Woodland Memorial Hospital

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Dignity Health
Woodland Memorial Hospital

A message from

Edmundo Castañeda, President and CEO of Woodland Memorial Hospital, and Roger Clarkson, Chair of the Dignity Health Woodland Healthcare Community Board.

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

Woodland Memorial Hospital (Woodland Memorial) shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2021 (FY21), Woodland Memorial provided $21,059,625 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $21,652,113 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 26, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to us at DignityHealthGSSA_CHNA@dignityhealth.org.

Sincerely,

Edmundo Castañeda
President/CEO

Roger Clarkson
Chairperson, Community Board

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At-a-Glance Summary

Community Served

Woodland Memorial is situated in Yolo County, located at 1325 Cottonwood Street in Woodland, CA. The general acute care hospital is a part of Dignity Health and has 720 employees, 105 licensed acute care beds, including: 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 a quarter of the region's population resides in unincorporated communities.

Economic Value of Community Benefit

$21,059,625 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$21,652,113 in unreimbursed costs of caring for patients covered by Medicare

Significant Community Health Needs Being Addressed

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

1. Access to Mental, Behavioral, and Substance Use 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

FY21 Programs and Services

The hospital delivered several programs and services to help address identified significant community health needs. These included:

- 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.

	• Patient Navigation 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. • Community Based Violence Prevention 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.
FY22 Planned Programs and Services 	Woodland Memorial plans to build upon many of the FY21 initiatives and explore new partnership opportunities with Yolo County, health plans and community organizations. Efforts to enhance patient navigation services in partnership with Empower Yolo will continue while adding additional organizations including health plans, community clinics, and other community resources. Woodland Memorial will continue to play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness, including: a medical respite program in partnership with Yolo Community Care Continuum and Sutter Health called Haven House; and a Street Medicine Program in partnership with Yolo County HHSA and Sutter Health. The hospital will continue to focus on access to behavioral health services through the Mental Health Continuum of Care Partnership and in partnership with Yolo County and other community partners.

This document is publicly available 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

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, 105 licensed acute care beds, including: 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

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

Woodland Memorial is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application 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 75% of discharges. In FY21, the hospital's service area encompassed seven zip codes (95695, 95776, 95627, 95912, 95987, 95616, and 95645). 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 a quarter of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison, Yolo, Dunnigan, Clarksburg, Guida, Knights Landing, Monument Hills, Capay, Plainfield, Brooks, Rumsey, El Macero and Zamora. Arbuckle and portions of Dixon are designated as Health Professional Shortage Areas by the U.S. government's Health Resources and Services Administration. Woodland Memorial's service area also includes the University of California, Davis one of the world's leading cross-disciplinary research and teaching institutions located near Davis, California and the Yocha Dehe Wintun Nation, an independent, sovereign, self-governed nation that supports its people, the Capay Valley community and the region by strengthening culture, stewarding the land and creating economic independence for future generations.

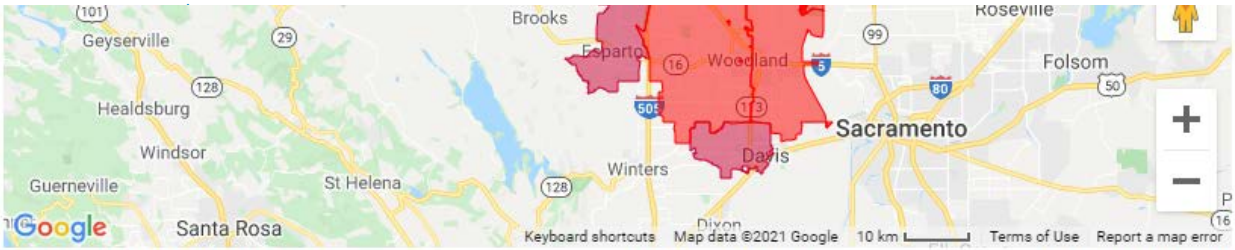
Demographics within Woodland Memorial's hospital service area are as follows, derived from 2021 estimates provided by Strategy's SG2 Analytics Platform (*Source: Claritas Pop-Facts® 2021)*:

- Total Population: 135,578
- Race/Ethnicity: Hispanic or Latino: 38.5%; White: 42.2%, Black/African American: 1.3% Asian/Pacific Islander: 13.9%, All Other: 4.1%.
- % Below Poverty: 9.7%
- Unemployment: 5.8%
- No High School Diploma: 17.2%
- Medicaid (household): 8.8%
- Uninsured (household): 5.5%

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): 4.3 / Mean(person): 4.3 CNI Score Median: 4.6 CNI Score Mode: 4.2,4.6

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 benefit plan and programs were identified in the most recent CHNA report, which was adopted in 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 https://www.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 Use 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, pollution-free living environment and access to dental care and prevention, as these priorities are beyond the capacity and expertise of Woodland Memorial.

2021 Report and 2022 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

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

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 Community Benefit Plan

Woodland Memorial 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

The following outlines the approach taken when planning and developing initiatives to address priority health issues. At the outset, 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.

Impact of the Coronavirus Pandemic

The COVID-19 pandemic has globally resulted in millions of confirmed cases and deaths numbering hundreds of thousands. It has caused an unprecedented challenge for our Greater Sacramento Market Hospitals and health care systems worldwide. In particular, the risk to health care; considering most health care workers are unable to work remotely, strategies had to be developed around early deployment of viral testing for asymptomatic and/or frontline health care staff. High health care costs, shortages of protective equipment, and low numbers of ICU beds and ventilators have been major challenges for our hospitals in the delivery of patient care. In communities across our Market, there is concern regarding uninsured individuals, who may work in jobs predisposing them to viral infection which may lead to significant financial consequences in the event of illness.

In response to this pandemic, our Market hospitals have had to implement immediate relief measures and engage in short, medium and longer term planning to re-balance and re-energize our communities in the midst of this crisis. Many of our hospitals have been engaging in collaborative efforts focusing on development of a broad clinical and socioeconomic plans with multi-disciplinary partners from health care, business, social services, government, community based organizations and wider society.

In FY21, Woodland Memorial took the following actions to respond to the needs created or exacerbated by COVID-19:

- The Community Health team partnered with our grant partners on adapting programs, where needed, to respond to COVID-19 or divert grant funding to support urgent needs arising due to the pandemic.
- Partnered with Yolo County on Project Room Key referring in homeless patients to the designated quarantine motels for shelter and follow-up care.
- Partnered with Woodland Clinic Medical Group, Yolo County and Sutter Hospital to launch a Street Medicine Program in partnership with CommuniCare, to specifically respond to COVID-19 and provide medical care to homeless patients quarantining in the Project RoomKey motels.
- County-wide Skilled Nursing Facilities COVID-19 prevention support: Staff at Woodland Memorial, led by the CNO/COO Gena Bravo, travelled around to most SNFs in Yolo County to provide COVID-19 infection prevention and PPE training to employees.
- Woodland Memorial Hospital partnered with Yolo County, Migrant Center leadership, and directly with migrant center residents to ensure these individuals and families are aware of local resources. Due to COVID-19 our team pivoted and enhanced our traditional programing to include: specialized infection prevention education, ensuring the residents knew it came from our local health educator who is a trusted resource for returning families; delivered face masks to various migrant centers (Madison, Davis, and Dixon); coordinated and delivered sanitation and hygiene items; on site education, mask, and sanitizer distribution to laborers; provided one-on-one support to migrant center residents as needed for diabetes management and education; partnered with local farmers throughout the region, including rural areas, to ensure education resources are available for their seasonal and year-round workers; and Puentes de Yolo, Promotoras coalition partnerships, were maintained and with our leadership, provided services to our migrant center workers and families. Partners in these efforts included: CommuniCare, UC Davis Department of Agricultural Health and Safety, Empower Yolo, Health Education Council, UC Davis CalAgrAbility Biological and Agricultural Engineering, and Yolo County Children Alliance. These are other member organizations of Puentes de Yolo, led by Woodland Healthcare Education Services Department.
- Mobilized division leadership, physicians, and clinical experts within the Dignity Health system through media and social media to answer questions and assuage concerns of our community around COVID-19.
- Woodland Memorial Hospital Leadership participated in ongoing COVID-19 calls with healthcare, county and other community organizationsto collaborate on providing the most up to date education and strategizing for how to best provide care for the community.
- Provided symptomatic testing and pre-procedure testing for all inpatients and symptomatic ED patients who are at risk for aerosolizing COVID at all Greater Sacramento Market hospitals.
- Yolo County Department of Public Health in partnership with Dignity Health hosted a series of community-based COVID-19 vaccination clinics that ran February – June, 2021. Community clinic strategies included both traditional site-based vaccination clinics and mobile vaccinations. The clinics were part of an effort to provide opportunities for Yolo area residents, with a special focus on those most vulnerable, to receive COVID-19 vaccines at convenient and accessible locations. Together we were able to immunize over 2,000 individuals.

In addition to continuing many of the actions identified above, Woodland Memorial plans to take the following actions in FY22 to continue helping alleviate pandemic-induced needs:

- Launching new programs focusing on homelessness, which is a particularly vulnerable population in light of COVID-19, including children and older adults. Specifically in Yolo County this

includes the Street Medicine Program in partnership with Woodland Clinic Medical Group, Sutter Health,Yolo County and CommuniCare; supporting case management services at a new low income housing site in West Sacramento in partnership with Mercy Housing and Communicare; additionally the CommonSpirit Homeless Health Initiative is supporting the East Beamer Way project in Woodland.

- Hosted a local Farmers Market supporting the County's efforts to ensure all community members have access to fresh, local foods. The Farmers Market utilized the CalFresh program ensuring EBT was an welcome form of payment.
- The hospital and community physicians are continuing to utilize telemedicine where appropriate, which allows us to keep patients home and safe, especially as we move into flu season.
- Continuing to mobilize Division leadership, physicians, and clinical experts within the Dignity Health system through media and social media to answer questions and assuage concerns of our community around COVID-19.
- Dignity Health is strongly encouraging community members to get their COVID-19 vaccine and flu shot throughout the coming fiscal year and educating patients regarding the importance.
- Alongside Health Systems, County Partners and other providers offering behavioral health services, we will continue to participate in the regional Behavioral Health Facilities call, convened bi-weekly by the Hospital Council, to identify gaps in the system of care and devise strategies for behavioral health across a multi-county region.
- Continue to advocate with the County proper utilization of federal funding to support ongoing programs exacerbated by the pandemic (e.g., homelessness, food insecurity, behavioral health).
- As a broader community health and community benefit strategy, we will be looking for future opportunities to continue to support programs and initiatives that seek to address issues related to COVID-19.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

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

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Mental Health Crisis Prevention and Early Intervention	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.	☒	☒
Substance Use Navigation	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.	☒	☒
Inpatient Mental Health Services	Yolo County is dependent upon Woodland Memorial as the only source of inpatient mental health treatment in the community.	☒	☒
Tele-Psychiatry	Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care. Access is available to both the ED and inpatient setting.	☒	☒
Baby & Me	Free postpartum and family 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.	☒	☒
Family Engagement and Wellness Initiative	Supported through the Community Grants Program, a partnership between Yolo Crisis Nursery, Stanford Sierra Youth & Families and Yolo County Children's Alliance, the Family Engagement and Wellness Initiative will provide education and counsel; direct assistance; health and food security referrals; and peer-to-peer support for underserved families. Every aspect of the initiative's trauma-informed programming reflects respect for diverse cultural norms and engages	☒	☒

	participants as partners working towards the common purpose of supporting healthy, safe children.		

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	Active FY21	Planned FY22
Healthier Living Program	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. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics and community partners to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☒	☒
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. Community health worker offers one on one consultations for Spanish speaking participants.	☒	☒
Congestive Heart Active Management Program (CHAMP®)	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits.	☒	☒

Disease-Specific Support Groups	Education and support are offered monthly to those affected by specific diseases in the community. Current groups include: cancer; and stroke. Program transitioned to phone based support due to COVID concerns.	☒	☒
Migrant Center Visits	The hospital sends a health educator to various centers to do a health screening and counseling for their residents. After initial visit, continuous follow-up and planning is offered to track the status and additional support.	☒	☒
Healthy Living Outreach & Screenings	Collaborating with various community organizations, the hospital participates in 10+ health outreach events each fiscal year where a plethora of screenings are offered dependent on the target audience and topic (e.g. flu shots). This effort transitioned from traditional health outreach events to COVID-19 screenings for various community partners beginning March 2020.	☒	☒

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: Basic Needs (Food Security, Housing, Economic Security and Education)

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Yolo Food Bank	Woodland Memorial has been a longstanding partner of the food bank and their efforts to coordinate the storage and distribution.	☒	☒
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.	☒	☒
Resources for Low-Income Patients	The hospital partially or fully subsidizes cost of transportation, prescription medication, medical supplies and equipment, and short term room and board in the community for patients unable to pay for or access these resources after being discharged from the hospital.	☒	☒
Resources for Homeless Patients	The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community resources to homeless patients being discharged from the hospital,	☒	☒

	with the intent to help prepare them for return to the community.		
East Beamer Project	Supported through the Homeless Health Initiative, the East Beamer Project is a collaborative between Friends of the Mission, City of Woodland, Yolo County, 4th and Hope and Woodland Opportunity Village. Project will provide 198 new beds (total 399 beds) located on corner of 102 and Beamer to include permanent supportive housing beds, shelter beds, and residential substance abuse treatment beds for those who are unhoused or unstably housed in our community. Funding supported the development of one and two-bedroom micro-duplexes that will house at least 75 individuals who are unhoused or unstably housed.	☒	☒
1801 West Capitol Ave Project	Partnership between Mercy Housing, West Sacramento, Yolo County and CommuniCare, 1801 West Capitol Avenue will be the largest permanent supportive housing project in Yolo County. 85 permanent supportive apartment homes includes on-site case management and community services staff. WMH is providing funding to support on-site case management services.	☐	☒
Family Engagement and Wellness Initiative	Supported through the Community Grants Program, a partnership between Yolo Crisis Nursery, Stanford Sierra Youth & Families and Yolo County Children's Alliance, the Family Engagement and Wellness Initiative will provide education and counsel; direct assistance; health and food security referrals; and peer-to-peer support for underserved families. Every aspect of the initiative's trauma-informed programming reflects respect for diverse cultural norms and engages participants as partners working towards the common purpose of supporting healthy, safe children.	☒	☒
Mercy Resource Station	Supported through the Community Grants Program, a partnership between Mercy Coalition of West Sacramento, City of West Sacramento, Yolo Food Bank, Society of St. Vincent De Paul and Center for Spiritual Awareness, the Mercy Resource Station will provide daily meals and weekly food boxes to the West Sacramento individuals experiencing homelessness who are currently housed by the City of West Sacramento through Project Roomkey. Also deliver weekly food boxes to those unable to attend local food distributions due to health or financial reasons. Furniture distribution system will provide necessary home supplies for families and individuals transitioning from homelessness to permanent housing.	☒	☒

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 Health Eating

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Farmers Market	Working with multiple agencies and local farmers, the hospital partners with the Certified Woodland farmers Market that offers inexpensive fresh foods for the community.	☒	☒
Nutritional Education and Counseling	Collaborating with various community organizations, the hospital offers nutrition education and counseling.	☒	☒
Family Engagement and Wellness Initiative	Supported through the Community Grants Program, a partnership between Yolo Crisis Nursery, Stanford Sierra Youth & Families and Yolo County Children's Alliance, the Family Engagement and Wellness Initiative will provide education and counsel; direct assistance; health and food security referrals; and peer-to-peer support for underserved families. Every aspect of the initiative's trauma-informed programming reflects respect for diverse cultural norms and engages participants as partners working towards the common purpose of supporting healthy, safe children.	☒	☒

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	Active FY21	Planned FY22
Federally Qualified Health Center Capacity Building	Beginning in FY20 the hospital has made a five year commitment to help Winters Healthcare build a new full-service clinic in Winters, which is providing much needed new capacity for primary, behavioral and dental health care, health education and patient support services for underserved populations.	☒	☒
Street Medicine Program	Dignity Health in partnership with Woodland Clinic Medical Group, Sutter Health and Yolo County HHSA,	☒	☒

	launched a Street Medicine Program to provide back pack medicine and mobile clinic services to the Homeless population in Yolo County. Services primarily focus on Primary Care, Triage, Immunizations, Vaccinations, Case Management, Dental Care and Behavioral Health.		
Patient Navigator Program	In partnership with community-based organization, Empower Yolo, The hospital to offers Emergency Department Navigation services. The focus will continue to be connecting individuals to primary care providers in the community and assisting in establishing a medical home and follow up care post emergency department visit.	☒	☒

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	Active FY21	Planned FY22
Yolo Adult Day Health Center	The hospital is the primary provider in Yolo County that addresses specialty health care and support needs of the elderly and disabled populations through the Adult Day Health Center. The Center offers an interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. The Center specializes in high touch chronic disease management with the added components of caregiver respite, transportation, nutrition, education, and socialization.	☒	☒
Oncology Nurse Navigator	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.	☒	☒

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	Active FY21	Planned FY22
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking 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. • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy	☒	☒
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 partners with Empower Yolo to ensure victims of domestic assault and human trafficking are connected to appropriate community resources.	☒	☒

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.

Community Grants Program

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

In FY21, the hospital awarded the grants below totaling $92,133. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Yolo Crisis Nursery	Family Engagement and Wellness Initiative	$40,600
Mercy Coalition of West Sacramento	Mercy Resource Station	$46,533
Time of Change	Coronavirus Pandemic Community Benefit Support Grant	$5,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. 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.

Patient Navigator Program

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance use 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 ❑ Safe and violence-free environment
Program Description	Assists patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to 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.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2021 Report	

Program Goal / Anticipated Impact	Increase access to healthcare services and other social support services for underserved populations; develop a more comprehensive referral system to ensure patients utilizing the emergency department are being connected with community resources.
Measurable Objective(s) with Indicator(s)	Increase numbers served by 10% or greater. Improve methods of outcomes measurement including referral sources and follow-up of services received. Look to build capacity and make program more visible for potentially referring patients utilizing the emergency department for non-urgent care to a clinic or provider.
Intervention Actions for Achieving Goal	Continue to build relationships between community service resources, case management, the emergency department and other staff at the hospital.
Collaboration	This program is a partnership between the hospital and community nonprofit, Empower Yolo.
Performance / Impact	287 individuals served and connected to a variety of community resources including primary care.
Hospital's Contribution / Program Expense	$60,364
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue to increase access to community healthcare services by focusing on emergency department navigation. Empower Yolo will work closely with the ED staff to ensure individuals utilizing the ED for non-urgent care needs are assisted with establishing a medical home and follow-up appointment in a more appropriate setting.
Measurable Objective(s) with Indicator(s)	Program will be measured by improved access for patients in the community setting; reduced emergency department primary care visits; increased linkages to additional community resources; and reduced costs.
Intervention Actions for Achieving Goal	Focus on strengthening relationships between the patient navigators and case management, emergency department, and other staff at the hospital. Build relationships with community clinics and local health plans to ensure access is available.
Planned Collaboration	Increase hospital staff engagement, build on existing partnerships and also create new, community-based partners such as federally qualified health centers, service providers and managed Medi-Cal health plans.

Healthier Living Program

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance use services ✓ Injury and disease prevention and management ❑ Access to Basic Needs

	✓ Active living and healthy eating ✓ Access to quality primary care health services ❑ Access to specialty and extended care ❑ Safe and violence-free environment
Program Description	Healthier Living provides community members with chronic diseases knowledge, tools and motivation needed to become proactive with their health. The Healthier Living program with Woodland Memorial Hospital allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. During the COVID-19 pandemic, this program also included community education on infection prevention for COVID-19 to various migrant centers and farms in Yolo County.
Community Benefit Category	A1 - Community Health Education – Lectures/Workshops.
FY 2021 Report	
Program Goal / Anticipated Impact	Provide education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the hospital. Include community and public health education on COVID-19 infection.
Measurable Objective(s) with Indicator(s)	Continue to increase the number of participants and persons served with community health education and prevention of chronic disease and management.
Intervention Actions for Achieving Goal	Outreach to the rural community including but not limited to migrant centers, farms, and other nonprofits. Build community partnerships to expand community health education outreach.
Collaboration	Community education is conducted in collaboration with a variety of community organizations and families in locations accessible to the residents such as in the migrant centers and farms.
Performance / Impact	1,664 persons were served through community education and outreach on healthier living, chronic disease management and prevention of infection COVID-19.
Hospital's Contribution / Program Expense	$12,248 which is a shared expense by Dignity Health hospitals in Sacramento, Yolo and Nevada Counties.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue providing education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital.
Measurable Objective(s) with Indicator(s)	Continue to increase the number of participants and persons served with community health education and prevention of chronic disease and management.

Intervention Actions for Achieving Goal	Outreach to the rural community including but not limited to migrant centers, farms, and other nonprofits. Build community partnerships to expand community health education outreach.
Planned Collaboration	Community education conducted in collaboration with a variety of community organizations and families in locations accessible to the residents such as in the migrant centers and farms.

Family Engagement and Wellness Initiative

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance use 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 ❑ Safe and violence-free environment
Program Description	This initiative provides trauma-informed education and counsel, direct access to resources, wellness and food security referrals, and facilitating lasting peer-to-peer support networks by assisting and strengthen families in crisis and transition, many of whom are at risk for child abuse and neglect.
Community Benefit Category	E2- Grants

FY 2021 Report

Program Goal / Anticipated Impact	At-risk children are healthy and safe by supporting and strengthening the capacity of their parents and caregivers with basic aid resources assistance, family engagement meetings, and parenting workshops.
Measurable Objective(s) with Indicator(s)	The number of attendance of families in the monthly family engagement meetings, number of basic needs application assistance for families and number of parents participated in the parenting workshops.
Intervention Actions for Achieving Goal	Meet with collaborative partners to improve family participation, aid in resources and increase parent participation for the health and safety of at-risk children.
Collaboration	A collaboration with Yolo Crisis Nursery, Stanford Sierra Youth & Families, and Yolo County Children's Alliance.
Performance / Impact	124 families attended the family engagement meetings, 112 CalFresh and CashAid applications submitted for families, and 49 parents participated in parenting workshops.
Hospital's Contribution / Program Expense	$40,600

FY 2022 Plan	
Program Goal / Anticipated Impact	At-risk children are healthy and safe by supporting and strengthening the capacity of their parents and caregivers with basic aid resources assistance, family engagement meetings, and parenting workshops.
Measurable Objective(s) with Indicator(s)	The number of attendance of families in the monthly family engagement meetings, number of basic needs application assistance for families and number of parents participated in the parenting workshops.
Intervention Actions for Achieving Goal	Continue to meet with collaborative partners to improve family participation, aid in resources and increase parent participation for the health and safety of at-risk children.
Planned Collaboration	A collaboration with Yolo Crisis Nursery, Stanford Sierra Youth & Families, and Yolo County Children's Alliance.

Congestive Heart Active Management Program (CHAMP®)

Significant Health Needs Addressed	❑ Access to mental/behavioral/substance use 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 ❑ Safe and violence-free environment
Program Description	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through regular phone interactions to support, educate and assist primary care physicians/cardiologists to manage this disease and monitoring of symptoms or complications.
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.
FY 2021 Report	
Program Goal / Anticipated Impact	Improve the health and quality of life for those who suffer from heart disease, enabling them to better understand and manage their disease through frequent communication and education - reducing their need to be admitted or readmitted to the hospital.
Measurable Objective(s) with Indicator(s)	Increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in the number of hospital admissions and readmissions for participants with heart failure. Establish collaboration between CHAMP®, the new Patient Navigator Program

	and the hospital's Readmission team to increase awareness and referrals. Provide ongoing education to community clinics about available services.
Intervention Actions for Achieving Goal	Regular meetings with the CHAMP® Team and continued partnership building with Federally Qualified Health Centers to connect heart failure patients to a medical home with assistance from the patient navigators as needed.
Collaboration	CHAMP® currently collaborates with the care coordinators at the hospitals, patient navigators, ambulatory teams, and community clinics.
Performance / Impact	The total enrollment was 170 patients and only 7 patients under protocol management had a 30 day all cause readmission.
Hospital's Contribution / Program Expense	$31,830
FY 2022 Plan	
Program Goal / Anticipated Impact	Improve the health and quality of life for those who suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
Measurable Objective(s) with Indicator(s)	Continue to increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Strengthen collaboration between CHAMP®, the Patient Navigator Program and the hospital's Readmission team to increase referrals. Provide ongoing education to community clinics about available services and CHAMP documentation in Cerner (CHAMP NOTE) to improve timely 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, ambulatory teams, and community clinics.

Oncology Nurse Navigator

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance use 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

	❑ Safe and violence-free environment
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 - Health Care Support Services – Information & Referral.
FY 2021 Report	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care. These measures will help to improve patient outcomes and experience.
Measurable Objective(s) with Indicator(s)	Increase the number of underserved patients through outreach and community collaboration. Build awareness of the program among community partners by providing more education within the community setting.
Intervention Actions for Achieving Goal	Promote services in the community and work with hospital and community partners to increase awareness of services and resources; this includes working with community partners, navigators and community clinics who serve the underserved.
Collaboration	Oncology nurse navigators collaborate with the multidisciplinary medical team and a variety of community partners to find available services for oncology patients in the community.
Performance / Impact	1,662 persons served -- shared by Dignity Health hospitals in Sacramento, Yolo and Nevada Counties.
Hospital's Contribution / Program Expense	$52,044 which is a shared expense by Dignity Health hospitals in Sacramento, Yolo and Nevada Counties.
FY 2022 Plan	
Program Goal / Anticipated Impact	Ensure timely access to treatment and other resources for those with cancer, with emphasis on the underserved who otherwise cannot afford care. These measures will help to improve patient outcomes and experience.
Measurable Objective(s) with Indicator(s)	Continue to build awareness and increase the number of underserved individuals through outreach and community collaboration. Emphasis will be on education and building 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 our patient navigators in the ED and community clinics who serve the underserved.
Planned Collaboration	Oncology nurse navigators collaborate with the multidisciplinary medical team and a variety of community partners to find available services for oncology patients in the community.

Haven House

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance use 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 ✓ Safe and violence-free environment
Program Description	This program, located in Woodland, focuses on providing a safe place for homeless individuals to recuperate after hospital discharge and getting them linked to wraparound services and resources. During their stay at Haven House, they get assistance with additional services including health insurance enrollment, finding a medical home, substance use and mental health services and placement in permanent housing.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	The program's goals are: 1) to improve the health of participants; 2) reduce the hospital stay of participants; 3) reduce the repetitive hospitalization of participants; and 4) provide participants with access to all services necessary to live in the least restrictive community setting possible.
Measurable Objective(s) with Indicator(s)	Number of participants referred into the program and provided service as well as the length of night stays needed to get transition out of the program with linked social services and continual healthcare.
Intervention Actions for Achieving Goal	Strengthening relationship and communication between the case management staff at Woodland Memorial, Yolo Community Care Continuum's (YCCC) Haven House staff and Sutter Health for referrals into the program.

Collaboration	This program is a collaboration between Yolo Community Care Continuum (YCCC), Dignity Health and Sutter Health to help homeless individuals in the Yolo County region.
Performance / Impact	50 persons served with a total of 282 bed nights, which otherwise would have been spent in the hospital.
Hospital's Contribution / Program Expense	$60,000
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue to 1) to improve the health of participants; 2) reduce the hospital stay of participants; 3) reduce the repetitive hospitalization of participants; and 4) provide participants with access to all services necessary to live in the least restrictive community setting possible.
Measurable Objective(s) with Indicator(s)	Number of participants referred into the program and provided service as well as the length of night stays needed to get transition out of the program with linked social services and continual healthcare.
Intervention Actions for Achieving Goal	Continue strengthening relationship and communication between the case management staff at Woodland Memorial, Yolo Community Care Continuum's (YCCC) Haven House staff and Sutter Health for referrals into the program.
Planned Collaboration	This program is a collaborative between Woodland Memorial Hospital, Yolo Community Care Continuum's (YCCC) Haven House and Sutter Health.

Other Programs and Non-Quantifiable Benefits

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

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

- Rural Community Assistance Corporation (RCAC)
  In June 2017 Dignity Health approved a 7-year $500,000 loan to RCAC for projects in rural California, Nevada and Arizona. RCAC assists rural communities in building social capital, environmental infrastructure, and affordable housing. It also provides nonprofit organizations

with access to financing. RCAC financing creates employment opportunities, affordable housing, safe and reliable environmental infrastructure, and much-needed community facilities and services. RCAC operates in rural California, Nevada and Arizona, and several other states west of the Rockies.

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

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

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

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

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

Economic Value of Community Benefit

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**5,380**	**2,932,738**	**0**	**2,932,738**	**1.5%**
Medicaid	**17,267**	**65,779,303**	**49,944,203**	**15,835,100**	**7.8%**
Means-Tested Programs	**1**	**6,191**	**1,069**	**5,122**	**0.0%**
Community Services					
A - Community Health Improvement Services	903	585,284	0	585,284	0.3%
C - Subsidized Health Services	99	66,780	0	66,780	0.0%
E - Cash and In-Kind Contributions	24	413,171	184,573	228,598	0.1%
Totals for Community Services	4	28,000	0	28,000	0.0%
G - Community Benefit Operations	0	101,432	0	101,432	0.1%
Totals for Community Services	**1,030**	**1,194,667**	**184,573**	**1,010,094**	**0.5%**
Totals for Poor	**23,678**	**69,912,899**	**50,129,845**	**19,783,054**	**9.8%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	2,168	36,870	0	36,870	0.0%
B - Health Professions Education	408	1,203,669	0	1,203,669	0.6%
C - Subsidized Health Services	424	1,730,021	1,693,989	36,032	0.0%
Totals for Community Services	**3,000**	**2,970,560**	**1,693,989**	**1,276,571**	**0.6%**
Totals for Broader Community	**3,000**	**2,970,560**	**1,693,989**	**1,276,571**	**0.6%**
Totals - Community Benefit	**26,678**	**72,883,459**	**51,823,834**	**21,059,625**	**10.4%**
Medicare	**17,243**	**74,667,093**	**53,014,980**	**21,652,113**	**10.7%**
Totals with Medicare	**43,921**	**147,550,552**	**104,838,814**	**42,711,738**	**21.1%**

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

Woodland Healthcare Community Board Roster

Roger Clarkson, Chair Retired, Yolo County Health Department	Lori Aldrete, Vice Chair President, Aldrete Communications
Jesse Salinas, Secretary Assessor/Clerk-Recorder/Chief Election Official Yolo County	Dennis Miller, Global Agriculture Consultant
Calvin Handy Retired, UC Davis Police Chief	Justin Chatten-Brown, MD Emergency Services Medical Director Valley Emergency Group
Eric Mitchel, MD Mercy Radiology Group	Sonia Reichert, MD Woodland Clinic Medical Group
Tim Bernard, DPM Woodland Clinic Medical Group	Michelle Ing, PA Woodland Clinic Medical Group
Andrew Lund, MD Central Anesthesia Service Exchange (CASE) Medical Group	Edmundo Castañeda Woodland Memorial President
Todd Strumwasser, MD President Dignity Health Northern California Division	