Woodland Memorial Hospital

2019 Community Health Implementation Strategy

Adopted October 2019

Dignity Health™
Woodland Healthcare

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At-a-Glance Summary

Community Served

Woodland Memorial Hospital is situated in Yolo County, located at 1325 Cottonwood Street in Woodland, CA. The general acute care hospital is a part of Dignity Health and has 720 employees, 108 licensed acute care beds, 17 emergency department beds and 31 inpatient mental health beds. The hospital provides compassionate, high quality health care and services to the residents of Woodland, Davis and the surrounding communities. Less than half of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison and Knights Landing.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

1. Access to Mental, Behavioral, and Substance Abuse Services
2. Injury and Disease Prevention and Management
3. Access to Basic Needs, Such as Housing, Jobs, and Food
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. Access to Specialty and Extended Care
7. Safe and Violence-Free Environment

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

- Enhanced Mental Health Crisis & Follow-Up: This strategic partnership addresses the limited access to behavioral health services by improving communication and collaboration abilities of the nonprofit agencies involved through direct referrals to lower levels of care which increases the number of individuals served and decrease delays in service.
- Congestive Heart Active Management Program (CHAMP®): Establishes a relationship with patients who have heart disease after discharge from the hospital through regular phone interaction to support and education to help manage this disease and monitoring of symptoms or complications.
- Resource Connection & Patient Navigator Program: Serves as an access point for vulnerable individuals and families to be connected to primary care/community health and social services, receive case management, education, and enrollment support

	• Haven House Interim Care Program: Medical respite transitional program that utilizes a four bed house and offers respite for homeless individuals upon discharge from the hospital • Oncology Nurse Navigator: Offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards including patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. • Yolo Adult Day Health Center: Addresses specialty health care and support needs of the elderly and disabled populations by offering a high touch interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. • Human Trafficking Response Program: Focuses on educating staff to identify and respond to victims within the hospital; Provide victim-centered, trauma-informed care; and Collaborate with community agencies to improve quality of care.
Anticipated Impact	The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Health Committee, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.
Planned Collaboration	• Empower Yolo • Sutter Davis • Yolo County Health and Human Services Agency • Yolo Community Care Continuum • Yolo County District Attorney's Office • Yolo County Mental Health leadership • Suicide Prevention of Yolo County • Yolo Community Care Continuum (YCCC) • CommuniCare Health Centers • Elica Health Centers • Northern Valley Indian Health • Winters Healthcare Medical Clinics • Dignity Health Medical Foundation – Woodland • Davis Clinic • Yolo Crisis Nursery • Fourth & Hope • Haven House

- Opening Doors
- Yolo Food Bank
- The Grace Network
- WEAVE
- Davis Community Meals
- RISE, Inc.
- Salvation Army
- Soroptimist
- Woodland Farmers Market
- Yolo Crisis Nursery
- Yolo Healthy Aging Alliance
- Yolo County Children's Alliance

This document is publicly available online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

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

Our Hospital and the Community Served

About Woodland Memorial Hospital

Woodland Memorial Hospital (Woodland Memorial) is a member of Dignity Community Care, which is a part of CommonSpirit Health.

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

Our Mission

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

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

Financial Assistance for Medically Necessary Care

Woodland Memorial Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

Woodland Memorial serves the residents of Woodland, Davis, West Sacramento and the surrounding communities. The community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives 80% of discharges. The hospital's primary service area is comprised of 21 zip codes (95605, 95606, 95607, 95616, 95618, 95620, 95627, 95637, 95645, 95653, 95679, 95691, 95694, 95695, 95697, 95698, 95776, 95912, 95932, 95937 and 95987). A summary description of the community is below. Additional details can be found in the CHNA report online.

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

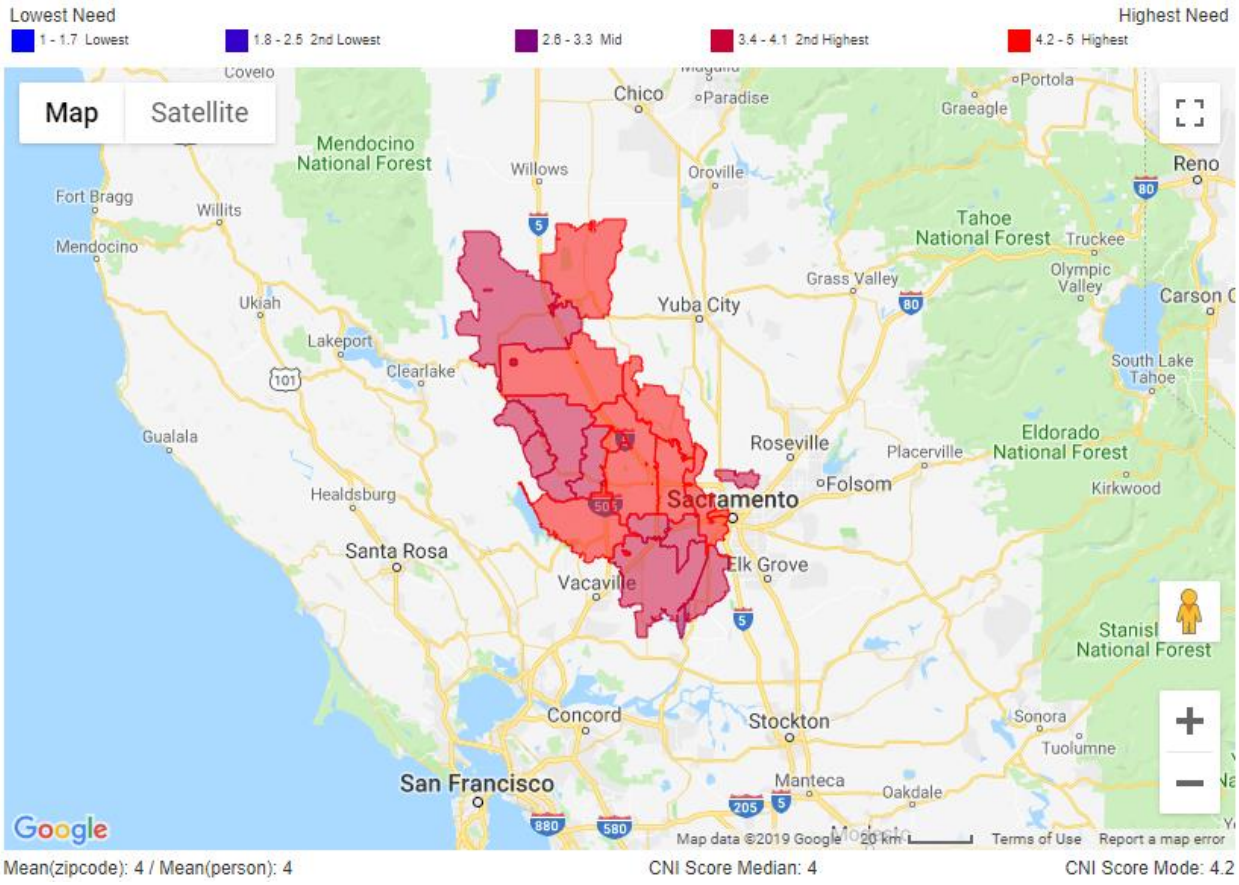
Demographics within Woodland's hospital service area are as follows, derived from 2018 estimates provided by Truven Health Analytics data:

- Total Population: 280,018
- Hispanic or Latino: 34.7%
- Race: 46.3% White, 2.3% Black/African American, 12.1% Asian/Pacific Islander, 4.6% All Other.
- Median Income: $66,316
- Uninsured: 9.9%
- Unemployment: 4.9%
- No HS Diploma: 15.5%
- CNI Score: 4.0
- Medicaid Population: 27.2%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 4 / Mean(person): 4 CNI Score Median: 4 CNI Score Mode: 4.2

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted June 2019.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

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

Significant Health Needs

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

1. **Access to Mental, Behavioral, and Substance Abuse Services**: Includes access to prevention and treatment services.
2. **Injury and Disease Prevention and Management**: Contains health outcomes that require disease prevention and/or management and treatment including: cancer, cardiovascular disease/stroke, HIV/AIDS/STDs and asthma.
3. **Access to Basic Needs, Such as Housing, Jobs, and Food**: Includes economic security, food security/insecurity, housing, education and homelessness.
4. **Active Living and Healthy Eating**: Encompasses all components of active living and healthy eating including health behaviors, associated health outcomes and aspects of physical environment/living conditions.
5. **Access to Quality Primary Care Health Services**: Encompasses access to primary care resources which include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar.
6. **Access and Functional Needs – Transportation and Physical Disability**: Includes the need for transportation options, transportation to health services and options for person with disabilities.
7. **Access to Specialty and Extended Care**: Encompasses access to specialty care and extended services including skilled nursing facilities, hospice care, in-home healthcare, etc.

8. **Safe and Violence-Free Environment**: Consists of safety from violence and crime including violent crime, property crimes and domestic violence.
9. **Pollution-Free Living Environment**: Contains measures of pollution such as air and water pollution levels.
10. **Access to Dental Care and Prevention**: Encompasses lack of providers and access, especially in rural areas.

Significant Needs the Hospital Does Not Intend to Address

Woodland Memorial does not have the capacity or resources to address all priority health issues identified in Yolo County, although the hospital continues to seek opportunities that respond to the needs that have not been selected as priorities. The hospital is not addressing access and functional needs – transportation and physical disability, pollution-free living environment and access to dental care and prevention, as these priorities are beyond the capacity and expertise of Woodland Memorial.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

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

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

Woodland Memorial Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners. The Community Board and Community Health Advisory Committee are composed of community members who provide stewardship and direction for the hospital as a community resource. These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

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

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

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

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

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Access to Mental/Behavioral/Substance Abuse Services

Strategy or Program Name	Summary Description
Inpatient Mental Health Services	Yolo County is dependent upon Woodland Memorial as the only source of inpatient mental health treatment in the community. There were over 600 vulnerable and at-risk indigent and Medi-Cal insured residents receiving acute psychiatric care in FY18, who otherwise would not have had access to care. The community benefit investment to care for these individuals was nearly $5 million.

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

Anticipated Impact: The hospital's initiative to address access to behavioral health services are anticipated to result in: improve patient linkages to outpatient behavioral health services; provide a seamless transition of care; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.

Health Need: Injury and Disease Prevention and Management

Strategy or Program Name	Summary Description
Healthy Lives (Vida Sana)	The hospital offers this six week course, which is based on the Stanford Chronic Disease Self-Management Program, to residents who have, or are at risk of diabetes, with an emphasis on outreach to the Hispanic community in partnership with Holy Rosary Church. The program is taught in Spanish and in English and engages participants in learning to recognize the signs and symptoms of diabetes. Participants are also taught proper nutrition, healthy eating habits, and medication management.

Diabetes Care Management Program	This program takes Woodland Memorial's focus on diabetes to the next level. High risk individuals with uncontrolled diabetes are involved in bimonthly diabetes group medical appointments, and monitored closely via phone by case managers. They also receive more in-depth individual counseling from a nurse certified diabetic educator, primary care case manager, or registered dietitian, who work closely with primary care providers.
Your Life, Take Care	The hospital offers this workshop to support 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 Memorial is also working in partnership with the community nonprofit, Centers for Families, to expand workshop offerings by providing training to staff members and volunteers who are involved in the "Promotoras for Active Living" (PAL) project.
CHAMP® (Congestive Heart Active Management Program)	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits. In FY18, the program received a Mercy Foundation grant for the purchase of scales, blood pressure cuffs and oximeter to better evaluate patients during phone consultations.
Disease-Specific Support Groups	Education and support are offered monthly to those affected by multiple sclerosis, cancer and stroke. Average group attendance varies between 10 and 15.
Migrant Center Visits	The hospital sends a health educator to various centers to do a health screening and counseling for their residents. A follow-up visit is done three months later to track the status and offer additional support.
Healthy Living Outreach & Screenings	Collaborating with various community organizations, the hospital participates in 10+ health fairs each fiscal year where a plethora of screenings are offer dependent on the target audience.

Anticipated Impact: The initiative to address this health need by the hospital is anticipated to result in: reduction of hospital admissions for chronic disease related; improve the health and quality of life for those who suffer from chronic illness; enable participants to better manage their disease; and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.

Health Need: Access to Basic Needs

Strategy or	Summary Description

Program Name	
Haven House	A partnership between Woodland Memorial, Sutter Davis, and the Yolo Community Care Continuum, Haven House is a medical respite transitional program that utilizes a four bed house and offers respite for homeless individuals upon discharge from the hospital. In Fy19, the program will provide temporary shelter as well as linkage to supportive services to patients who have been cleared from a local hospital, yet remain medically fragile and do not have a safe place to go. Woodland Memorial committed $65,000 in FY18 to launch the program.
Anticipated Impact: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option.	

Health Need: Active Living and Healthy Eating

Strategy or Program Name	Summary Description
Farmers Market	Working with multiple agencies and local farmers, the hospital hosts a weekly farmers market that offers inexpensive fresh foods.
Yolo Food Bank	Woodland Memorial has been a longstanding partner of the food bank and their efforts to coordinate the storage and distribution of over 4 million pounds of food to 19,000 households annually.
Nutrition Education and Counseling	The hospital takes advantage of its farmers market as a forum to offer nutrition education and counseling.
Anticipated Impact: The anticipated result is to increase access to healthy foods and safe activity and improve the knowledge of the community about the importance of living a healthy and active lifestyle.	

Health Need: Access to Quality Primary Care Health Services

Strategy or Program Name	Summary Description
Federally Qualified Health Center Capacity Building	Between FY15-FY19 the hospital has made a five year commitment to help CommuniCare build a new full-service clinic in Woodland, which is providing much needed new capacity for primary, behavioral and dental health care, health education and patient support services for underserved populations. Beginning in FY20 the hospital has made a new five year commitment to support Winters Healthcare.

Resource Connection & Patient Navigator Program	The hospital partners with community nonprofit, Empower Yolo, to offer this resource, which serves as an access point for vulnerable individuals and families to be connected to community health and social services, receive case management, education, and enrollment support. In May of 2018, services were expanded to include Emergency Department Navigation services which will continue to be the main emphasis of the program. The focus will be on connecting individuals to primary care providers in the community and assisting in establishing a medical home and follow up care post emergency department visit.
Financial assistance for uninsured/underinsured and low income residents	The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy.
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.

Anticipated Impact: The hospital's initiatives to address access to high quality primary care health and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; and improve collaborative efforts between all health care providers.

Health Need: Access to Specialty and Extended Care

Strategy or Program Name	Summary Description
Yolo Adult Day Health Center	• The hospital is the primary provider in Yolo County that fills the specialty health care and support needs of the elderly through the Adult Day Health Center, which offers a diverse program of health, social and rehabilitation services for adults struggling to function independently. The Center also specializes in Alzheimer's and Parkinson's disease and services include nursing and medication assistance, care coordination, caregiver respite, transportation, therapies, exercise and activities.
Yolo Healthy Aging Alliance	The hospital is collaborating with the Yolo Healthy Aging Alliance to increase awareness and care intervention skills for those dealing with persons suffering from dementia and to develop a referral and care planning program engaging community resources. Training has been provided to hospital staff and ongoing efforts will continue to provide education on community resources. The alliance has conducted cross training, bringing providers and community-based organizations together to begin building relationships and share information on services and referral processes.

Cancer Nurse Navigator	This hospital program is designed to help patients navigate the maze of options related to 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.
Baby and Me Support Group	Encourages new parents and caregivers, with babies' age 0 to 9 months, to come together weekly to share experiences, successes and challenges. The main objective is to offer support during the transitional time of having a new baby. Through the support group, attendees will be better equipped to handle day-to-day stresses, have an outlet to voice concerns, share stories and offer insight.
RISE Inc.	Woodland Memorial provides financial support and advocacy to the community organization which provides services to the rural communities included the hospital service area. RISE, Inc. services include youth programs, employment services, emergency food, clothing, and a variety of resource and referrals with to goal of enhancing the quality of life and opportunity for self-sufficiency.

Anticipated Impact: The hospital's initiatives to address access to specialty and extended care services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; and improve collaborative efforts between all health care providers.

Health Need: Safe and Violence Free Environment

Strategy or Program Name	Summary Description
Human Trafficking Response Program	The Human Trafficking Response Program initiative focuses on: • Educating staff to identify and respond to victims within the hospital; • Provide victim-centered, trauma-informed care; • Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration; • Participate in the Yolo County Commercially Sexually Exploited Children (Human Trafficking) Steering Committee.
Yolo Crisis Nursery	Through financial support and advocacy, the hospital continues to support the Yolo Crisis Nursery that has now become its own not-for-profit 501(c)3 organization. The Nursery is a unique asset that over the years has prevented thousands of child abuse and neglect emergencies through emergency respite care for children when families are facing crisis or hardship.

Empower Yolo	Empower Yolo provides twenty-four hour crisis intervention, emergency shelter, confidential counseling, training, legal assistance, and other services for individuals and families persons affected by domestic violence, sexual assault, stalking, human trafficking, and child abuse. The hospital is partnering with the organization to ensure victims of domestic assault and human trafficking are connected to appropriate community resources. Empower Yolo is also assisting in training hospital staff of available services when a victim is identified

Anticipated Impact: The initiative to address safe, crime, and violence free communities are anticipated to result in: prevent unsafe environments; improve safety for the patient population served; provide education to all hospital staff on trauma informed care; increase the awareness of services available; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.

Program Digests

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

Farmer's Market

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance abuse services ❑ Injury and disease prevention and management ❑ Access to basic needs ✓ Active living and health eating ❑ Access to quality primary care health services ❑ Access and functional needs ❑ Access to specialty and extended care ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	Working with multiple agencies, local farmer's and community partners, the hospital hosts a weekly farmers' market running June through the end of August. The market purposely establishes basic price points, ensuring the locally sourced foods are accessible, affordable and beneficial to both the local food economy, the community as a whole and those touched with food insecurities which includes CalFresh.
Community Benefit Category	A2. Community-based clinical services

Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Fresh, affordable foods will be easily accessible to the community complemented with healthy eating and food sourcing education.
Measurable Objective(s) with Indicator(s)	Farmer's Market income and CalFresh Market Match dollars used. Impact will be measured by tracking both noted objectives, ensuring the market continues to grow thrive.
Intervention Actions for Achieving Goal	Locally sourced food booths, on Tuesdays, June through the end of August. Education on healthy eating. Visibility to new, healthy foods.
Planned Collaboration	This is a partnership between Woodland Memorial Hospital and the Woodland Farmer's Market.

Enhanced Mental Health Crisis & Follow-Up

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance abuse services ✓ Injury and disease prevention and management ❑ Access to basic needs ❑ Active living and health eating ✓ Access to quality primary care health services ❑ Access and functional needs ❑ Access to specialty and extended care ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	This strategic partnership addresses the limited access to behavioral health services by improving communication and collaboration abilities of the nonprofit agencies involved. The project facilitates direct referrals to lower levels of care which increases the number of individuals served and decreases delays in service; moreover, it improves the quality of services by providing comprehensive follow-up services designed to increase the efficacy of treatment and decrease recidivism due to a recurrence of symptoms.
Community Benefit Category	E2-a Grants - Program grants

Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	All individuals served by the project will experience greater access to non-crisis resources and follow up support and services enhancing the continuum of care.

Measurable Objective(s) with Indicator(s)	Improve access to mental health treatment for our most vulnerable residents who have not been served in the traditional mental health system by addressing the current gap in after-hours resources for individuals living in high need areas of our community. The efforts will result in the reduction of hospital services required by individuals served.
Intervention Actions for Achieving Goal	This collaborative program will continue to expand access to mental health care by providing telephone support and referrals, crisis residential services and resource coordination, and follow up counseling services to identified individuals. By facilitating lower levels of care through comprehensive follow-up, the program partners will be able to increase the efficacy of treatment and decrease recidivism through ongoing symptom management.
Planned Collaboration	This is a partnership between the hospital, Suicide Prevention Yolo County, Yolo Community Care Continuum and new partner, Davis Community Meals.

Congestive Heart Active Management Program (CHAMP)

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance abuse services ✓ Injury and disease prevention and management ❑ Access to basic needs ❑ Active living and health eating ✓ Access to quality primary care health services ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
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.
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Improve the health and quality of life for those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.

Measurable Objective(s) with Indicator(s)	Continue to increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Strengthen collaboration between CHAMP®, the Patient Navigator Program and the hospital's Readmission team to increase referrals. Provide ongoing education to community clinics about available services and improve communication between CHAMP staff and primary care providers.
Intervention Actions for Achieving Goal	Regular meetings with the CHAMP® Team and continued partnership building with Federally Qualified Health Centers to connect heart failure patients to a medical home with assistance from the patient navigators as needed.
Planned Collaboration	CHAMP® currently works with the care coordinators at the hospitals, patient navigators, and community clinics.

Healthier Living

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance abuse services ✓ Injury and disease prevention and management ❑ Access to basic needs ✓ Active living and health eating ❑ Access to quality primary care health services ❑ Access and functional needs ❑ Access to specialty and extended care ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	Provides residents with chronic diseases knowledge, tools and motivation needed to become proactive with their health. Healthier Living workshops are open to anyone with any ongoing health condition, as well as those who care for persons with chronic health conditions. The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Provide education and skills to help those with chronic diseases manage their symptoms and lead healthier and more productive lives; thus improving their health and 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).

Measurable Objective(s) with Indicator(s)	Continue to meet/exceed the stated metric goal. Develop new lay leaders and community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants.
Intervention Actions for Achieving Goal	Outreach to the Hispanic community to promote the program; continue to build community partnerships for expansion of workshops and increase program participants; outreach to the community clinics and other nonprofits; continue to identify community lay leaders for growth.
Planned Collaboration	These workshops and educational sessions are conducted in collaboration with a variety of community organizations and are held in locations that are accessible to residents, such as senior housing communities and local organizations that serve a high percentage of residents that have or are caring for family members with chronic illnesses.

Resource Connection/Patient Navigator Program

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance abuse services ❑ Injury and disease prevention and management ❑ Access to basic needs ✓ Active living and health eating ✓ Access to quality primary care health services ❑ Access and functional needs ❑ Access to specialty and extended care ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	Located on the hospital's campus, the Resource Connection center provides a one stop access point for community services and health education in both Spanish and English including linkages to primary care, health insurance enrollment assistance, health education, case management and community referrals. In the second half of FY18, a major emphasis was placed on emergency department navigation to assist individuals in establishing a medical home.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Continue to increase access to community healthcare services by focusing on emergency department navigation. Empower Yolo will work closely with the ED staff to ensure individuals utilizing the ED for non-urgent care needs are assisted with establishing a medical home and follow up appointment in a more appropriate setting.

Measurable Objective(s) with Indicator(s)	Program will be measured by improved access for patients in the community setting; reduced emergency department primary care visits; increased linkages to additional community resources; and reduced costs.
Intervention Actions for Achieving Goal	Focus on strengthening relationship between the patient navigators and case management, emergency department, other staff at the hospital. Build relationships with community clinics and local health plans to ensure access is available.
Planned Collaboration	The Resource Connection is a partnership between the hospital and community nonprofit, Empower Yolo.

Oncology Nurse Navigator

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance abuse services ✓ Injury and disease prevention and management ❑ Access to basic needs ✓ Active living and health eating ✓ Access to quality primary care health services ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	The program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit around their diagnosis and treatment options. The program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care, and Improve patient/doctor relationships.
Measurable Objective(s) with Indicator(s)	Continue to build awareness to increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners.

Intervention Actions for Achieving Goal	Continue to promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with the Resource Connection staff operated by Empower Yolo and community clinics who serve the underserved.
Planned Collaboration	Oncology nurse navigators work with a variety of community partners in terms of finding available services and well as receiving referrals for patients who need assistance.

Yolo Adult Day Health Center (YADHC)

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance abuse services ✓ Injury and disease prevention and management ❑ Access to basic needs ❑ Active living and health eating ✓ Access to quality primary care health services ✓ Access to specialty and extended care ❑ Access and functional needs ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	Yolo Adult Day Health Center (YADHC), operated by the hospital, targets adults at high risk of hospitalizations due to complex chronic conditions impacting independent living. A strong medical, social and rehabilitation interdisciplinary service approach is offered to promote the well-being, dignity and self-esteem of individuals, and their caregivers.
Community Benefit Category	C3-Hospital Outpatient Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Provide comprehensive interdisciplinary support for a growing vulnerable elderly and disabled population that otherwise would go without adequate community-based interventions to minimize need to transition to a higher level of care. Care model addresses medication management, care coordination, functional issues, psycho-social needs and caregiver stress.
Measurable Objective(s) with Indicator(s)	Focused outreach and educational efforts that target underserved in the community, and enhance collaborative community partnerships to ensure community members have access to a variety of resources. Continue measuring outcomes associated with the prevention of hospital admissions. Collaborate with Yolo County to increase capacity.

Intervention Actions for Achieving Goal	Continue outreach in community and among physicians to increase awareness of, and access to, center services for elderly and disabled individuals in need. Explore the possibility of moving physical location to increase capacity.
Planned Collaboration	YADHC works collaboratively with the hospital, community partners, Yolo County, and coalitions that focus on the same target population such as the Yolo Healthy Aging

Haven's House

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance abuse services ❑ Injury and disease prevention and management ✓ Access to basic needs ❑ Active living and health eating ❑ Access to quality primary care health services ❑ Access and functional needs ❑ Access to specialty and extended care ❑ Safe and violence-free environment ❑ Pollution-free living environment ❑ Access to dental care and preventive services
Program Description	A partnership between Woodland Memorial, Sutter Davis, and the Yolo Community Care Continuum, Haven House is a medical respite transitional program that utilizes a four-bed house and offers respite for homeless individuals upon discharge from the hospital
Community Benefit Category	E1-a-Cash Donations – General contributions to nonprofit organizations

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Through multi-agency collaboration, Haven House was developed in late FY18 with services starting in early FY19. The medical respite transitional program utilizes a four bed house to offer respite and recuperative services for homeless individuals upon discharge from the hospital. The program will provide temporary shelter as well as linkages to supportive services to patients who have been cleared from a local hospital, yet remain medically fragile and do not have a safe place to go. Outreach efforts continue to leverage additional partnerships based on the needs of the guests served
Measurable Objective(s) with Indicator(s)	New program, plan to establish measurable objectives over the next year. Outcomes measures will likely include: number of patients referred by the hospital, number and types of services provided, length of stay, etc.

Intervention Actions for Achieving Goal	The program will provide temporary shelter as well as linkage to supportive services to patients who have been cleared from a local hospital, yet remain medically fragile and do not have a safe place to go
Planned Collaboration	A partnership between Woodland Memorial, Yolo Community Care Continuum and Sutter Davis Hospital.

Hospital Board and Committee Rosters

Woodland Healthcare Community Board Roster

Mike Chandler, Chair Retired Yocha Dehe Fire Chief	Roger Clarkson, Vice Chair Retired Yolo County Health Department
Lori Aldrete, Secretary President, Aldrete Communications	Tim Bernard, DPM Woodland Clinic Medical Group
Calvin Handy Retired UC Davis Police Chief	Jesse Salinas Assessor/Clerk-Recorder/Chief Election Official Yolo County
Melissa Marshall, MD Chief Executive Officer CommuniCare Health Centers	Tim Bernard, DPM Woodland Clinic Medical Group
Eric Mitchel, MD Mercy Radiology Group	Rafael Rodriguez, MD Diagnostic Pathology Medical Group
Justin Chatten-Brown, MD Emergency Services Medical Director Woodland Emergency Group	Michelle Ing, PA Woodland Clinic Medical Group
Kevin Vaziri Woodland Memorial President	Laurie Harting Dignity Health Senior Vice President, Operations

Woodland Memorial Community Health Advisory Committee Roster

Roger Clarkson, Chair Retired Yolo County Health Department	Heidi Mazeres Manager, Mission Integration Woodland Memorial Hospital
Dr. Sarada Mylavarapu Chief Medical Officer Woodland Memorial Hospital	Gina Daleiden Executive Director First 5 Yolo
Tico Zendejas Executive Director, RISE, Inc.	Tandy Burton Director, Behavioral Health Services Woodland Memorial Hospital
Calvin Handy Retired UC Davis Police Chief	Rachel Raymond Deputy District Attorney Yolo County District Attorney's Office
Liza Kirkland Manager, Community Health and Outreach Dignity Health Sacramento Service Area	Katie Curran Manager, Community Relations Woodland Memorial Hospital
Diana Landeros Community Health Specialist Dignity Health Sacramento Service Area	Elissa Southward Director, Community Health and Outreach Dignity Health Sacramento Service Area