



Woodland Healthcare
Community Benefit Report 2014
Community Benefit Implementation Plan 2015



A Message From:

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

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

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

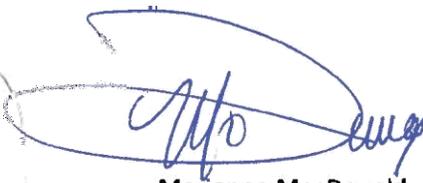
In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report community benefit efforts and measurable objectives as well as plans for the coming year. Encouraged and mandated by its governing body, Dignity Health complies with both mandates at all of its facilities,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

In fiscal year 2014, Woodland Healthcare provided \$15,985,198 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, total expense was \$25,128,762.

The Woodland Healthcare Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 28, 2014 meeting. Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 916 851-2731.



Kevin Vaziri
President and Chief Executive Officer
Woodland Healthcare



Marianne MacDonald
Chair, Woodland Healthcare
Community Board

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EXECUTIVE SUMMARY

Woodland Healthcare has a rich history of healing in Yolo County that dates back over a century to the opening of the Woodland Sanitarium in 1905 by a pioneering registered nurse and her two sisters who rented a home on College Street in the City of Woodland to serve the medical needs of the community. The Woodland Sanitarium had only nine beds and a surgical suite. The Woodland Sanitarium grew to become the Woodland Clinic Hospital in the 1920s and moved to Third and Cross Street in Woodland. With the help of the community, the full service acute care hospital that Woodland Healthcare has grown to be was established at 1325 Cottonwood Street in Woodland, CA. The hospital joined the Dignity Health family in 1996, and today has 715 employees, 108 licensed acute care beds, 17 emergency department beds, and 31 inpatient mental health beds.

A wide range of medical services at the hospital have received numerous local and national recognitions and accreditations. The hospital is certified as a Primary Stroke Center by the Joint Commission, accredited as a Chest Pain Center by the Society of Chest Pain Centers, and has received the “Get with the Guidelines® Stroke Silver Plus Quality Achievement Award” from the American Heart/American Stroke Association. In addition, the hospital received Quality Oncology Practice Initiative certification from the American Society of Clinical Oncology, was named for its excellence in pediatric care by Valley Emergency Physicians, is noted as a “Baby Friendly Hospital” by the World Health Organization and the United Nations Children’s Fund, and is considered a “Top Agency” by HomeCare Elite.

Woodland Healthcare must continuously balance its responsibility caring for the acutely ill with the role it serves as a safety net provider for the poor and vulnerable in a region where public and community capacity is limited. The region’s safety net is challenged by a lack of access to both primary and mental health care and minimal health prevention and education options for underserved and at-risk populations. These challenges are reflected in hospital utilization trends and through assessments of the community, and serve as the basis for community benefit planning. In FY 2014, the hospital advanced a number of core community benefit programs in partnership with others in the community that respond to these priority health issues, while undertaking several new initiatives. Highlights include:

Mental Health Continuum of Care Collaborative

In addition to increasing capacity at its inpatient mental health treatment center, which serves as the only resource of its kind in Yolo County, Woodland Healthcare began work on a new community-based initiative in FY 2014 to address the urgent need for mental health services. Evolving through the Dignity Health Community Grants Program, a collaboration has been forged with two community based nonprofit organizations, Suicide Prevention of Yolo County and the Yolo Community Care Continuum, to create a seamless process for connecting individuals in mental health crises with intervention and supportive resources they need to maintain health and stability in their lives. This collaborative initiative will be expanded in FY 2015 and include a third partner, Yolo Family Service Agency.

Building Better Caregivers Research Pilot at Yolo Adult Day Health Center

Woodland Healthcare’s Yolo Adult Day Health Center, the only specialty facility of its kind in the community serving the vulnerable elderly population, was selected in FY 2014 as the site for a “Building Better Caregivers” research program. Being conducted in partnership with the Stanford University School of Medicine, the research program will help determine whether a specific curriculum involving education

and support can have a lasting beneficial impact on the health and wellbeing of caregivers who care for individuals with cognitive impairment. Building Better Caregivers workshops will commence in FY 2015, taking participants through a series of educational topics focused on reducing stress, improving management techniques for handling difficult behaviors, enhancing communication skills, and improving self-efficacy. Workshops will complement the current efforts of the Yolo Adult Day Health Center, which specializes in Alzheimer's and Parkinson's disease and offers a diverse program of health, social and rehabilitation services for adults struggling to function independently.

Emphasis on Chronic Disease

With chronic disease consistently identified through assessment as a priority health issue in Yolo County, Woodland Healthcare continues to place significant emphasis on educational programs and support services to enable residents to better manage their conditions and lead healthier lives. The **Your Life, Take Care** Chronic Disease Self-Management Program brings participants with various chronic illnesses together to learn how to minimize symptoms and have greater control over their conditions. **Healthy Lives (Vida Sana)** focuses on doing the same for residents with diabetes, with an emphasis on outreach to the Hispanic community where the prevalence for diabetes is higher. The hospital's **Diabetes Care Management Program** provides an even greater level of support for high risk individuals with uncontrolled diabetes, involving them in bi-monthly group medical appointments, providing individual counseling by case managers and dietitians, and monitoring their conditions on a regular basis. Residents suffering from heart disease have access to the hospital's Congestive Heart Active Management Program, **CHAMP®**, which provides symptom and medication monitoring as well as education. All of these programs grew in FY 2014, and all achieved an 80% or better reduction in hospital readmissions by participants.

Friends of the Yolo Crisis Nursery

A new relationship with the Yolo Crisis Nursery evolved in FY 2014 when the hospital helped lead a community-wide effort to prevent this rare community asset from closing its doors. The Yolo Crisis Nursery has prevented thousands of child abuse and neglect emergencies since it opened its doors in 2001. Woodland Healthcare will continue to work with Friends of the Yolo Crisis Nursery in FY 2015 to ensure this important asset has a long-term plan for sustainability.

CommuniCare Capacity Building

Woodland Healthcare and local Federally Qualified Health Center, CommuniCare, are working together to build much needed capacity within the region's safety net. The hospital made a five-year commitment to support CommuniCare's new health center in Woodland, which celebrated its grand opening in FY 2014. The hospital continues to work with CommuniCare leadership to evaluate partnership opportunities to enhance delivery of care.

Cancer Nurse Navigator

A new Cancer Nurse Navigator program was launched by the hospital in FY 2014 to increase access to, and quality of care for patients with breast cancer. In addition to receiving referrals to needed resources, patients receive assistance in understanding the various options related to breast cancer, as well as education and support in dealing with the stresses of being diagnosed with cancer.

Details on these programs and other community benefit investments by Woodland Healthcare are documented in more detail in this report. The total value of community benefit for FY 2014 is \$15,985,198 which excludes \$9,143,564 in unpaid Medicare costs.

MISSION STATEMENT

We share the mission of Dignity Health:

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

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

ORGANIZATIONAL COMMITMENT

A commitment to improving the health of the community has been an essential part of Woodland Healthcare's mission for decades. The hospital is proud of its history of investing in community health programs and partnering with others to identify and address urgent health needs in the community it serves. Every three years, the hospital conducts a Community Health Needs Assessment that brings administrative and clinical leadership together with public health experts, nonprofit providers, representatives of medically underserved populations and other stakeholders to understand community needs and resources. The hospital uses the assessment to guide the development of health improvement strategies and investments that are aligned with priority health issues.

Priorities for community health improvement efforts focus on five broad areas of need specifically for underserved populations:

- Access to primary health care
- Access to mental health care
- Access to care for the elderly
- Access to preventative health services and education, with emphasis on chronic disease management
- Access to healthy foods and nutrition education

Initiatives that respond to these priority needs are conducted in collaboration with community partners to leverage resources and areas of expertise for higher impact, create a community-wide system of care and foster long-term sustainable change. Such programs, like the Yolo Adult Day Health Center, Resource Connection, Healthy Lives, and other preventative programs are incorporated into the hospital's strategic plan and tied to specific goals and measurable outcomes. Hospital leadership works with community benefit staff to plan, evaluate and budget for these initiatives each year.

Woodland Healthcare's commitment to the health of its community is reflected through other key programs. Offered each year since 1990, the Dignity Health Community Grants Program is a way for the hospital to support the work of other nonprofit organizations that share the same mission to improve the health and lives of underserved populations. The grants program maintains a focus on the five priority areas of need and further encourages collaboration by requiring organizations to partner on programs in order to provide a greater continuum of care. In the 2014 grants cycle, for example, two organizations joined forces to prevent suicides and ensure at-risk individuals received the mental health care and support services needed to maintain stability in their lives. In addition, the Dignity Health Community Investment Program is helping build community capacity by providing loans at below-market rate interest to nonprofit organizations that are working to increase access to health care, create jobs, develop low-income housing, and enhance educational opportunities for underserved populations.

Governance

Oversight for community benefit at Woodland Healthcare 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 address the unmet health needs of the community 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 are to:

- Ensure services and programs align with the mission and values of Dignity Health and are in keeping with five core principles:
 - Focus on disproportionate unmet health and health-related needs
 - Emphasize prevention
 - Contribute to a seamless continuum of care
 - Build community capacity
 - Demonstrate collaborative governance
- Ensure the hospital follows uniform methods of accounting for community benefit activities and expenses
- Review and approve the Community Health Needs Assessment and ensure alignment of programs and services with priority health issues
- Evaluate and approve the community benefit budget
- Evaluate community benefit program design and content
- Monitor and evaluate program progress, and determine program continuation or termination

Non-Quantifiable Benefits

Recognizing that true health improvement requires shared ownership of strategies and goals, Woodland Healthcare makes it a responsibility to engage with the community in many ways that are hard to measure and go beyond financial and programmatic investments. Whether serving on coalitions, boards or committees, members of the hospital's leadership and management teams volunteer significant time and expertise to help develop and implement strategies for long-term positive change in the health, wellbeing and economic vitality of the region. Leadership in the community extends to multiple organizations; from the Yolo County Health Council which serves as an advisory body to the Yolo County Board of Supervisors on public health needs, to the Center for Families, which works to increase access to care and promote health, stability and self-sufficiency in the community. Members of the hospital's leadership team are also involved in the Yolo County Food Bank, Yolo Healthy Aging Alliance, Red Cross Advisory Committee, Woodland Fitness Initiative, Rotary Club of Woodland, and the Woodland Chamber of Commerce. Hospital case managers and social workers can be found volunteering at local health and health-related events, and educators travel to remote areas of the community where exposure is limited to speak at forums to increase awareness about prevention and early detection of disease.

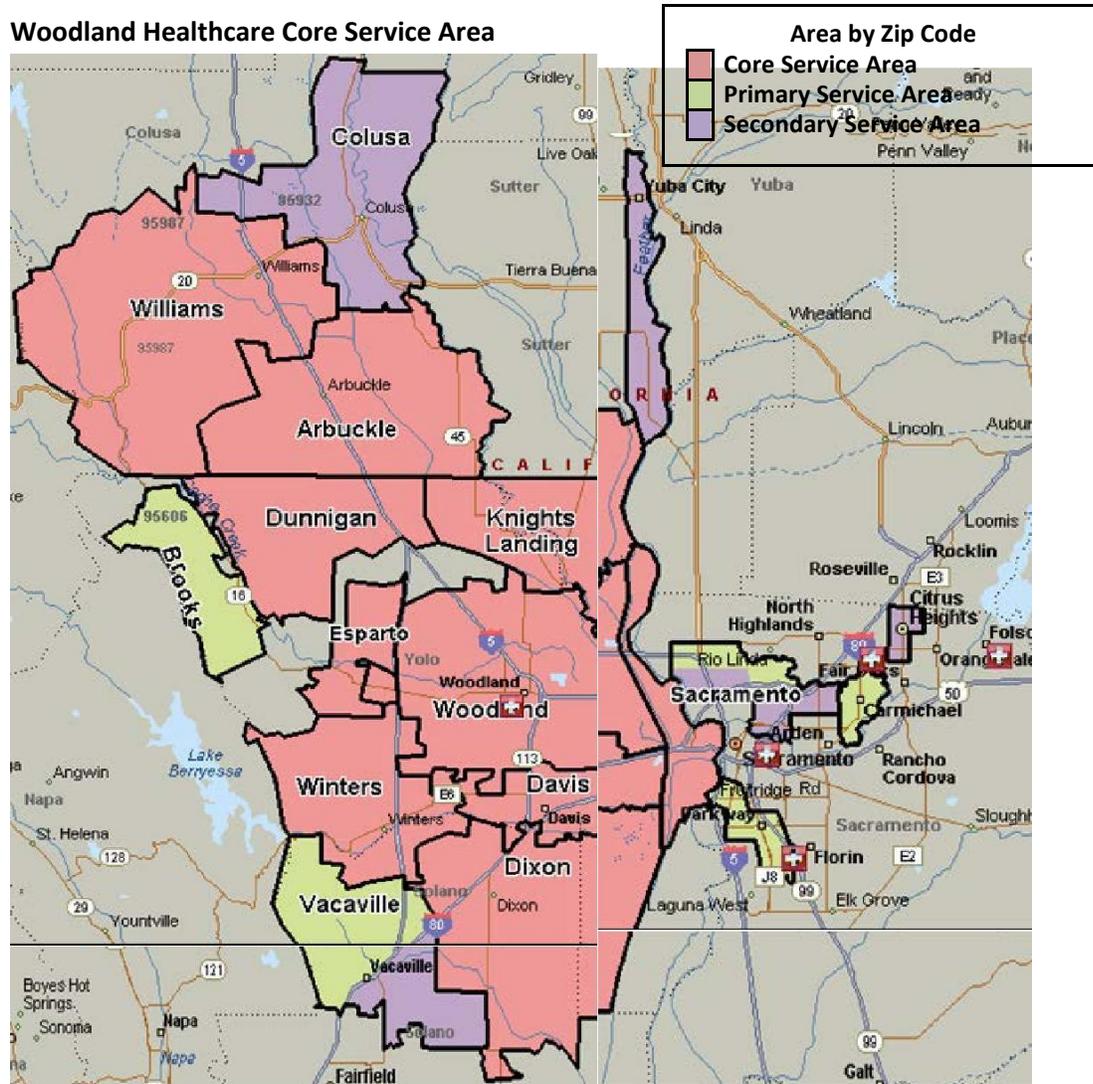
The hospital also maintains a leadership role in the Yolo County "Healthy Yolo: Our Community, Our Future" coalition. This countywide planning initiative aims to improve the health and wellbeing of residents and provides a platform for community members to come together to share and understand the specific health concerns and strengths of their community, prioritize public health issues, and determine goals and strategies for the future.

COMMUNITY

Definition of Community

Woodland Healthcare’s community, or core service area, in Yolo County is defined as the geographic area which it serves and determined by analyzing patient discharge data. The Hospital’s core service area is shown on the map below and encompasses 13 zip codes (95616, 95618, 95620, 95627, 95645, 95691, 95694, 95695, 95776, 95912, 95605, 95937, and 95687). The community of Knights Landing and portions of Esparto and West Sacramento within zip code 95645 are designated as Health Professional Shortage Areas by the US Government Health Resources and Services Administration. The communities of Dunnigan and Knights Landing are designated as a Medically Underserved Areas.

Woodland Healthcare Core Service Area



Description of the Community

Much of Yolo County remains a rural agricultural region. Sixty percent of the more than one million acres in the County are dedicated to farming and the County dominates California’s tomato industry. Nearly 19% of Yolo County residents live below the Federal Poverty Level, and while those who are clustered in suburban

areas have easier access to care at community health centers, for rural residents finding care is a significant challenge. As Woodland Healthcare’s Community Health Needs Assessment pointed out, access to care is an even greater issue for the County’s large Hispanic community, which accounts for 34% of the total population. Hispanic immigrants find the safety net difficult to navigate, and fear discrimination. The needs assessment also found that access to care is an issue for the growing underserved elderly population in Yolo County.

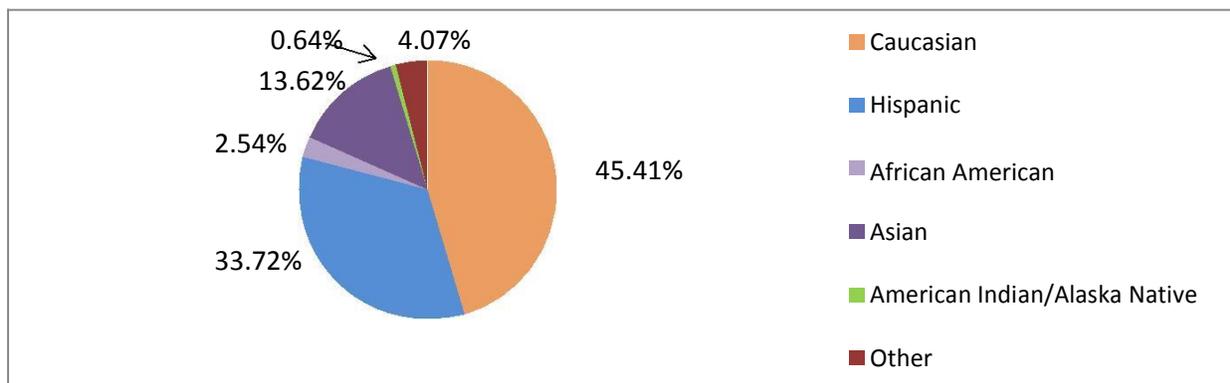
Woodland Healthcare continues to fill a major gap in needed safety net services for these vulnerable residents. Of the hospital’s total emergency department visits, 30% are by low-income and at-risk residents who are admitting for non-urgent care because they are unable to navigate the safety net system. Increasing access to appropriate care and ensuring these residents have a health care home is a priority area of focus for the hospital.

Accessing mental health care treatment and services is an even greater challenging for the underserved in Yolo County. The recession led to the discontinuation of a wide range of County services, including crisis care, and these have not been replaced. Yolo County is in the process of developing new Community Based Crisis Response Teams, but until they are established, the only remaining choice for those suffering from mental crisis is to call the police and be taken to the emergency department or the jail. Mental health continues to be a priority area of focus for Woodland Healthcare; in fact, the hospital offers the only mental health residential treatment facility in Yolo County for all residents, including the poor.

Demographics of the Community

Woodland Healthcare’s core service area encompasses a broad suburban/rural area in Yolo County. Included within are the communities of Woodland, Davis, Dixon, Esparto, Winters, West Sacramento, Dunnigan, Arbuckle, Knights Landing and Williams. There are 630,955 residents living within the hospital’s primary service area. Other demographics include:

Diversity

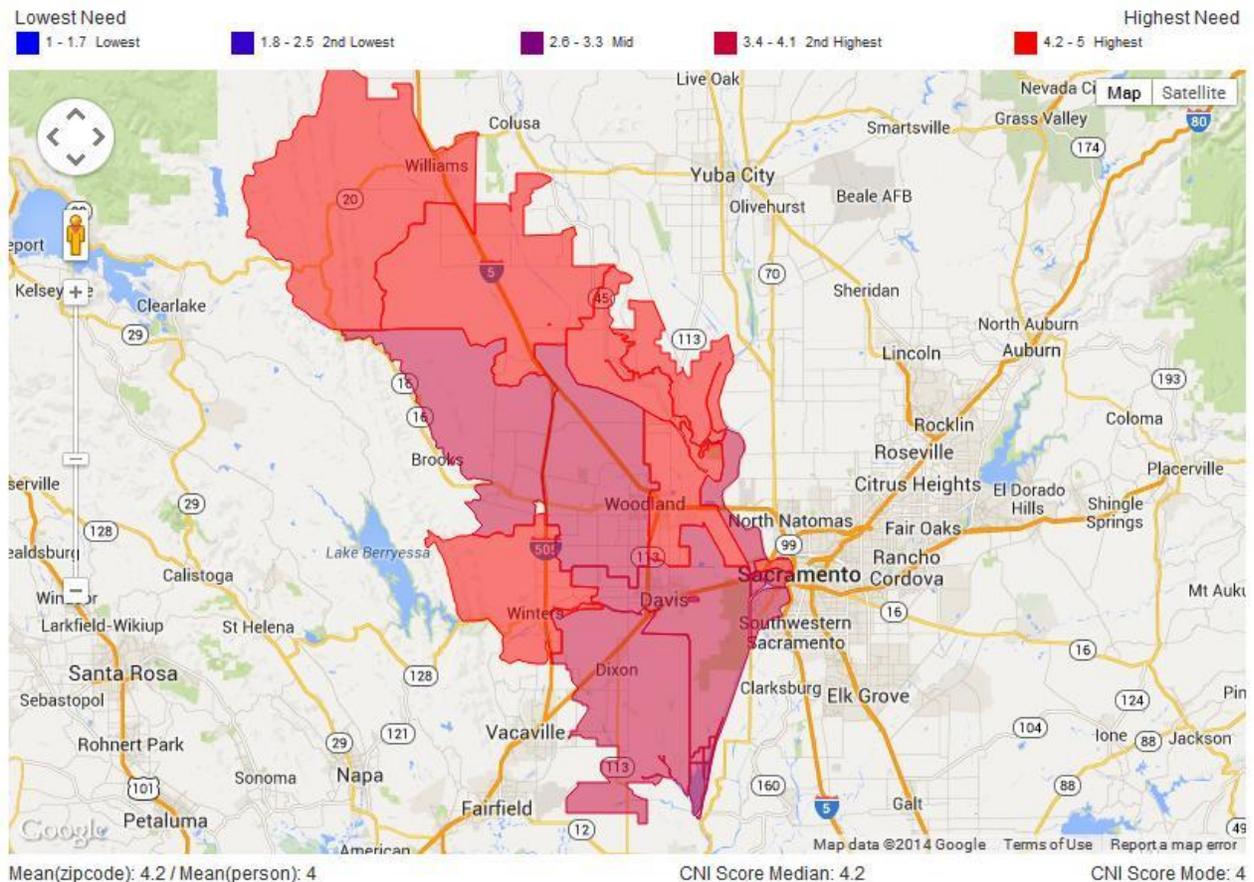


- **Median Income:** \$54,971
- **Uninsured:** 15.8%
- **Unemployment:** 6.95%
- **No High School Diploma:** 17.5%
- **Medically Underserved Areas:**
 - Zip codes 95937 and 95645
- **Renters:** 39.5%
- **CNI Score:** 4.2
- **Medicaid Patients:** 19.4%
- **Other Area Hospitals:** Sutter Davis Memorial
- **Health Professional Shortage Areas:**
 - Zip code 95645 (Esparto; West Sacramento)

Woodland Healthcare Community Needs Index Data

The hospital's CNI Score of 4.2 score falls in the highest 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).

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



Zip Code	CNI Score	Population	City	County	State
95605	5	14395	West Sacramento	Yolo	California
95616	4	47886	Yolo County	Yolo	California
95618	3.4	28282	Yolo County	Yolo	California
95620	3.8	21297	Solano County	Solano	California
95627	3.8	3730	Esparto	Yolo	California
95645	4.6	1590	Sutter County	Sutter	California
95691	4	37588	West Sacramento	Yolo	California
95694	4.2	9269	Winters	Yolo	California
95695	4	38762	Yolo County	Yolo	California
95776	4.2	23170	Yolo County	Yolo	California
95912	4.8	5171	Arbuckle	Colusa	California
95937	4.6	1830	Colusa County	Yolo	California
95987	4.4	6423	Williams	Colusa	California

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

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

Study area for the assessment included the hospital's primary service area. Zip code boundaries were selected as the unit-of-analysis for most indicators to allow for closer examination of health outcomes at the community level, which are often hidden when viewed at the county level. Some indicators (demographic, behavioral, and environmental in nature) were included in the assessment at the census tract, census block, or point prevalence level, which again, allowed for deeper community level examination. A specific objective was to identify within the hospital's primary service area, those communities experiencing disparities related to chronic disease and mental health.

The assessment used a mixed methods research approach. Primary qualitative data was obtained from interviews with hospital clinical and community benefit staff members and 13 key informants (area health and community experts). Three focus groups were conducted with area residents, and phone interviews and website analyses were conducted to assess community health assets. Secondary quantitative data was collected on health, demographic, behavioral, and environmental factors. County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity of health issues. Secondary data collected included information on the specific factors shown in Tables 1 and 2.

Table 1: Emergency Department Visits, Hospitalization, Mortality

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

*Age adjusted by 2010 California standard population

Table 2: Socio-Demographic, Behavioral, and Environmental

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

Identifying Vulnerable Communities

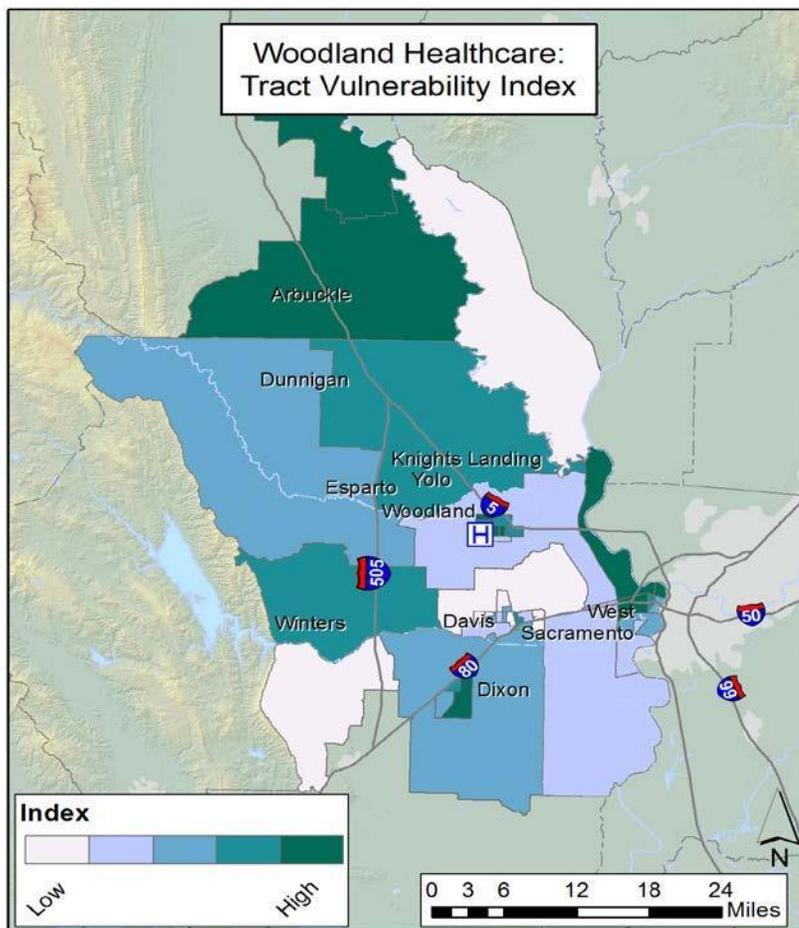
Socio-demographics were examined to identify neighborhoods in the hospital's service area with high vulnerability to chronic disease and mental health. Race/ethnicity, household make-up, income, and age variables were combined into a vulnerability index that described the level of vulnerability within each census tract. This index was then mapped for the entire service area. A tract was considered more vulnerable, or more likely to have poor health outcomes than others, if it had a higher: 1) percent Hispanic or non-White population; 2) percent single parent headed households; 3) percent below 125% of the poverty level; 4) percent under five years old; and 5) percent of individuals 65 years of age or older. This information helped identify areas that required a greater level of examination and discussion with key informants. The vulnerability index for the hospital's service area is shown at right.

Focus Group Selection

Areas selected for focus groups were determined from key informant feedback and through the analysis of health outcome indicators (emergency department visits, hospitalization and mortality rates). Key informants were asked to identify populations that were most at risk for health disparities and mental health issues. In addition, an analysis of health outcome indicators by zip code, race and ethnicity, age, and sex revealed communities with high rates that exceeded state and county benchmarks and Healthy People 2020 targets.

Communities of Concern

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



Analysis of data revealed five communities of concern, including Knights Landing (95645); two zip codes within West Sacramento (95605 and 95691); and two zip codes within the City of Woodland (95695 and 95776). These five areas of concern are home to more than 110,000 residents and cover 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, to the small rural community of Knights Landing. The areas of concern have higher rates of poverty than other areas within the hospital's service area, as well as low educational attainment, high levels of unemployment, and more home renters versus owners.

There are more single female-headed households and elderly residents 65 years of age or older living in poverty in these areas than the national average.

Priority Health Needs

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

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

These health needs were found to be greater among certain populations, including Hispanic and low-income elderly residents. Specific conditions, including heart disease and diabetes, were more prevalent than other chronic diseases in Yolo County, as well as Alzheimer's disease, which is the fifth leading cause of death in Yolo County. Communities of concern had rates of emergency department visits for self-inflicted injury that exceeded county and state benchmarks. The assessment also highlighted the challenges that low-income residents face when trying to enroll in government programs, principally Medi-Cal. There is a lack of awareness about where to go to find assistance.

Communicating the Results

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

Assets Assessment

With the hospital's emphasis on collaborating with partners for more impactful health improvement efforts, gaining a more in-depth understanding of the available resources in the community was an important consideration in the assessment process. Nearly 40 community resources were identified and evaluated. The hospital is currently working with a number of these resources; several others are now being targeted for future partnership initiatives.

Through financial support and partnership programs like the Resource Connection, Healthy Lives and others that have been formed through the Dignity Health Community Grants Program, Woodland Healthcare has established strong relationships with numerous community-based nonprofit providers and social service agencies. The hospital is working with the Center for Families, Rise, Inc., Suicide Prevention of Yolo County, the Yolo Community Care Continuum and others to address priority health and health-related

needs for adults, including the elderly, children and families. The hospital initiated collaborative efforts in FY 2014 with CommuniCare, a Federally Qualified Health Center in Yolo County, to increase access to care, as well as the Yolo Crisis Nursery, to prevent young and vulnerable children from neglect and abuse. Planning got underway during the year to expand an existing partnership addressing crisis mental health care with Suicide Prevention of Yolo County and other nonprofit agencies, and work is underway as well on a new senior initiative in FY 2015 in partnership with the Yolo Healthy Aging Alliance. A complete listing of community assets within Woodland Healthcare's core service area can be found in the Community Health Needs Assessment in Attachment 1.

Implementation Plan Development

In participation with assessment partners, stakeholders and the Community Benefit Advisory Committee, Woodland Healthcare used the following criteria to evaluate and prioritize community health issues:

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

Through this process of evaluation, five priority health issues were selected from the broader list of priorities identified in the Community Health Needs Assessment as specific areas of focus for the hospital. These include: 1) access to primary health care; 2) access to mental health care; 3) access to care for the elderly; 4) access to preventative health services and education, with emphasis on chronic disease management, and; 5) access to healthy foods and nutrition education. Initiatives that address these priorities will target vulnerable and at-risk populations, with emphasis on identified communities of concern and collaboration with other community partners to maximize efforts and have a greater region-wide impact. Initiatives will also require methodologies be developed to measure and demonstrate health improvement outcomes. Woodland Healthcare will continue to work with its partners to refine goals and strategies over time to ensure they effectively address the needs identified.

Implementation Strategies/Actions

1. Access to Primary Health Care

The Community Health Needs Assessment found there were significant barriers that contribute to poor access to primary health care. While capacity remains a major concern, equally troublesome is the

fragmentation that exists within the region's safety net and the lack of attention paid by providers to outreach, education, and care coordination, confusion about Medi-Cal eligibility and benefits, and where to go to find assistance present additional barriers to care. Initiatives by the hospital to address the need for increased access to care take these barriers, which are also identified as priority health needs, into consideration. A few of these initiatives are highlighted below.

CommuniCare Capacity Building

Woodland Healthcare partnered with CommuniCare in FY 2014, making a five year commitment to support construction of this Federally Qualified Health Center's new Hansen Family Health Center in the City of Woodland. This new capacity was desperately needed as demand for services at CommuniCare has increased by 40%. The new Center, located just a mile from the hospital, features 21,000 square feet and conveniently houses expanded health services beneath one roof, including primary, behavioral health, and dental care and health education and patient support resources.

Emergency Department Care Coordinator

The hospital is also partnered with CommuniCare to coordinate the care of individuals admitting to the emergency department in need of follow-up care and a medical home. Emergency department staff and case managers are connected to a CommuniCare care coordinator to provide this linkage.

Resource Connection

Nearly 1,000 residents receive assistance each year through Resource Connection, a service center located on the campus of Woodland Healthcare. The hospital partners with the Center for Families (formerly the Family Resource Center) to offer this resource, which serves as an access point for vulnerable individuals and families to be connected to community health and social services and receive case management and education.

Cancer Nurse Navigator

The Cancer Nurse Navigator program was also introduced by the hospital in FY 2014, to increase access to care for patients with breast cancer. The program is designed to help patients navigate the maze of options related to breast cancer and to complement and enhance services provided by physicians. Nurses provide information, resources and referrals for follow-up biopsies and other treatments that low-income patients otherwise would not be able to access. They provide education, and support both patients and families in dealing with the stresses of being diagnosed with cancer. Nurse navigators also coordinate a peer support volunteer program.

Affordable Care Act Education and Enrollment

Woodland Healthcare expanded its enrollment assistance program in the hospital during FY 2014 to include outreach, education and enrollment services in the community. One event hosted by the hospital, for example, brought Yolo County representatives, community nonprofit organizations, vendors and others together to educate and assist residents with enrollment. Emphasis was on the community's large newly Medi-Cal eligible individuals.

Dignity Health Community Grants Program

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

2. Access to Mental Health Care

Similar to Sacramento, mental illness is perhaps the most pronounced health care problem in Yolo County. Overall care for people with mental illness in the region, rather than improve, has grown worse over the last half decade. Woodland Healthcare, affiliate Dignity Health hospitals, and other health systems are working together to develop strategies and drive the system change that is needed to address what is truly a mental health crisis. The hospital is a leading member of the Community Mental Health Partnership, convened by the Hospital Council of Northern & Central California, and continues to evaluate new internal and external initiatives to improve quality of care for the mentally ill.

Inpatient Mental Health Services

Yolo County is dependent upon Woodland Healthcare as the only source of inpatient mental health treatment in the community. Nearly 500 vulnerable and at-risk indigent and Medi-Cal-insured residents received acute psychiatric care in FY 2014, who otherwise would not have had access to care. The community benefit investment to care for these individuals approached \$3 million. Woodland Healthcare's inpatient 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. The hospital completed a major expansion of its inpatient mental health facility in FY 2014, opening significant new capacity for care.

Mental Health Continuum of Care Collaborative

In addition to the need for acute inpatient mental health treatment, the Community Health Needs Assessment found there was a priority need for short-term crisis residential and intensive outpatient mental health care within Woodland Healthcare's service area. Through a collaborative effort that evolved through the Dignity Health Community Grants Program, the hospital is responding to this with Suicide Prevention of Yolo County, the Yolo Community Care Continuum and the Yolo Family Service Agency. Partners link individuals admitting to the hospital who do not need inpatient treatment to Suicide Prevention of Yolo County for crisis intervention, stabilization and if needed, short-term residential treatment services at community-based nonprofit, Safe Harbor. Individuals also receive follow-up care and outpatient mental health care through Yolo Community Care Continuum and the Yolo Family Service Agency.

3. Access to Care for the Elderly

The hospital's Community Health Needs Assessment found that access to care was an even greater problem for Yolo's growing vulnerable elderly population. Barriers to care facing the elderly included lack of support when transitioning from independence to higher levels of care, mobility, difficulty navigating the safety net system and geriatric mental health issues. Yolo County's "Healthy Yolo" initiative findings were also similar. Lack of access to care, education and support for Alzheimer's disease in particular was noted as a significant problem; it is the fifth leading cause of death in the County. Woodland Healthcare is committed to improving the health and lives of the elderly in its community and demonstrates this commitment in several impactful ways.

Yolo Adult Day Health Center

Woodland Healthcare is the primary provider in Yolo County that fills the specialty health care and support needs for the elderly. 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. The center also specializes in Alzheimer's and Parkinson's disease. Services include nursing and medication assistance, care coordination, ongoing rehabilitative therapies, exercise and activities, companionship, caregiver respite and support and transportation. Center staff can also be found conducting outreach in the community and to physicians to increase awareness and access to services at the center. Over 1,100 underserved residents benefited from these services in FY 2014.

Building Better Caregivers

Groundwork was laid at Woodland Healthcare in FY 2014 to embark on a Building Better Caregivers research pilot program in FY 2015 in partnership with Stanford University School of Medicine. Building Better Caregivers involves a workshop series for caregivers taking care of a loved one who has cognitive impairment. Participants will design a personal self-management program while workshop sessions focus on breaking the caregiver stress cycle and managing difficult behaviors, enhancing communication between family, friends and healthcare teams, finding help when needed and improving self-efficacy. The goal of the research program is to determine whether this caregiver education and support can have a lasting beneficial impact in helping caregivers reduce stress and improve their health through self-management skills.

Community Based Services for Seniors Program

Woodland Healthcare and four community based organizations will be teaming in FY 2015 on an initiative created through the Dignity Health Community Grants Program to increase access to primary, preventative, and mental health care, and substance abuse services for the growing senior population in Yolo County. Partners include Yolo Health Aging Alliance, Legal Services of Northern California, Meals on Wheels of Yolo County and the Yolo Adult Day Health Center. The collaborative has three primary goals: 1) through evidence-based training, increase awareness, knowledge and care intervention skills for hospital clinicians and staff when dealing with persons who suffer from dementia; 2) develop a referral and care planning program engaging community resources, and; 3) bring Yolo community leaders together to plan a Yolo Center for Aging that will serve as a home for information and referral services, geriatric specialty consultation and care management.

4. Access to Preventative Health Services and Education

Chronic disease was consistently mentioned in the 2013 Community Health Needs Assessment as a condition affecting a large number of residents, and has been identified as such in all past assessments. Assessment participants described the lack of available education and support services as major barriers to staying healthy, leading normal lives, and keeping their costs for health care in check. An inability for individuals to manage their chronic disease is also a cause for high emergency department readmission rates. Diabetes, and the lack of available education and support for this disease, was the most frequently discussed health condition among key informants and community focus groups, and findings pointed to the Hispanic community as facing the greatest obstacles. Heart disease was also another health problem common to many assessment participants. Woodland Healthcare, along with affiliate Dignity Health hospitals in the broader region, offers the only community-based chronic disease health prevention and education programs that target both diabetes and heart disease specifically.

Healthy Lives (Vida Sana)

This six week course is offered to residents who have, or are at risk of diabetes, with an emphasis on outreach to the Hispanic community in partnership with Holy Rosary Church. The program is taught in

Spanish and in English and engages participants in learning to recognize the signs and symptoms of diabetes. Participants are also taught proper nutrition, healthy eating habits, and medication management.

Diabetes Care Management Program

This program takes Woodland 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

Your Life, Take care is a six-week workshop that supports individuals who suffer from various chronic illnesses and share common symptoms. Goal setting and problem solving, nutrition, communication skills, relaxation techniques, medication usage, community resources and physician relationships are all part of the Your Life, Take Care curriculum. Woodland Healthcare is also working in partnership with the Centers for Families (formerly the Yolo Family Resource Center) to expand workshop offerings by providing training to staff members and volunteers who are involved in the “Promotoras for Active Living” (PAL) project.

CHAMP®

The Congestive Heart Active Management Program, CHAMP® provides support and assistance to those who suffer from heart failure and disease. The program keeps individuals linked to the medical world once they leave the hospital through symptom and medication monitoring and education. Consistently, the program achieves an 80% or better reduction in hospital readmissions by participants each year.

Friends of the Yolo Crisis Nursery

Woodland Healthcare rallied with Yolo County and other community leaders and businesses in FY 2014 to provide a lifeline for Yolo County’s youngest and most vulnerable children at risk. The hospital made a significant commitment to the Yolo Crisis Nursery when this valued community organization lost its host agency. Yolo Crisis Nursery is a unique asset that over the years has prevented thousands of child abuse and neglect emergencies. The nursery provides emergency respite care for children when their families are facing crisis or hardship, providing a safe environment and supervision for children day or night. Families are also connected to community resources to help reduce isolation, lower stress levels and resolve a crisis or hardship. Other services offered at the Nursery include assessment referrals for children, parenting strategies and support, nutritional advice, problem-solving assistance and support networks. Woodland Healthcare will continue to work with Friends of the Yolo Crisis Nursery in FY 2015 to ensure this important asset has a long-term sustainability plan.

5. Access to Healthy Foods and Nutrition Education

Numerous participants in the Community Health Needs Assessment reported that many people within the community have poor nutrition, often due to an abundance of unhealthy, convenience foods in urban areas and a lack of high quality, affordable fresh food in both urban and rural areas. Both the key informants interviewed and others who participated in focus groups noted that many people do not make eating healthy a priority, nor do they have adequate knowledge of nutrition.

Farmers Market

A weekly Farmers Market hosted by Woodland Healthcare responds to the need for affordable fresh foods, and provides local residents inexpensive and healthier food choices. The hospital takes the opportunity at these markets to provide nutrition and exercise education and conduct free health screenings.

Needs Not Prioritized

Woodland Healthcare responds to the health needs of its community in many ways, and in times that are critical for those in crisis. In addition to financial assistance, indigent care, and un-funded Medi-Cal care, a significant investment is being made to address the five priority health needs outlined in this report. While Woodland Healthcare has focused on these priority areas, this report is not exhaustive of everything the hospital does to enhance the health of its community. However, the needs in Yolo County are significant and Woodland Healthcare does not have the available resources to develop and/or duplicate efforts to meet them all. To the extent that it can, the hospital provides transportation services and prescription medications, although has not included these in priority focus areas. The hospital is not directly addressing dental care; this is offered to the underserved in the community by CommuniCare. Woodland Healthcare will continue to seek collaboration opportunities that address needs that have not been selected where it can appropriately contribute to addressing those needs.

Planning for the Uninsured/Underinsured Patient Population

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% of the federal poverty level (see Appendix B for a summary of the Dignity Health Patient Payment Assistance Policy).

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

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

In addition to financial assistance, the hospital further supports the specific needs of uninsured and underinsured patient populations through enrollment assistance in government health insurance programs. With implementation of the Affordable Care Act, the hospital greatly expanded enrollment efforts in FY 2014, hosting community-wide enrollment health fairs, particularly targeting the thousands of newly Medi-Cal eligible residents. The hospital also ensures underserved patients have prescription medications and transportation services at no cost. Over 700 individuals without the means to travel received transportation assistance in FY 2014, and prescription medications were provided to nearly 250 individuals who could not afford to purchase their own.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives

Key community benefit initiatives and community-based programs directly provided, or substantially supported, by Woodland Healthcare in FY 2014 are summarized below. These initiatives and programs are mapped to align with the five priority health areas selected through the Community Health Needs Assessment process, and are guided by five core principles:

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

Initiative I: Access to Primary Health Care

- Financial assistance
- Resource Connection Partnership
- CommuniCare Capacity Building (new in FY 2014)
- Emergency Department Care Coordinator (new in FY 2014)
- Affordable Care Act Awareness and Enrollment (new in FY 2014)
- Cancer Nurse Navigator (new in FY 2014)
- Dignity Health Community Grants Program
- Dignity Health Community Investment Program
- Charity prescriptions
- Community health screenings
- Transportation
- Yolo County “Healthy Yolo: Our Community, Our Future” coalition (new in FY 2014)

Initiative II: Access to Mental Health Care

- Inpatient Mental Health Services
- Mental Health Continuum Collaborative (new in FY 2014)
- Participation in Community Mental Health Partnership

Initiative III: Access to Care for the Elderly

- Yolo Adult Day Health Center
- Community Based Services for Seniors Program (planned in FY 2015)
- Building Better Caregivers (new in FY 2014)
- Participation in Yolo Healthy Aging Alliance

Initiative IV: Access to Preventative Health Services and Education

- Healthy Lives (Vida Sana)
- Diabetes Care Management Program
- Your Life, Take Care
- CHAMP®
- Friends of the Yolo Crisis Nursery

Initiative V: Access to Healthy Foods and Nutrition Education

- Farmers Market
- Nutrition Education Counseling
- Healthy Cooking Classes through the Healthy Lives Program

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

DESCRIPTION OF KEY PROGRAMS AND INITIATIVES - PROGRAM DIGESTS

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®)	
Hospital Priority Areas	<ul style="list-style-type: none"> <input type="checkbox"/> Access to Primary Health Care <input type="checkbox"/> Access to Mental Health Care <input type="checkbox"/> Access to Care for the Elderly <input checked="" type="checkbox"/> Access to Preventative Health Services and Education <input type="checkbox"/> Access to Healthy Foods and Nutrition Education
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate unmet health-related needs <input checked="" type="checkbox"/> Primary prevention <input checked="" type="checkbox"/> Seamless continuum of care <input checked="" type="checkbox"/> Build community capacity <input checked="" type="checkbox"/> Collaborative governance
Link to CHNA Vulnerable Population	The program responds to a priority health need identified in the CHNA. Heart failure is a leading cause of hospitalization for residents.
Program Description	CHAMP® establishes a care relationship with patients who have heart disease after discharge from the hospital through regular phone interaction; support and education, monitoring of symptoms or complications and recommendations for diet changes, and medicine modifications.
FY 2014	
Goal FY 2014	Improve the health and quality of life of those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2014 Objective Measure/Indicator of Success	Continue to increase enrollment of underserved through outreach and community collaboration, and maintain reduction in number of hospitals admissions and readmissions for enrolled participants.
Baseline	Heart failure is a priority health issue for Yolo County, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Teams at hospital; continued partnership building in the community.
Result FY 2014	145 participants enrolled in the program and less than 1% were readmitted to the hospital three months post intervention.
Hospital's Contribution / Program Expense	\$22,984.
FY 2015	
Goal 2015	Improve the health and quality of life of those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2015 Objective Measure/Indicator of Success	Continue to increase enrollment by the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants.
Baseline	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 disease.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Teams at hospitals; continued partnership building in the community.
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.

CANCER NURSE NAVIGATOR

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Primary Health Care ✓ Access to Mental Health Care ☐ Access to Care for the Elderly ✓ Access to Preventative Health Services and Education ☐ Access to Healthy Foods and Nutrition Education
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ☐ Collaborative Governance
Link to CHNA Vulnerable Population	Access to care, including preventative health care, is a priority health issue for Yolo County, identified in past and current CHNAs. The program demonstrates improvement in the health of participants while offering services free of cost that would not otherwise be accessible.
Program Description	This program provides continuity of care, enhancing patient/doctor communication whenever an abnormality shows up on mammogram, breast ultrasound, or breast MRI. Patients receive information, resources, and support for assisting with biopsies. Education about pathology results and assistance obtaining referrals to specialists is provided in a timely manner. The navigators also coordinate a group of peer support volunteers who are matched up with patients newly diagnosed with breast cancer.

FY 2014

Goal FY 2014	Ensure timely access to treatment and related resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and improve patient/doctor relationships.
2014 Objective Measure/Indicator of Success	Continue to increase the number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers resources that would otherwise not be accessible to the underserved.
Intervention Strategy for Achieving Goal	Promote services into community and work with hospital and community partners to increase awareness of services and resources; this includes working with patient navigators who are located in the emergency departments.
Result FY 2014	2589 persons served -- shared by Dignity Health hospitals in Sacramento and Yolo counties.
Hospital's Contribution / Program Expense	\$68,855 -- shared by Sacramento and Yolo County Dignity Health Hospitals

FY 2015

Goal 2015	Ensure timely access to treatment and related resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and improve patient/doctor relationships.
2015 Objective Measure/Indicator of Success	Continue to increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.
Baseline	Services and resources for specialty care, especially cancer, continue to be identified as a priority in the CHNA. The program offers resources that would otherwise not be accessible to the underserved.
Intervention Strategy for Achieving Goal	Promote services into community and work with hospital and community partners to increase awareness of services and resources; this includes working with patient navigators who are located in the ED's.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.

RESOURCE CONNECTION

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Primary Health Care ✓ Access to Mental Health Care ☐ Access to Care for the Elderly ✓ Access to Preventative Health Services and Education ☐ Access to Healthy Foods and Nutrition Education
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ☐ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	Access to primary care and other health-related and social support services for uninsured and low-income populations is a priority health issue that is identified through assessment and reflected in high hospital utilization rates for non-urgent care by the underserved.
Program Description	The Resource Connection is a partnership between the hospital and community nonprofit, Centers for Families (formerly the Family Resource Center). Located on the hospital's campus, a Resource Connection center provides a one stop access point for community services and health education in both Spanish and English. Services include linkages to primary care, health insurance enrollment assistance for children and adults, health education, case management, referrals to social services in the community, and homeless prevention and intervention services.

FY 2014

Goal FY 2014	Increase access to healthcare services and other social support services for the underserved.
2014 Objective Measure/Indicator of Success	Increase numbers served by 10% or greater. Improve methods of outcomes measurement.
Baseline	The need for the program is evident in the CHNA, which identifies access to primary care and preventative services as priority issues for underserved.
Intervention Strategy for Achieving Goal	Connect the Resource Center with case management, emergency department and other staff at the hospital and enhance education in the community about this available resource.
Result FY 2014	908 unique individuals served and connected to a variety of community resources.
Hospital's Contribution / Program Expense	\$26,668

FY 2015

Goal 2015	Increase access to healthcare services and other social support services for underserved populations.
2015 Objective Measure/Indicator of Success	Increase numbers served by 10% or greater. Improve methods of outcomes measurement including referral sources and follow-up of services received. Look to build capacity for potentially referring patients utilizing ED for non-urgent care to a clinic or provider.
Baseline	The need for the program is evident in the assessment, which identifies access to primary care and preventative services as priority issues for underserved.
Intervention Strategy for Achieving Goal	Continue to build relationship between the Resource Center and case management, emergency department and other staff at the hospital.
Community Benefit Category	E1-a Financial Donations - General contributions to nonprofit organizations/Community Groups

PRESCRIPTIONS

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Primary Health Care ✓ Access to Mental Health Care ☐ Access to Care for the Elderly ☐ Access to Preventative Health Services and Education ☐ Access to Healthy Foods and Nutrition Education
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ☐ Seamless Continuum of Care ☐ Build Community Capacity ☐ Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	Lack of access to primary care and preventative services, including access to medication, was identified as a priority in the 2013 assessment, specifically for patients trying to manage a chronic disease that requires strict medication compliancy.
Program Description	The hospital donates prescription medications to uninsured and underserved patients who cannot afford them to ensure accessibility regardless of their ability to pay.

FY 2014

Goal FY 2014	Continue to fill prescriptions for Medi-Cal and uninsured patients who cannot afford them; ensure medication is available upon discharge to minimize risk of readmission.
2014 Objective Measure/Indicator of Success	Provide medication for patients who are unable to otherwise afford it and ensure education is offered about medication usage and side effects. Continue to report number of patients served and additional outcomes as appropriate.
Baseline	Access to free or affordable medications remains to be a challenge as identified in the CHNA, specifically for patients trying to manage a chronic disease that requires strict medication compliancy. This service fills a gap which otherwise would leave patients with unfilled prescriptions.
Intervention Strategy for Achieving Goal	Increase awareness among hospital staff of this service that is available to patients.
Result FY 2014	248 patients received free medication.
Hospital's Contribution / Program Expense	\$110,617

FY 2015

Goal 2015	Continue to fill prescriptions for Medi-Cal and uninsured patients who cannot afford them; ensure medication is available upon discharge to minimize risk of readmission.
2015 Objective Measure/Indicator of Success	Provide medication for patients who are unable to afford it and ensure education is offered about medication usage and side effects. Continue to report number of patients served and additional outcomes as appropriate.
Baseline	Access to free or affordable medications remains a challenge as identified in the CHNA, specifically for patients trying to manage a chronic disease that requires strict medication compliancy. This service fills a gap which otherwise would leave patients with unfilled prescriptions.
Intervention Strategy for Achieving Goal	Increase awareness among hospital staff of this service that is available to patients.
Community Benefit Category	A3-g Health Care Support Services - Case management post-discharge

YOUR LIFE, TAKE CARE (CHRONIC DISEASE SELF-MANAGEMENT PROGRAM)

Hospital Priority Areas	<ul style="list-style-type: none"> <input type="checkbox"/> Access to Primary Health Care <input type="checkbox"/> Access to Mental Health Care <input checked="" type="checkbox"/> Access to Care for the Elderly <input checked="" type="checkbox"/> Access to Preventative Health Services and Education
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Access to Healthy Foods and Nutrition Education <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	Preventative health services and education have been identified in CHNAs as priority issues with a specific emphasis on diabetes. The program specifically targets uninsured and underserved Hispanic residents in Yolo county who are at greater risk for chronic illness.
Program Description	Your Life, Take Care is a workshop series in Spanish and English to help people cope with chronic diseases. The program focuses on goal setting and problem solving, nutrition, communication, relaxation techniques, medication usage, and use of community resources.
FY 2014	
Goal FY 2014	Provide education and skills to help those with chronic diseases 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).
2014 Objective Measure/Indicator of Success	Continue to grow number of participants and workshop offerings, with an emphasis on collaboration; exceed System metric goal.
Baseline	Chronic disease negatively impacts the lives of a significant number of residents in Yolo County and is a priority CHNA health issue.
Intervention Strategy for Achieving Goal	Outreach to the Hispanic community to promote the program, and seek collaborative partnerships within the community to expand program capacity.
Result FY 2014	620 individuals participated in the workshops and metric goal was exceeded.
Hospital's Contribution / Program Expense	\$26,370
FY 2015	
Goal 2015	Provide education and skills to help those with chronic diseases 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).
2015 Objective Measure/Indicator of Success	Continue to grow number of participants, workshop offerings, and lay leader facilitators through collaboration. Meet or exceed metric goal.
Baseline	Chronic disease negatively impacts the lives of a significant number of residents in Yolo County and is a priority CHNA health issue.
Intervention Strategy for Achieving Goal	Outreach to the Hispanic community to promote the program, and seek collaborative partnerships within the community to expand program capacity.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops

ADULT DAY HEALTH CENTER

Hospital Priority Areas	<ul style="list-style-type: none"> ✓ Access to Primary Health Care ✓ Access to Mental Health Care ✓ Access to Care for the Elderly ✓ Access to Preventative Health Services and Education ☐ Access to Healthy Foods and Nutrition Education
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ☐ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	The CHNA identified that Yolo County’s growing elderly population 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.
Program Description	Yolo Adult Day Health Center operated by the hospital targets adults struggling to function independently. Diverse health, social and rehabilitation services are offered to promote the well-being, dignity and self-esteem of individuals, and their caregivers. The hospital is the only provider of adult day health in Yolo County.
FY 2014	
Goal FY 2014	Provide access to care for a growing vulnerable elderly population that otherwise would go without services and programs that address transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric health issues.
2014 Objective Measure/Indicator of Success	Continue focused outreach and educational efforts that target underserved in the community, and enhance collaborative community partnerships.
Baseline	Access to care for elderly is a priority health issue identified in the CHNA; this is the only adult day health service available to elderly in the community.
Intervention Strategy for Achieving Goal	Outreach in community and among physicians to increase awareness of, and access to, center services for elderly in need.
Result FY 2014	1,155 underserved individuals served who would otherwise have gone without this care.
Hospital’s Contribution / Program Expense	\$466,397
FY 2015	
Goal 2015	Provide access to care for a growing vulnerable elderly population that otherwise would go without services and programs that address transitioning from independence to higher levels of care, mobility issues, difficulty navigating the system, and geriatric health issues.
2015 Objective Measure/Indicator of Success	Continue focused outreach and educational efforts that target underserved in the community, and enhance collaborative community partnerships. Develop method of measuring outcomes associated with the prevention of hospital admissions.
Baseline	Access to care for elderly is a priority health issue identified in the CHNA; this is the only adult day health service available to elderly in the community.
Intervention Strategy for Achieving Goal	Outreach in community and among physicians to increase awareness of, and access to, center services for elderly in need. Work with Community Benefit for outcomes measurement.
Community Benefit Category	C3-Hospital Outpatient Services

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

COMMUNITY BENEFIT AND ECONOMIC VALUE

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

Benefits for Those Living In Poverty	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Financial Assistance	512	641,068	0	641,068	0.5	0.5
Medicaid	15,217	29,791,603	18,225,132	11,566,471	8.4	8.6
Means-Tested Programs	1,487	3,864,074	1,652,421	2,211,653	1.6	1.6
Community Services						
Community Benefit Operations	0	83,637	0	83,637	0.1	0.1
Community Building Activities	1	4,406	0	4,406	0	0
Community Health Improvement Services	2,698	258,813	0	258,813	0.2	0.2
Financial and In-Kind Contributions	946	189,645	0	189,645	0.1	0.1
Totals for Community Services	3,645	536,501	0	536,501	0.4	0.4
Totals for Those Living In Poverty	20,861	34,833,246	19,877,553	14,955,693	10.8	11.1

Benefits for the Broader Community	Persons Served	Total Expenses	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Community Services						
Community Building Activities	41	17,001	0	17,001	0	0
Community Health Improvement Services	3,302	82,759	0	82,759	0.1	0.1
Financial and In-Kind Contributions	3	463,348	0	463,348	0.3	0.3
Subsidized Health Services	1,155	1,645,418	1,179,021	466,397	0.3	0.3
Totals for Community Services	4,501	2,208,526	1,179,021	1,029,505	0.7	0.8
Totals for the Broader Community	4,501	2,208,526	1,179,021	1,029,505	0.7	0.8

Totals - Community Benefit	25,362	37,041,772	21,056,574	15,985,198	11.6	11.8
Medicare	14,184	28,521,885	19,378,321	9,143,564	6.6	6.8
Totals with Medicare	39,546	65,563,657	40,434,895	25,128,762	18.2	18.6
Grand Totals	39,546	65,563,657	40,434,895	25,128,762	18.2	18.6

TELLING THE STORY

Effectively telling the community benefit story is essential to creating an environment of awareness, understanding and interest in the priority health issues challenging the region and importantly, to inform the public about the ways in which these issues are being addressed by Woodland Healthcare. The 2014 Community Benefit Report and 2015 Community Benefit Implementation Plan will be distributed to hospital leadership, members of the Community Board and Community Benefit Advisory Committee, and widely to management and employees of the hospital. It serves as a valuable tool for ongoing community benefit awareness and training.

The document will also be broadly distributed externally to Community Health Needs Assessment partners, community leaders, government and public health officials, program partners and other agencies and businesses throughout the region. It can be found, along with the 2013 Community Health Needs Assessment, under “Community Health” in the “Who We Are” section on Dignity Health’s Website: www.DignityHealth.org. It will also be available on the Healthy Living Website (www.healthylivingmap.com), a site developed and provided to the public by Woodland Healthcare and other health system partners.

APPENDIX A

Woodland Healthcare Community Board Roster

Betsy Marchand Retired Yolo County Supervisor Community Representative	Laurie Harting Senior Vice President Operations Dignity Health Sacramento Service Area
Mike Chandler Community Representative	Kevin Vaziri President and CEO Woodland Healthcare
Marianne MacDonald, Chair Realtor Community Representative	Matt Zavod, MD
Katie Knisely Secretary	Carol Kimball, MD
Art Pimentel Dean, Los Rios Community College District Sacramento City College, West Sacramento Center	Justin Chatten-Brown Community Representative
Phil Laughlin, MD	Al Alali, MD

Woodland Healthcare Community Board Community Health Committee Roster

Betsy Marchand, Chair Retired Yolo County Supervisor	Heidi Mazeres Manager, Education Woodland Healthcare
Bob Ekstrom Executive Director Center for Families	Katie Curran Community Relations, Woodland Healthcare
Tico Zendejas Executive Director, RISE, Inc.	Rosemary Younts Director, Community Benefit Dignity Health Sacramento Service Area
Katie Villegas Executive Director Yolo County Children's Alliance	Ashley Brand Manager, Community Benefit Dignity Health Sacramento Service Area
Viola DeVita Curriculum, Instructional & Intervention Services Yolo County Office of Education	Josh Clapper Community Benefit Coordinator 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.