



## **WOODLAND HEALTHCARE**

### **COMMUNITY BENEFIT REPORT 2012 COMMUNITY BENEFIT IMPLEMENTATION PLAN 2013**

A Message from the President and Chief Executive Officer  
and Board Chair of Woodland Healthcare

At Woodland Healthcare, we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012, Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$16,976,695 in charity care, community benefits, and unreimbursed patient care.

At Woodland Healthcare, we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy, the Woodland Healthcare Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at a meeting on October 23, 2012.



Kevin Vaziri  
President and Chief Executive Officer



Marianne MacDonald  
Chair of the Board

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## EXECUTIVE SUMMARY

Woodland Healthcare's history in Yolo County 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, formerly Catholic Healthcare West (CHW) in 1996<sup>1</sup>. Located at 1325 Cottonwood Street in Woodland, CA, the hospital has 108 licensed acute care beds, 20 emergency department beds, and 20 inpatient mental health beds. The hospital has 974 employees and an active medical staff of 110.

To address the needs of a region characterized by a diverse population living in small towns scattered across a rural landscape and segments of the County being largely urban, the hospital's community benefit programs center on chronic disease prevention and self management, and increasing access to health care. The hospital plays a key role improving the health of the Yolo County region by broadening the use of preventive and educational services, promoting healthy living, and improving the quality of healthcare in our region through a variety of core community benefit initiatives.

Attention to chronic disease prevention, education and management is at the core of strategic community benefit planning and programming efforts at Woodland Healthcare. Efforts specifically target underserved populations, and the Hispanic community, where chronic disease is more prevalent and often goes unattended until illnesses have progressed to an urgent state.

The **Congestive Heart Active Management Program, CHAMP®**, serves as a unique model of health intervention, providing support and assistance for patients who suffer from heart failure. The program responds to a priority health issue identified through needs assessments that indicate heart failure is the second leading cause of hospitalization for residents living in Yolo County and the surrounding region. Heart failure is the fifth highest reason for emergency department visits, and the number one cause of death. 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. It is one of the hospital's Long Term Improvement Plan (LTIP) initiatives.

**The Healthy Lives Program (Vida Sana)**, is a six week course offered to people in the community with uncontrolled diabetes. The program specifically targets the underserved Hispanic population in Yolo County, where the incidence of diabetes is present in one of three people. The program is taught in Spanish and in English with participants learning 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 the Healthy Lives Program go on to participate in the complementary chronic disease self management program, workshops offered by the hospital. This is one of the hospital's Long Term Improvement Plan (LTIP) initiatives.

The **Your Life, Take Care (Tomando Control De Salud)** Chronic Disease Self Management Program is a six-week course offered to help people cope with ongoing health issues and a variety of chronic diseases, such as heart disease, cancer and diabetes, arthritis, obesity, and depression. Classes are held in Spanish and English and focus on goal setting and problem solving, nutrition, communication

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<sup>1</sup> For more information on the name change, please visit [www.dignityhealth.org](http://www.dignityhealth.org).

skills, relaxation techniques, medication usage, community resources and partnering with primary care providers.

Woodland Healthcare is the only provider in the county that fills the need for adult day health care. The **Yolo Adult Day Health Center** is specifically designed for adults struggling to function independently. 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.

The Yolo Family Resource Center partners with Woodland Healthcare to provide the **Resource Connection** on campus. The Resource Connection serves as a satellite community service hub by providing a one stop access point for community services and resources, insurance enrollment, case management, intervention services and health education.

The FY 2012 Community Benefit Report and FY 2013 Community Benefit Implementation Plan highlights Woodland Healthcare's commitment to improving the health of its community. The total value of community benefit for FY 2012 was \$10,409,046, which excludes \$6,567,649 in unpaid Medicare costs.

# MISSION STATEMENT

## Dignity Health 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.

# ORGANIZATIONAL COMMITMENT

## **Woodland Healthcare's Organizational Commitment**

Community Benefit is a direct expression of Woodland Healthcare's mission. Senior hospital leaders and the Hospital Community Board have a strong commitment to community benefit planning and programming. Annually, the Hospital President/CEO and Community Board Chair assign a Community Board Member to a subcommittee for Community Benefit activities called the Community Benefit Advisory Committee that exists to guide and participate in the planning, and as appropriate, the development of projects and programs aimed at improving the health of community. Members represent diverse sectors of the community and interact to raise issues and identify areas for community outreach opportunities. In addition to key community stakeholders, the committee includes representation from the Hospital Community Board, Medical Staff, Foundation and Management Team. The composition of the committee is such that the number of community stakeholders exceeds the number of hospital staff. The committee serves as a catalyst for relationship building and partnering with community organizations, the business community, and residents. Committee members engage in defining targeted community health needs, refining target populations, establishing objectives that create synergy with strategic clinical and operational priority areas, and budgeting accordingly in an effort to achieve these objectives. Emphasis in the strategic planning process is placed on key community benefit priorities such as reducing the prevalence of chronic disease in the region.

Responsibility for program targeting, budgeting, continuation and termination, and monitoring resides with the Executive Management Team and the Woodland Healthcare Community Board. Board members provide input into the annual Community Benefit Report and Implementation Plan, and review and approve the final document. Members of the Board also receive community benefit updates on core strategic programs on a bi-annual basis (see Appendix A for a roster of the Woodland Healthcare Community Board Members and the Community Benefit Advisory Committee).

The process of enhancing organization-wide awareness and understanding of community benefit as it relates to Woodland Healthcare's mission, priority health issues in the community, the hospital's strategies, and responsibilities as a not-for-profit health provider is ongoing. Community benefit orientation and training programs are presented periodically during the year at hospital team meetings. As a result, community benefit has become a systematic process rather than a series of community health activities.

One key aspect of annual community benefit programming involves the Dignity Health Community Grants Program. Woodland Healthcare promotes and supports the continuum of care in its community through this program. The program fosters collaboration and helps maximize resources by providing an opportunity for the hospital to partner with other nonprofit community-based health and social service organizations to improve the health status of low-income and minority residents.

## **Non-Quantifiable Benefit**

Organizational participation in community benefit occurs at many clinical and administrative levels across hospital departments. Woodland Healthcare cultivates strong relationships with members of the community to better understand the needs and expectations of the people it serves, and to receive perspectives on health issues and initiatives. Hospital leaders serve on the boards and are members 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, Workforce Investment Board. They lend expertise and advocate for change that will positively impact health, quality of life and economic well-being. 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.

## COMMUNITY

### Definition of Community

Several sources of information are utilized to define the community served by Woodland Healthcare, both geographic and demographic in nature, including:

- Service areas as prescribed by the Office of Statewide Health Planning and Development (OSHPD).
- Demographic information provided by regional and local government agencies; reimbursement agencies; the United States Census Bureau; and research organizations, such as Claritas, Inc., and Thomson Healthcare.
- Types of patient populations served and types of insurance coverage.

### 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 percent live within cities in the county, with an estimated 97 percent 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.

An estimated 23.2 percent of the population in Yolo County is estimated to be under or uninsured. This represents the second highest rate of under or uninsured residents in the region behind Sacramento County. A large proportion of the county is designated by the federal government as a medically underserved area (MUA). Dunnigan (95937), Knights Landing (95645), Zamora (95698), Madison (95653), Woodland (95776), and Davis (95616) have the highest proportion of low income residents in Yolo County. No regions within the county are designated as a health professional shortage area (HPSA)<sup>2</sup>.

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

### Community Demographics

Woodland Healthcare's primary service area in Yolo County (see map on page 9) encompasses eleven zip codes in the communities of Woodland, Davis, Dixon, Esparto, Winters, West Sacramento, Dunnigan, Arbuckle and Knights Landing (95616, 95618, 95620, 95627, 95645, 95691, 95694, 95695, 95776, 95912, 95937).

- **Population** = 237,085
  - Under 18 = 24.92%
  - 18-44 = 42.92%
  - 45-64 = 22.42%
  - 65+ = 9.74%
- **Diversity**

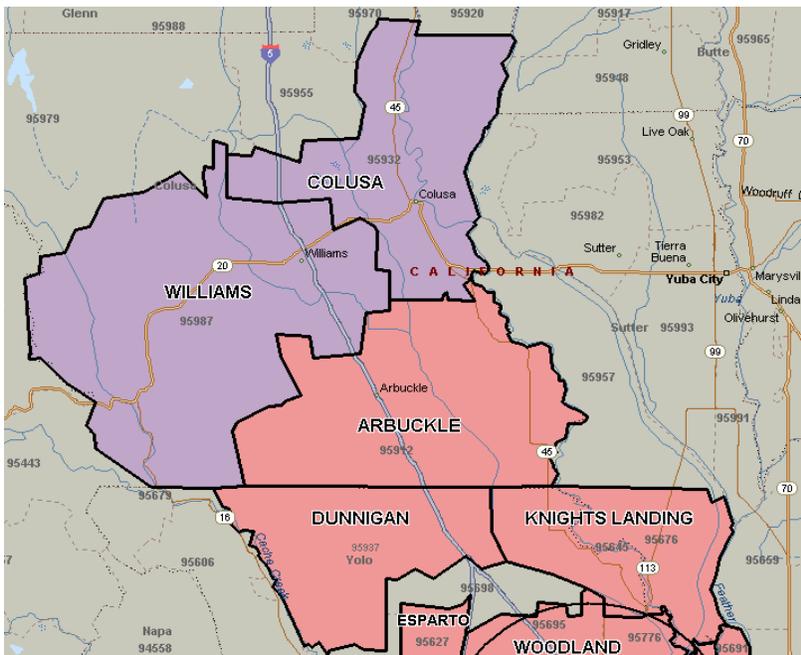
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<sup>2</sup> Sacramento Region Health Care Partnership, Yolo County, Market Analysis Findings, 2012, February 24.

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

- Caucasian: 46.60%
- Hispanic: 27.01%
- Asian: 13.91%
- African American: 7.57%
- American Indian/Alaska Native & Other: 4.91%
- **Average Income:** \$54,675
- **Uninsured:** 23.92%
- **Unemployment:** 13.9%
- **No High School Diploma:** 15.9%
- **Renters:** 38.8%
- **Community Needs Index Score (CNI):** 4.2
- **Medicaid Patients:** 13.49%
- **Other Area Hospitals:** Sutter Davis Hospital

### Woodland Healthcare Primary Service Area





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

	<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
■	95616	3.6	45984	Davis	Yolo	California
■	95618	3.4	26393	Davis	Yolo	California
■	95620	3.6	20066	Dixon	Solano	California
■	95627	4.4	2726	Esparto	Yolo	California
■	95645	4.8	1770	Knights Landing	Yolo	California
■	95691	4.4	35443	West Sacramento	Yolo	California
■	95694	4.2	9335	Winters	Yolo	California
■	95695	4.2	40138	Woodland	Yolo	California
■	95776	4.2	21823	Woodland	Yolo	California
■	95912	4.4	5025	Arbuckle	Colusa	California
■	95937	3.8	1127	Dunnigan	Yolo	California

# COMMUNITY BENEFIT PLANNING PROCESS

## Community Health Needs Assessment

### Process

Woodland Healthcare, in partnership with other regional Dignity Health hospitals, Kaiser Permanente, Sutter Health Sacramento Sierra Region and UC Davis Medical center worked collaboratively and in consultation with one another and the broader community to complete the 2010 Community Health Needs Assessment. With the assistance of Valley Vision, a nonprofit community-based organization dedicated to the quality of life in the Sacramento region, the health systems conducted the 2010 CHNA over a two-year period between October 2008 and October 2010.

The community included in the assessment was a four-county area within the greater Sacramento region, often referred to as California's Capital Region. This area is home to over two million residents. The regional approach to the assessment was selected due to the collaboration between the assessment sponsors. Each of the sponsors has multiple facilities spread across the study area.

### Approach

Valley Vision and the participating sponsors used both qualitative and quantitative data to identify key members of the safety net community to participate in key information interviews and to help convene focus groups with their clients. The interviews and focus group information was used to verify and better understand unmet health needs identified through the quantitative data.

In all, 29 key informant interviews were conducted with health experts across the region. These included each of the participating County's Public Health Officers, Executive Directors of multiple community-based organizations delivering health-related and social services in the community, physicians delivering care to underserved populations, and others serving the community in similar capacities. Also, 12 focus groups were conducted across the study area with populations representative of community members that served as the focus of the assessment. Participants included under and uninsured populations, recent immigrants with limited English skills, homeless populations, ethnic groups and others.

### Data

To identify the unmet health needs of underserved populations, a Community Health Vulnerability index that identified nine socio-demographic characteristics known to contribute to poor health was created. These variables were combined to create a CHVI score for each ZIP code. The highest ranked ZIP codes were compared to the lowest, and health conditions with statistically significant differences were identified.

Focus groups and key informant interviews were conducted throughout the region to identify unmet health needs not easily measured in quantitative terms. Over the course of 2009, 15 focus groups with 134 community members were conducted throughout the region to gather qualitative data for the needs assessment. An additional 12 community members were interviewed individually. Additionally, secondary data for the years 2006, 2007 and 2008 were collected at the ZIP code level for the following variables:

- Rates of ER and hospitalization by cause
- Demographic data (socio-economic indicators)
- Low birth weight rates
- Age-adjusted mortality rates
- Birth and mortality data
- Age-stratified population data
- Infant mortality rates
- Life expectancy at birth

Trend analysis was also conducted on all secondary data to identify conditions that increased consistently over the three-year collection period.

### Results

Analysis of the quantitative and qualitative data revealed four conditions experienced at greater rates among underserved populations:

- Diabetes
- Asthma
- Mental Health
- Hypertension

In addition, these populations showed lower life expectancies, higher mortality rates, higher infant mortality rates, and higher rates of low birth weight infants. The following challenges were identified as barriers to improving and maintaining health among underserved populations:

- Affordability of health care services, especially health insurance
- Locating physicians, specialists, dentists, mental/behavioral health, and other providers who accept Medi-Cal or work at reduced rates
- Navigating a complex system of safety net and related social services
- Poor diet resulting from lack of access to affordable and healthy foods
- Cultural barriers, including language and social customs
- The stress of being poor

### Healthy Living Map Website Development

An important component of the project included the redesign of the assessment website, [www.healthlivingmap.com](http://www.healthlivingmap.com). The site now contains health indicators in much greater detail and provides interactive tools to display community health information in such a way that is easy for members of the community to interpret and utilize.

### Assets Assessment

Information about the community's health assets was collected to better understand the resources currently available to underserved populations throughout the region and identify potential partnership linkages to leverage resources and services provided. This information was incorporated into a Provider Directory section of the Healthy Living Map ([www.healthylivingmap.com](http://www.healthylivingmap.com)).

### Communicating the Results

Results of the assessment have been widely disseminated. Forums to examine the findings were conducted within the hospital, and extended for management teams and employees who perform community service. Forums were also extended to local government officials and over 100 nonprofit community-based organizations. Tutorials for maneuvering the [www.healthylivingmap.com](http://www.healthylivingmap.com) website were also provided. The information and conclusions contained in the assessment report are available to all. The report can be downloaded from [www.healthylivingmap.com](http://www.healthylivingmap.com). (See Attachment 1 for the full report).

#### 2013 Community Health Needs Assessment

Work by the hospital and regional partners is well underway for the 2013 Community Health Needs Assessment, which will be complete June 30, 2013. As part of the 2013 assessment process, more detailed information about community health assets providing services related to specific health outcomes is being gathered. Partners are also working in collaboration with Sierra Health Foundation to conduct a gap analysis to determine the current capacity that exists within the region's safety-net, and the capacity the region actually needs to adequately provide appropriate levels of care.

#### **Developing the Hospital's Implementation Plan**

The 2010 Community Health Needs Assessment provided a thorough study of health outcomes between the most vulnerable and least vulnerable communities, coupled with information gathered from speaking directly with the community. It is assisting Woodland Healthcare in focusing and refining community benefit planning and programming efforts to address the greatest needs of the community. In prioritizing significant health issues in Yolo County, the hospital works closely with the assessment partner group, Yolo County public health officials and other community leaders. The hospital also follows trends in utilization rates closely to understand how they link to particular health issues and to identify consistent and/or emerging health concerns.

Program planning efforts attempt to target identified priority health needs, particularly in pockets of the hospital's service area with an MUA designation, like Knights Landing, Woodland and Davis, which are among the communities with the highest proportion of low income residents. In addressing priority health issues, the hospital's prevention and management of chronic disease conditions, particularly among underserved residents of Yolo County, align with the Community Health Needs Assessment. An emphasis on diabetes prevention and management is consistent with the assessment, as is the hospital's effort to specifically target the Hispanic community where the disease is highly prevalent. Programs that address diabetes and other chronic diseases are showing positive outcomes, measured by reductions in avoidable hospital admissions.

Addressing the priority issue of access to care for the underserved in Yolo County is a collaborative undertaking by the hospital. While the county has strong and growing federal health centers with capacity to serve under and uninsured residents, there is still the need identified through assessment to help members of this population navigate the safety-net system. In partnership with the Yolo Family Resource Center, the Resource Connection on campus serves as a community service hub for both Spanish and English speaking residents. The initiative is a one-stop access point for health services, offering health insurance enrollment assistance for children and adults, education, case management, referrals to community-based providers, and homelessness prevention and intervention services.

#### **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 each hospital serves are posted in the hospital's emergency departments, in admitting and registration areas, and in the business and financial services office. Notices are also placed in all patient bills and include a toll-free contact number. In addition to financial assistance, the hospital further supports the specific needs of uninsured and underinsured patient populations by assisting them with government health insurance program enrollment, 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 12, 735 uninsured patients received this free assistance. Hospital-sponsored expense for this assistance was \$140,881.

#### Prescription Medications

Woodland Healthcare provides free prescription medications for those who lack the means to afford them. Community benefit expense for this service in FY 12 was \$29,177 supporting 334 people who otherwise would not received vital medicine.

#### 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 482 patients who received this service in FY 12 at a community benefit expense of \$12,570.



# PLAN REPORT AND UPDATE

## INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

### Summary of Key Programs and Initiatives – FY 2012

Core community benefit initiatives/programs provided by Woodland Healthcare in FY 12 are highlighted below. Most respond to needs identified through assessment, in addition to hospital and community partners. These core community benefit services will be evaluated against the new Community Health Needs Assessment in FY 13. All hospital programs 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: Increasing Access to Care

- Charity care for uninsured, underinsured and indigent in the region
- Resource Connection
- Enrollment assistance
- Transportation
- Free prescription medications
- Various free health screenings (blood pressure, cholesterol, etc.)
- Dignity Health Community Grants Program

#### Initiative II: Chronic Disease Management, Prevention and Education

- Congestive Heart Active Management Program (CHAMP®)
- Healthy Lives Diabetes Management Program (Vida Sana)
- “Your Life Take Care” Chronic Disease Management Program (Tomando Control De Salud)
- Support Groups (education, counseling and support for patients and families dealing with stroke or cancer)
- Farmer’s Market

#### Initiative III: Focus on Elderly

- Yolo Adult Day Health Care
- Support Groups (Triple-S Family Caregiver Group, Women Spouses Support Group)

These community benefit programs are monitored and evaluated on an ongoing basis to ensure they provide the greatest benefit to participants. Those that are considered core among the program offerings are reviewed during the year by Woodland Healthcare’s Community Board, the Community Benefit Advisory Committee and hospital leadership. Program Digests with detailed information on several of these initiatives are provided in the following pages.

## Description of Key Programs and Initiatives (Program Digests)

<b>RESOURCE CONNECTION</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>✓ Access to Care</li> <li><input type="checkbox"/> Chronic Disease Prevention, Education and Management</li> <li><input type="checkbox"/> Continuum of Care to End Homelessness</li> <li><input type="checkbox"/> Women's and Children's Health and Safety</li> <li><input type="checkbox"/> Community Health and Well-Being</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>✓ Disproportionate Unmet Health-Related Needs Primary Prevention</li> <li>✓ Seamless Continuum of Care</li> <li>✓ Build Community Capacity</li> <li>✓ Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<p>Access to primary and specialty 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, a part of the region that has been identified as a DUHN area that has been devastated by local government budget cuts and the recession; and operates in an area where services are not available.</p>
<b>Program Description</b>	<p>The Resource Connection (A Program of the Yolo Family Resource Center) is located in the Woodland Healthcare Clinic and serves as a community service hub by providing a one stop access point for community services and health education in both Spanish and English. Services provided: health insurance enrollment assistance for children and adults, health education, case management, referrals to local community organizations/resources, homelessness prevention &amp; intervention services.</p>
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Improve and Increase access to healthcare services and other community services.
<b>2012 Objective Measure/Indicator of Success</b>	To offer an additional service hub site in Woodland with varied day/evening hours to address the needs of 150 families (600 individuals) a year with 700 resource connections.
<b>Baseline</b>	Budget cuts by local government have severely impacted health insurance enrollment services and resource programs for our neediest families.
<b>Intervention Strategy for Achieving Goal</b>	Education and outreach about the partnership and services of the service hub in the Woodland Healthcare Clinic.
<b>Result FY 2012</b>	Served 750 individuals (187 families) with 869 resource connections.
<b>Hospital's Contribution / Program Expense</b>	\$26,668
<b>FY 2013</b>	
<b>Goal 2013</b>	Improve and Increase access to healthcare services and other community services.
<b>2013 Objective Measure/Indicator of Success</b>	To offer an additional service hub site in Woodland with varied day/evening hours to address the needs of 200 families (800 individuals) a year with 1,500 resource connections.
<b>Baseline</b>	Budget cuts by local government have severely impacted health insurance enrollment services and resource programs for our neediest families.
<b>Intervention Strategy for Achieving Goal</b>	Education and outreach about the partnership and services of the service hub in the Woodland Healthcare Clinic.
<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>	<p>Access to Care</p> <ul style="list-style-type: none"> <li>✓ Chronic Disease Prevention, Education and Management</li> </ul> <p>Continuum of Care to End Homelessness            Women's and Children's Health and Safety            Community Health and Well-Being</p>
<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 Needs Assessment</b>	<p>Responds to a priority need identified through community health needs assessments. Heart failure is a leading cause of hospitalization for residents throughout the broader Sacramento region. It is the fifth highest reason for emergency department visits, and the number one cause of death.</p>
<b>Program Description</b>	<p>The Congestive Heart Active Management Program (CHAMP®) provides patients with a vital link after they leave the hospital through regular phone intervention, educational classes and better disease management skills. This program targets patients diagnosed with Congestive Heart Failure (CHF), post heart attack high cholesterol and/or high blood pressure. Regular phone calls are made regarding weight and blood pressure changes, pain, medication side effects, or any other complications. Staff members make recommendations for diet, medicine modification, or physician visits. Follow up is conducted with physicians.</p>
<b>FY 2012</b>	
<b>Goal FY 2012</b>	<p>Assist patients with ongoing intensive management of heart disease to improve health and reduce hospital readmissions.</p>
<b>2012 Objective Measure/Indicator of Success</b>	<p>Objectives for FY 12 were to enroll 30 people annually and decrease readmissions by 5% for CHF.</p>
<b>Baseline</b>	<p>Heart failure is a priority health issue for the region, identified in past and current assessments of the community and hospital utilization rates. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease. Heart Disease is # 5 in top causes in Yolo County for ES visits; #3 in top causes for hospitalization and #2 in top causes of mortality. It is identified in the 2010 CNA as a priority health issue.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Continue education from staff and physicians to patients on the importance of healthy choices; additional outreach to increase enrollment.</p>
<b>Result FY 2012</b>	<p>23 patients were enrolled. At year end 100% of the patients were on ACEI, surpassing the goal of 82%. At year end 83.3% of the patients were on Beta Blockers, surpassing the goal of 82%. There were 3 re-admissions by CHAMP patients, therefore reducing re-admissions by 91%. During the 4<sup>th</sup> quarter of FY 12 patient satisfaction surveys (8 questions) were distributed with a target of 4.5 of 5. Overall satisfaction score was 4.34. A six question Physician Satisfaction Survey was sent out in March, 2012, with a target of 4.5. Overall satisfaction score was 3.75. This was up .60 from previous year.</p>
<b>Hospital's Contribution / Program Expense</b>	<p>\$10,036</p>
<b>FY 2013</b>	
<b>Goal 2013</b>	<p>Assist patients with ongoing intensive management of heart disease to improve health and reduce hospital readmissions.</p>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Enroll 30 people annually.</li> <li>• Avoid hospital or emergency department admissions among 70% of participants.</li> </ul>
<b>Baseline</b>	<p>Need in community; number of participants and successful rate of reduction in hospital admits/readmits determined basis for FY 13.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Continue education from staff and physicians to patients of importance of healthy choices; additional active outreach to increase enrollment.</p>
<b>Community Benefit Category</b>	<p>A2-e Community Based Clinical Services – Ancillary/Other Clinical Services.</p>

<b>HEALTHY LIVES</b>	
<b>Hospital CB Priority Areas</b>	<p>Access to Care</p> <ul style="list-style-type: none"> <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 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>	Healthy Lives is a six week course offered to people in the community with uncontrolled diabetes. The program specifically targets the underserved Hispanic population in Yolo County, where the incidence of diabetes is present in one out of three people. 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.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Improve the health of the target population in the community by providing education to enable them to manage diabetes and improve overall well-being.
<b>2012 Objective Measure/Indicator of Success</b>	<p>Enroll 350 people in sessions.</p> <p>Incorporate participants into Tomando de Salud, the Spanish version of Chronic Disease Self Management classes.</p> <p>Measure success by attendance in classes and maintenance of healthy diabetic living.</p>
<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.
<b>Intervention Strategy for Achieving Goal</b>	Outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians
<b>Result FY 2012</b>	<p>357 served.</p> <p>All participants had reductions in their Blood Sugars, 203 participants had reductions in their weight of at least 3-5 pounds and 110 participants saw decreases in their Body Mass Index (BMI) by 2%. 280 participants have continued a regular exercise program. Achieved a 100% reduction in ED admissions by participants.</p> <p>62 participants went on to the Tomando Control De Su Salud workshops (Chronic Disease Management Program-CDSMP) which are also well attended.</p> <p>The workshop was featured in the quarterly Choose Health newsletter, which is distributed to members within Yolo County.</p> <p>The hospital's Spanish Diabetic group is the only one of its kind in the Sacramento Valley.</p>
<b>Hospital's Contribution / Program Expense</b>	\$16,022
<b>FY 2013</b>	
<b>Goal 2013</b>	Improve the health of the target population in the community by providing education to enable them to manage diabetes and improve overall well-being.
<b>2013 Objective Measure/Indicator of Success</b>	<p>Hold classes supporting 400 participants.</p> <p>Include a behavioral component or a support group as almost half of the participants reported symptoms of anxiety and depression with no available resources in the community.</p>
<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. The number of participants of the Healthy Lives classes in FY 2012 provides the basis for improvement FY 2013.
<b>Intervention Strategy for Achieving Goal</b>	Ongoing collaboration with Yolo County community agencies; encouraging participation and education for those living with diabetes and other chronic diseases; continue to train lay leaders so more classes can be offered.
<b>Community Benefit Category</b>	A1-a Community Health Education – Lectures/Workshops.

<b>YOUR LIFE, TAKE CARE</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 Needs Assessment</b>	Obesity, Heart Disease, Stroke, Asthma, Cancer and Diabetes are among the top chronic diseases identified as priority health issues in the 2010 CHNA above the state average. The program specifically targets uninsured and underserved Hispanic residents in Yolo county who are at greater risk for these diseases.
<b>Program Description</b>	The Your Life, Take Care Chronic Disease Self Management Program offers free, six-week courses taught in both Spanish and English in Yolo County, to help people cope with ongoing health issues and chronic diseases. Chronic diseases – such as heart disease, cancer and diabetes, arthritis, obesity, depression – have been identified as a priority health issue in Yolo County. The program, taught by three Master Trainers who have been Stanford University certified, focuses on goal setting and problem solving, nutrition, communication skills, relaxation techniques, medication usage, community resources and partnering with your doctor.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Improve the health of the target population in the community by providing education to enable them to manage their chronic disease and improve overall well-being.
<b>2012 Objective Measure/Indicator of Success</b>	Enroll 100 people in sessions. Train 10 Promotoras (Community Health Educators) Lay Leaders. Measure success by attendance in classes and improved health status
<b>Baseline</b>	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes and Heart Disease within this community is the second highest cause for ED admissions.
<b>Intervention Strategy for Achieving Goal</b>	Targeted outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians
<b>Result FY 2012</b>	In FY 12, 216 people benefited from the 6 week classes. A Promatora (Community Health Educator) Lay Leader training was held for 15 people.
<b>Hospital's Contribution / Program Expense</b>	\$17,969
<b>FY 2013</b>	
<b>Goal 2013</b>	Improve the health of the target population in the community by providing education to enable them to manage their chronic disease and improve overall well-being.
<b>2013 Objective Measure/Indicator of Success</b>	Enroll 200 people in sessions. Train 10 Promotoras (Community Health Educators) Lay Leaders. Measure success by attendance in classes and improved health status.
<b>Baseline</b>	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes and Heart Disease within this community is the second highest cause for ED admissions.
<b>Intervention Strategy for Achieving Goal</b>	Targeted outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians.
<b>Community Benefit Category</b>	A1-a Community Health Education – Lectures/Workshops.

<b>SUPPORT GROUPS</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 Needs Assessment</b>	The prevalence of cancer and stroke, indicated in the 2010 CHNA, creates a need for support groups to improve the mental well-being of those in the community suffering from these illnesses.
<b>Program Description</b>	Woodland Healthcare offers support groups to cancer and stroke patients, and their family and friends to assist in coping with the diagnosis, treatment and side effects of cancer and stroke.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Provide support services to those affected by cancer and strokes.
<b>2012 Objective Measure/Indicator of Success</b>	<p>Continue to provide cancer and stroke support groups to address the issues that accompany a diagnosis and assist participants in solving the common issues arising from living with that diagnosis and treatment.</p> <p>Increase community awareness of support groups.</p> <p>Success is measured by repeated attendance and periodic satisfaction surveys.</p>
<b>Baseline</b>	<p>Of the top 5 causes for hospitalization in Yolo County, cancer is #4 and stroke is #5.</p> <p>Of the top 5 causes of mortality in Yolo County - cancer is #1 and stroke is #3.</p> <p>No other support groups are available within the hospital's service area for cancer and stroke victims.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Outreach in community.</p> <p>Physician referral processes.</p>
<b>Result FY 2012</b>	<p>303 cancer participants and 118 stroke participants served.</p> <p>Support group information is now listed on website and presentations have been made in the community about stroke awareness and services available.</p>
<b>Hospital's Contribution / Program Expense</b>	\$4,998
<b>FY 2013</b>	
<b>Goal 2013</b>	Provide support services for those affected by cancer and stroke.
<b>2013 Objective Measure/Indicator of Success</b>	Continue to provide support groups to address the issues that accompany the diagnosis of cancer and stroke; assist participants in solving the common issues arising from living with their diagnosis and treatment.
<b>Baseline</b>	<p>Of the top 5 causes for hospitalization in Yolo County, cancer is #4 and stroke is #5.</p> <p>Of the top 5 causes of mortality in Yolo County - cancer is #1 and stroke is #3.</p> <p>No other support groups are available within the hospital's service area for cancer and stroke victims. The number of participants of the support group classes in FY 2012 provides basis for FY 2013.</p>
<b>Intervention Strategy for Achieving Goal</b>	Ongoing communication through healthcare providers, WOODLAND HEALTHCARE website, press releases, and community presentations will ensure the public is aware of the services/support available.
<b>Community Benefit Category</b>	A1-d Community Health Education – Support Groups.

<b>ADULT DAY HEALTH CARE</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>x 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 Needs Assessment</b>	Eldercare services in an outpatient setting are few and far between. Home care is very expensive for most families. This is an alternative to nursing homes.
<b>Program Description</b>	Yolo Adult Day Health Center is a program of the hospital specifically designed for adults struggling to function independently. Our diverse program of health, social and rehabilitation services promote the well-being, dignity and self-esteem of an individual.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	To provide support, enjoyment and stimulation in a safe and comfortable environment. Individual programs are tailored to meet the needs of the participant and those they love, taking into consideration physical and cognitive limitations
<b>2012 Objective Measure/Indicator of Success</b>	Our 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.
<b>Baseline</b>	Maximum capacity of program based on staffing and funding
<b>Intervention Strategy for Achieving Goal</b>	Outreach in community. Physician referral processes.
<b>Result FY 2012</b>	938 Elders were served in program
<b>Hospital's Contribution / Program Expense</b>	\$529,554
<b>FY 2013</b>	
<b>Goal 2013</b>	To provide support, enjoyment and stimulation in a safe and comfortable environment. Individual programs are tailored to meet the needs of the participant and those they love, taking into consideration physical and cognitive limitations
<b>2013 Objective Measure/Indicator of Success</b>	Our 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.
<b>Baseline</b>	The number of participants in FY 2012 provides basis for FY 2013.
<b>Intervention Strategy for Achieving Goal</b>	Ongoing communication through healthcare providers, WOODLAND HEALTHCARE website, press releases, and community presentations will ensure the public is aware of the services/support available.
<b>Community Benefit Category</b>	C3-Subsidized Services: Outpatient Hospital Services

<b>SUPPORT GROUPS FOR THE ELDERLY</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 Needs Assessment</b>	The emphasis is prevention of stress on elderly individuals and their family caregivers-stress that can lead to mental and physical breakdown, care giver "burnout", premature institutionalization of the frail adult, and even elder abuse. Transfer to a long-term care facility often has a depressing impact on patient and family health, and every resource that supports independence is important.
<b>Program Description</b>	Yolo Adult Day Health Center offers a Triple-S (Share, support & solve) Family Caregiver Support Group for those caring for a loved-one with Alzheimer's Disease, Parkinson's Disease and other brain impairments. This group is a unique opportunity to discuss caregiving issues and strategies and find resources. The Women Spouses Support Group offers a support group specifically for women caring for their husbands.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Provide support services to those affected by elder care giving.
<b>2012 Objective Measure/Indicator of Success</b>	Continue to provide elder care support groups to address the issues that accompany care giving for an elderly loved one and assist participants in solving the common issues arising from living with that care. Increase community awareness of support groups. Success is measured by repeated attendance and periodic satisfaction surveys.
<b>Baseline</b>	Caregiver stress is the number 1 reason for hospitalizations with spouses caring for an elder. No other support groups are available within the hospital's service area
<b>Intervention Strategy for Achieving Goal</b>	Outreach in community. Physician referral processes.
<b>Result FY 2012</b>	393 participants were served. Support group information is listed on website and presentations have been made in the community about services available.
<b>Hospital's Contribution / Program Expense</b>	\$19,809
<b>FY 2013</b>	
<b>Goal 2013</b>	Provide support services for those affected by elder care giving.
<b>2013 Objective Measure/Indicator of Success</b>	Continue to provide elder care support groups to address the issues that accompany care giving for an elderly loved one and assist participants in solving the common issues arising from living with that care. Increase community awareness of support groups. Success is measured by repeated attendance and periodic satisfaction surveys.
<b>Baseline</b>	Caregiver stress is the number 1 reason for hospitalizations with spouses caring for an elder. No other support groups are available within the hospital's service area. The number of participants of the support group classes in FY 2012 provides basis for FY 2013.
<b>Intervention Strategy for Achieving Goal</b>	Ongoing communication through healthcare providers, WOODLAND HEALTHCARE website, press releases, and community presentations will ensure the public is aware of the services/support available.
<b>Community Benefit Category</b>	A1-d Community Health Education – Support Groups.

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

# COMMUNITY BENEFIT AND ECONOMIC VALUE

FY 2012 Complete Summary Report – Classified Including Non Community Benefit (Medicare)

For period from 7/1/2011 through 6/30/2012

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	Net % of Expenses	Organization Revenues
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	729	1,076,177	0	1,076,177	0.9	0.8
Medicaid	12,193	24,135,747	17,598,051	6,537,696	5.3	4.9
Means-Tested Programs	1,121	3,517,397	2,188,603	1,328,794	1.1	1.0
<b>Community Services</b>						
Community Benefit Operations	0	23,501	0	23,501	0.0	0.0
Community Building Activities	981	14,472	0	14,472	0.0	0.0
Community Health Improvement	1,435	175,511	0	175,511	0.1	0.1
Financial and In-Kind Contributions	2,870	193,500	0	193,500	0.2	0.1
Subsidized Health Services	1,353	49,177	0	49,177	0.0	0.0
<b>Totals for Community Services</b>	<b>6,639</b>	<b>456,161</b>	<b>0</b>	<b>456,161</b>	<b>0.4</b>	<b>0.3</b>
<b>Totals for Living in Poverty</b>	<b>20,682</b>	<b>29,185,482</b>	<b>19,786,654</b>	<b>9,398,828</b>	<b>7.7</b>	<b>7.0</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	3,887	24,479	0	24,479	0.0	0.0
Community Health Improvement	7,037	62,651	0	62,651	0.1	0.0
Financial and In-Kind Contributions	80	305,143	0	305,143	0.2	0.2
Health Professions Education	45	88,391	0	88,391	0.1	0.1
Subsidized Health Services	938	1,501,098	971,544	529,554	0.4	0.4
<b>Totals for Community Services</b>	<b>11,987</b>	<b>1,981,762</b>	<b>971,544</b>	<b>1,010,218</b>	<b>0.8</b>	<b>0.8</b>
<b>Totals for Broader Community</b>	<b>11,987</b>	<b>1,981,762</b>	<b>971,544</b>	<b>1,010,218</b>	<b>0.8</b>	<b>0.8</b>
<b>Totals - Community Benefit</b>	<b>32,669</b>	<b>31,167,244</b>	<b>20,758,198</b>	<b>10,409,046</b>	<b>8.5</b>	<b>7.7</b>
<b>Unpaid Cost of Medicare</b>	<b>13,290</b>	<b>26,857,749</b>	<b>20,290,100</b>	<b>6,567,649</b>	<b>5.4</b>	<b>4.9</b>
<b>Totals with Medicare</b>	<b>45,959</b>	<b>58,024,993</b>	<b>41,048,298</b>	<b>16,976,695</b>	<b>13.9</b>	<b>12.6</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 in the Yolo County region. The 2012 Community Benefit Report and 2013 Plan will be distributed to hospital leadership, members of the Community Board and the hospital's management team, as well as the Community Benefit Advisory Committee and employees engaged in community benefit activities. It serves as a valuable tool for ongoing community benefit awareness and training.

The document will also be more broadly distributed within the organization to all departments, and outside of the organization to community leaders, government and health officials, partners and other agencies and businesses throughout the region. It will be downloadable on the [www.healthylivingmap.com](http://www.healthylivingmap.com) website, and a summary report can be found under "Community Health" in the "Who We Are" section on [www.DignityHealth.org](http://www.DignityHealth.org).

## **APPENDIX A**

### **Woodland Healthcare Community Board Roster**

Marianne MacDonald, Chair, Realtor  
Betsy Marchand, Retired, Former Yolo County Supervisor  
Katie Knisely, Retired, WHC Auxiliary Past President  
Art Pimentel, Program Director, Community College  
Cindy Holst, Vice President, Strategy and Marketing, Dignity Health  
Carol Kimball, MD  
Alborz Alali, MD  
John Bringhurst, MD  
Clyde Brooker, CEO, Credit Union  
Mark Ewens, MD  
Jim Nielsen, State Assemblyman  
Christopher Rumery, MD  
Kevin Vaziri, WOODLAND HEALTHCARE President

### **Woodland Healthcare Community Benefit Advisory Committee**

Colleen Brock, Chair, Executive Director, WHC Foundation  
Viola DeVita, Executive Assistant, Education  
Tim Wilson, Epidemiologist, Yolo County  
Bob Ekstrom, Executive Director, Non-Profit  
Tom March, MD  
Heidi Mazeres, Manager, Education Services, WHC  
Josie Enriquez, Case Manager Supervisor, Non-Profit  
Carol Brehmer, Manager, Business Services, WHC  
Kathy Glatter, MD

# 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 ONE**

## **2010 Community Health Needs Assessment**

Available upon request or visit [www.valleyvision.org](http://www.valleyvision.org)

Additional resource: [www.healthylivingmap.com](http://www.healthylivingmap.com)