection fills a gap in the region's safety-net, by providing health education information and insurance enrollment assistance to uninsured and underinsured in Yolo County.   |
| <b>Program Description</b>                         | The Resource Connection is a partnership with the Hospital and the Yolo Family Resource Center. Located on the Hospital's campus, the Resource Connection serves as a community service hub, providing a one stop access point for community services and health education in both Spanish and English. Services provided include health insurance enrollment assistance for children and adults, health education, case management, referrals to local community organizations/resources, homelessness prevention and intervention services. |
| <b>FY 2013</b>                                     |   |
| <b>Goal FY 2013</b>                                | Increase access to healthcare services and other social support services.   |
| <b>2013 Objective Measure/Indicator of Success</b> | Provide an additional resource center in the Woodland community with varied day/evening hours to address the needs of 150 families (600 individuals)  |
| <b>Baseline</b>                                    | The need for the program is evident in the CHNA, which identifies access to care as an issue for underserved; need also evident in high ED utilization rates.   |
| <b>Intervention Strategy for Achieving Goal</b>    | Outreach in community to create awareness about services.   |
| <b>Result FY 2013</b>                              | 1,216 served and connected to community resources; double FY 2012   |
| <b>Hospital's Contribution / Program Expense</b>   | \$26,668  |
| <b>FY 2014</b>                                     |   |
| <b>Goal 2014</b>                                   | Increase access to healthcare services and other social support services.   |
| <b>2014 Objective Measure/Indicator of Success</b> | Increase numbers served by 10% or greater. Improve methods of outcomes measurement.   |
| <b>Baseline</b>                                    | The need for the program is evident in the CHNA, which identifies access to care as an issue for underserved; need also evident in high ED utilization rates.   |
| <b>Intervention Strategy for Achieving Goal</b>    | Connect the Resource Center with Hospital Case Management; build relationships with ED staff; education in community of available resource.   |
| <b>Community Benefit Category</b>                  | E1-a Financial Donations – Contributions to Nonprofit orgs/Community groups.  |

| <b>CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®)</b> |  |
|--|--|
| <b>Hospital CB Priority Areas</b>                          | <ul style="list-style-type: none"> <li>✓ Access to Care</li> <li>✓ Chronic Disease Prevention, Education and Management</li> <li>Continuum of Care to End Homelessness</li> <li>Women's and Children's Health and Safety</li> <li>Community Health and Well-Being</li> </ul>   |
| <b>Program Emphasis</b>                                    | <ul style="list-style-type: none"> <li>✓ Disproportionate Unmet Health-Related Needs</li> <li>✓ Primary Prevention</li> <li>✓ Seamless Continuum of Care</li> <li>✓ Build Community Capacity</li> <li>✓ Collaborative Governance</li> </ul>  |
| <b>Link to Community Health Needs Assessment</b>           | Responds to a priority need identified through community health needs assessments. Heart failure is a leading cause of hospitalization for residents in Yolo County. It is the fifth highest reason for ED visits, and the number one cause of death.  |
| <b>Program Description</b>                                 | CHAMP® establishes a care relationship with patients that have heart disease after discharge from the Hospital through: <ul style="list-style-type: none"> <li>- Regular phone interaction; support and education to help manage this disease.</li> <li>- Monitoring of symptoms or complications and recommendations for diet changes, medicine modifications or physician visits.</li> </ul> |
| <b>FY 2013</b>   |  |
| <b>Goal FY 2013</b>  | Improve the health and quality of life of those that suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.   |
| <b>2013 Objective Measure/Indicator of Success</b>         | Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of Hospital admissions and readmissions for enrolled participants.   |
| <b>Baseline</b>  | Heart failure is a priority health issue for the region, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.  |
| <b>Intervention Strategy for Achieving Goal</b>            | Regular meetings with CHAMP® team at Hospital.<br>Increase awareness of program to enhance participation.  |
| <b>Result FY 2013</b>                                      | 300 participants enrolled during the year.<br>Exceeded System metric goal for 50% of participants to avoid hospitalization or ED admission six months post intervention.   |
| <b>Hospital's Contribution / Program Expense</b>           | \$21,057   |
| <b>FY 2014</b>   |  |
| <b>Goal 2014</b>   | Improve the health and quality of life of those that suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.   |
| <b>2014 Objective Measure/Indicator of Success</b>         | Continue to increase enrollment of underserved through outreach and community collaboration, and exceed metric goal to avoid Hospital admissions by participants.  |
| <b>Baseline</b>  | Heart failure is a priority health issue for the region, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.  |
| <b>Intervention Strategy for Achieving Goal</b>            | Regular meetings with CHAMP® Teams at Hospitals.<br>Continued partnership with community partners to expand program offerings.   |
| <b>Community Benefit Category</b>                          | A2-e Community Based Clinical Services – Ancillary/Other Clinical Services.  |

| <b>ADULT DAY HEALTH CENTER</b>                     |  |
|--|--|
| <b>Hospital CB Priority Areas</b>                  | <ul style="list-style-type: none"> <li>✓ Access to Care<br/>Chronic Disease Prevention, Education and Management<br/>Continuum of Care to End Homelessness<br/>Women's and Children's Health and Safety</li> <li>✓ Community Health and Well-Being</li> </ul>  |
| <b>Program Emphasis</b>                            | <ul style="list-style-type: none"> <li>✓ Disproportionate Unmet Health-Related Needs<br/>Primary Prevention</li> <li>✓ Seamless Continuum of Care<br/>Build Community Capacity</li> <li>✓ Collaborative Governance</li> </ul>  |
| <b>Link to Community Health Needs Assessment</b>   | The CHNA identified that a growing elderly population in Woodland Healthcare's was particularly vulnerable, and faced multiple issues including accessing care, transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric mental health issues.   |
| <b>Program Description</b>                         | Yolo Adult Day Health Center is a program of the Hospital specifically designed for adults struggling to function independently. A diverse program of health, social and rehabilitation services is offered to promote the well-being, dignity and self-esteem of individuals, and their care givers.  |
| <b>FY 2013</b>                                     |  |
| <b>Goal FY 2013</b>                                | Provide access to care for a growing elderly and vulnerable population that otherwise would go without, by services and programs that address transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric mental health issues. Overall, maximize independence, improve management of chronic symptoms, prevent hospitalization and/or premature nursing home placement and provide support and relief to caregivers. |
| <b>2013 Objective Measure/Indicator of Success</b> | Maintain maximum capacity at the center through enhanced community outreach and education, and increased physician referrals.  |
| <b>Baseline</b>                                    | Access to care for elderly is a key issue identified in the CHNA; there is no other service available to elderly in the community.   |
| <b>Intervention Strategy for Achieving Goal</b>    | Increased outreach in community and improved physician referral process.   |
| <b>Result FY 2013</b>                              | 1,029 elderly adults benefited from services offered at the center.<br>452 individuals and caregivers benefited from community educational programs.   |
| <b>Hospital's Contribution / Program Expense</b>   | \$693,859 (Center)<br>\$8,090 (outreach activities)  |
| <b>FY 2014</b>                                     |  |
| <b>Goal 2014</b>                                   | Provide access to care for a growing elderly and vulnerable population that otherwise would go without, by services and programs that address transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric mental health issues. Overall, maximize independence, improve management of chronic symptoms, prevent hospitalization and/or premature nursing home placement and provide support and relief to caregivers. |
| <b>2014 Objective Measure/Indicator of Success</b> | More focused outreach and educational efforts, particularly in Communities of Concern. Develop collaborative community partnerships.   |
| <b>Baseline</b>                                    | Access to care for elderly is a key issue identified in the CHNA; there is no other service available to elderly in the community.   |
| <b>Intervention Strategy for Achieving Goal</b>    | Outreach in community and among physicians to increase awareness of and access to center services for elderly in need.   |
| <b>Community Benefit Category</b>                  | C3-Subsidized Services: Outpatient Hospital Services   |

| <b>HEALTHY LIVES AND HIGH RISK DIABETES CARE MANAGEMENT PROGRAM</b> |   |
|---|---|
| <b>Hospital CB Priority Areas</b>                                   | <ul style="list-style-type: none"> <li>✓ Access to Care</li> <li>✓ Chronic Disease Prevention, Education and Management</li> <li>Continuum of Care to End Homelessness</li> <li>Women's and Children's Health and Safety</li> <li>Community Health and Well-Being</li> </ul>  |
| <b>Program Emphasis</b>   | <ul style="list-style-type: none"> <li>✓ Disproportionate Unmet Health-Related Needs</li> <li>✓ Primary Prevention</li> <li>✓ Seamless Continuum of Care</li> <li>✓ Build Community Capacity</li> <li>✓ Collaborative Governance</li> </ul>   |
| <b>Link to Community Health Needs Assessment</b>                    | Diabetes is among the top chronic diseases identified as priority health issues in the 2010 CHNA. The program specifically targets uninsured and underserved Hispanic residents in Yolo county who are at greater risk for this disease.  |
| <b>Program Description</b>  | The Healthy Lives program follows the Stanford evidence-based Diabetes Self-Management Program and is a six week course offered to those in the community with diabetes. The program specifically targets the underserved Hispanic population in Yolo County, where the incidence of diabetes is present in one out of three individuals. The program is taught in Spanish and in English with participants learning to recognize the signs and symptoms of diabetes, nutrition, medications, etc. Collaborations with other community agencies offer an optional healthy cooking class and an exercise component. A physician assists with medication questions. For individuals at very high-risk, additional care and support is offered through the Diabetes Care Management Program. This program targets individuals who have uncontrolled diabetes, have been recently hospitalized, or are at greater risk due to a marginal social environment that affects treatment plans. |
| <b>FY 2013</b>  |   |
| <b>Goal FY 2013</b>   | Healthy Lives - Provide education and skills management to help those with diabetes manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention.<br>Diabetes Care Management Program – specialized care beyond diabetes education that includes more clinical disease management working with physicians, ensuring access to care through bi-monthly group medical appointments, and ongoing telephonic case management.  |
| <b>2013 Objective Measure/Indicator of Success</b>                  | Continue to grow number of participants and workshop offerings, with an emphasis on collaboration; exceed System metric goal.   |
| <b>Baseline</b>   | Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes within this community is the second highest cause for ED admissions, and a major health issue identified in the CHNA.  |
| <b>Intervention Strategy for Achieving Goal</b>                     | Outreach to the Hispanic community and Communities of Concern to promote free classes and identify participants who have no access to preventative services; improve referrals from community physicians and health centers. Seek collaborative partnerships (i.e. Yolo Family Resource Center) within the nonprofit community to extend the program.   |
| <b>Result FY 2013</b>   | 673 individuals participated/benefited; exceeded System metric goal.  |
| <b>Hospital's Contribution / Program Expense</b>                    | \$28,575  |
| <b>FY 2014</b>  |   |
| <b>Goal 2014</b>  | Healthy Lives - Provide education and skills management to help those with diabetes manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention.<br>Diabetes Care Management Program – specialized care beyond diabetes education that includes clinical disease management working with physicians, ensuring access to care through bi-monthly group medical appointments, and ongoing telephonic case management.   |
| <b>2014 Objective Measure/Indicator of Success</b>                  | Continue to grow number of participants and Healthy Lives workshop offerings, with an emphasis on collaboration; exceed System metric goal. Develop process for measuring outcomes for Diabetes Care Management Program.  |
| <b>Baseline</b>   | Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes within this community is the second highest cause for ED admissions, and a major health issue identified in the CHNA.  |
| <b>Intervention Strategy for Achieving Goal</b>                     | Outreach to the Hispanic community and Communities of Concern to promote free classes and identify participants who have no access to preventative services; improve referrals from community physicians and health centers. Seek collaborative partnerships within the nonprofit community to grow the program.  |
| <b>Community Benefit Category</b>                                   | A1-a Community Health Education – Lectures/Workshops.   |

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

# COMMUNITY BENEFIT AND ECONOMIC VALUE

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

|  | Persons       | Total Expense     | Offsetting Revenue | Net Benefit       | % of Organization Expenses Revenues |             |
|--|---------------|-------------------|--------------------|-------------------|-------------------------------------|-------------|
| <b><u>Benefits for Living in Poverty</u></b> |               |                   |                    |                   |                                     |             |
| Financial Assistance                         | 1,210         | 913,873           | 0                  | 913,873           | 0.7                                 | 0.7         |
| Medicaid                                     | 12,587        | 28,954,357        | 24,908,838         | 4,045,519         | 3.1                                 | 3.0         |
| Means-Tested Programs                        | 2,113         | 5,093,636         | 2,415,567          | 2,678,069         | 2.0                                 | 2.0         |
| <b>Community Services</b>                    |               |                   |                    |                   |                                     |             |
| Community Benefit Operations                 | 0             | 47,449            | 0                  | 47,449            | 0.0                                 | 0.0         |
| Community Building Activities                | 505           | 13,523            | 0                  | 13,523            | 0.0                                 | 0.0         |
| Community Health Improvement Services        | 2,822         | 394,925           | 0                  | 394,925           | 0.3                                 | 0.3         |
| Financial and In-Kind Contributions          | 1,101         | 366,846           | 0                  | 366,846           | 0.3                                 | 0.3         |
| <b>Totals for Community Services</b>         | <b>4,428</b>  | <b>822,743</b>    | <b>0</b>           | <b>822,743</b>    | <b>0.6</b>                          | <b>0.6</b>  |
| <b>Totals for Living in Poverty</b>          | <b>20,338</b> | <b>35,784,609</b> | <b>27,324,405</b>  | <b>8,460,204</b>  | <b>6.4</b>                          | <b>6.2</b>  |
| <b><u>Benefits for Broader Community</u></b> |               |                   |                    |                   |                                     |             |
| <b>Community Services</b>                    |               |                   |                    |                   |                                     |             |
| Community Building Activities                | 3,388         | 37,438            | 0                  | 37,438            | 0.0                                 | 0.0         |
| Community Health Improvement Services        | 24,497        | 67,364            | 0                  | 67,364            | 0.1                                 | 0.0         |
| Financial and In-Kind Contributions          | 0             | 379,907           | 0                  | 379,907           | 0.3                                 | 0.3         |
| Health Professions Education                 | 31            | 365,335           | 0                  | 365,335           | 0.3                                 | 0.3         |
| Subsidized Health Services                   | 1,029         | 1,532,682         | 838,823            | 693,859           | 0.5                                 | 0.5         |
| <b>Totals for Community Services</b>         | <b>28,945</b> | <b>2,382,726</b>  | <b>838,823</b>     | <b>1,543,903</b>  | <b>1.2</b>                          | <b>1.1</b>  |
| <b>Totals for Broader Community</b>          | <b>28,945</b> | <b>2,382,726</b>  | <b>838,823</b>     | <b>1,543,903</b>  | <b>1.2</b>                          | <b>1.1</b>  |
| <b>Totals - Community Benefit</b>            | <b>49,283</b> | <b>38,167,335</b> | <b>28,163,228</b>  | <b>10,004,107</b> | <b>7.5</b>                          | <b>7.4</b>  |
| <b>Unpaid Cost of Medicare</b>               | <b>13,067</b> | <b>26,704,610</b> | <b>18,317,145</b>  | <b>8,387,465</b>  | <b>6.3</b>                          | <b>6.2</b>  |
| <b>Totals with Medicare</b>                  | <b>62,350</b> | <b>64,871,945</b> | <b>46,480,373</b>  | <b>18,391,572</b> | <b>13.9</b>                         | <b>13.6</b> |
| <b>Grand Totals</b>                          | <b>62,350</b> | <b>64,871,945</b> | <b>46,480,373</b>  | <b>18,391,572</b> | <b>13.9</b>                         | <b>13.6</b> |

## **Telling the Story**

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

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

# APPENDIX A

## Woodland Healthcare Community Board and Community Benefit Advisory Committee Rosters

### Woodland Healthcare Community Board

#### *Community Members*

Betsy Marchand, Retired Yolo County Supervisor

Clyde Brooker, Bank Executive

Marianne MacDonald, Realtor, Board Chair

Katie Knisely, Retired, WCH Auxiliary Past President, Board Secretary

Art Pimentel, Director, Woodland Community College

#### *Physician Members*

Chris Rumery, MD, Anesthesiologist

Mark Ewens, MD, Woodland Clinic Medical Group Chief of Staff

Al Alali, MD, Woodland Clinic Medical Group

John Bringham, MD, Woodland Clinic Medical Group, Board Vice Chair

Carol Kimball, MD, Woodland Clinic Medical Group

#### *Dignity Health Members*

Cindy Holst, Vice President Strategy/Marketing

Kevin Vaziri, Woodland Healthcare President

### Woodland Healthcare Community Benefit Advisory Committee

Betsy Marchand, Retired Yolo County Supervisor, Chair

Tico Zendejas, Executive Director, Rise

Viola DeVita, Educational Services, Yolo County Office of Education

Bob Ekstrom, Executive Director, Yolo Family Resource Center

Josie Enriquez, Case Manager Supervisor, Yolo Family Resource Center

Heidi Mazeris, Manager, Education Services, Woodland Healthcare

Rosemary Younts, Director, Community Benefit, Dignity Health Sacramento Service Area

Ashley Brand, Manager, Community Benefit Manager, Dignity Health Sacramento Service Area

# APPENDIX B

## Dignity Health Summary of Patient Payment Assistance Policy

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

#### Policy Overview:

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

#### Eligibility for Patient Payment Assistance:

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

#### Determination of Financial Need:

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

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

Patient Payment Assistance Guidelines:

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

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

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

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

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

Budgeting and Reporting:

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

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

Relationship to Collection Policies:

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

Regulatory Requirements:

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

# **ATTACHMENT 1**

## **2013 Community Health Needs Assessment**