Woodland Memorial Hospital

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020

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 2020 Report and 2021 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 2020 (FY20), Woodland Memorial provided $24,866,821 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $25,730,670 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 27, 2020 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 (916) 851-2005.

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, 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 a quarter of the region's population resides in unincorporated communities.

Economic Value of Community Benefit

$24,866,821 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$25,730,670 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 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

FY20 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.

	• 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. • 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.
FY21 Planned Programs and Services	For FY21, the hospital plans to build upon many of the FY20 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. Hospital ED staff will work in collaboration with Empower Yolo to identify individuals that need assistance with establishing a medical home and understanding their health coverage and benefits. In FY20, Woodland Memorial will played an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness which will continue into FY21, 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, 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

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 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.

A plain language summary of the policy is at the end of this report. The financial assistance policy and plain language summary 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 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.

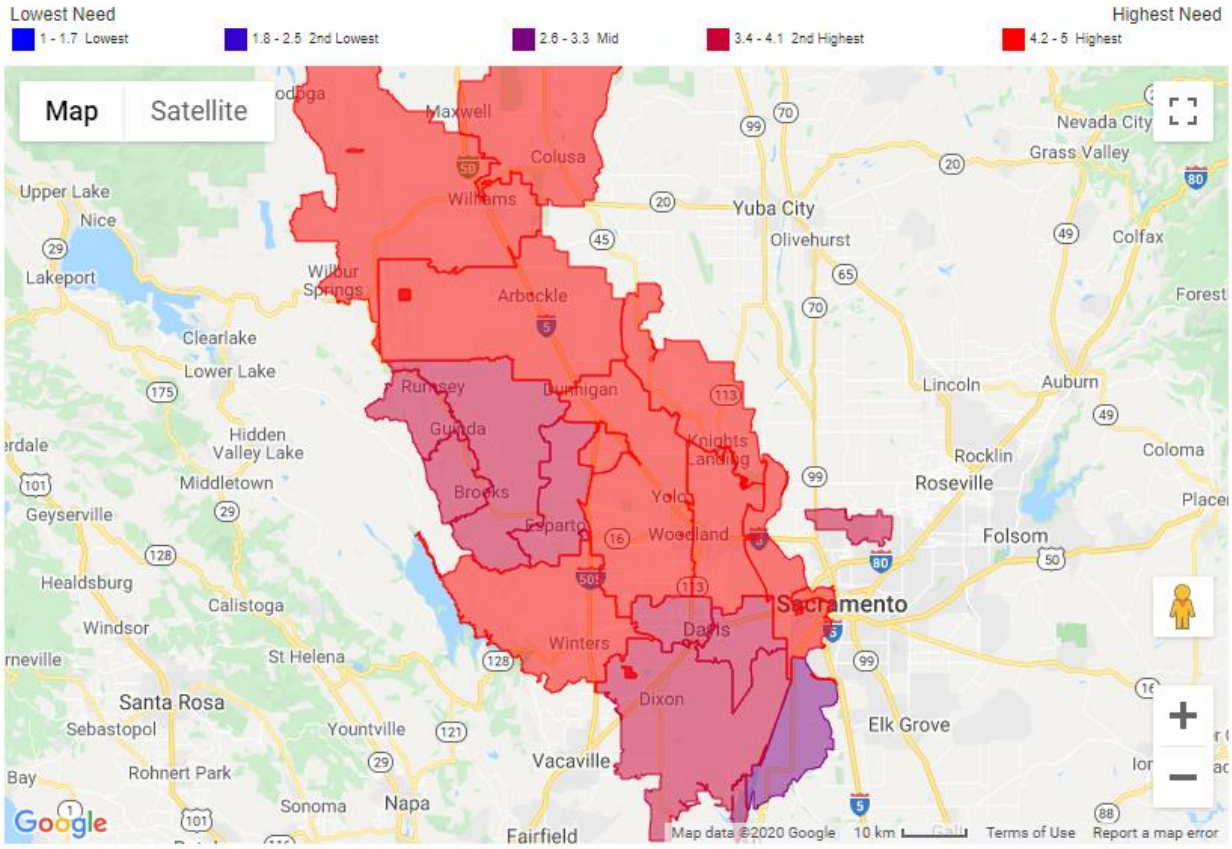
Demographics within Woodland Memorial's hospital service area are as follows, derived from 2020 estimates provided by Strategy's SG2 Analytics Platform (*Source: Claritas Pop-Facts® 2020)*:

- Total Population: 284,159
- Race/Ethnicity: Hispanic or Latino: 35.5%; White: 44.9%, Black/African American: 2.3% Asian/Pacific Islander: 12.6%, All Other: 4.7%.
- % Below Poverty: 8.7%
- Unemployment: 6.8%
- No High School Diploma: 15.9%
- Medicaid (household): 8.2%
- Uninsured (household): 5.1%

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): 4.1 CNI Score Median: 4 CNI Score Mode: 4.4

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 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, pollution-free living environment and access to dental care and prevention, as these priorities are beyond the capacity and expertise of Woodland Memorial.

2020 Report and 2021 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 FY20 and planned activities for FY21, 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

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.

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 also sparked fears of an impending economic crisis and recession. Social distancing, self-isolation and travel restrictions have led to a reduced workforce across all economic sectors and caused many jobs to be lost. Schools have closed down, and the need for commodities and manufactured products has decreased. The food sector is also facing increased demand due to panic-buying and stockpiling of food products.

Moreover, the COVID-19 pandemic has caused an unprecedented challenge for our Greater Sacramento Division 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 Division 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 Division 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 FY20, Woodland Memorial took the following actions to respond to the needs created or exacerbated by COVID-19:

- The Community Health team partnered with our FY20 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.
- Nobody Dies Alone Program: Staff at Woodland Memorial stepped in to provide additional support a local Skilled Nursing Facility – Stollwood – which had significant COVID-19 infections among both residents and staff. In addition to providing PPE and Infection Prevention training as described above, the program included: hospital staff performing COVID-19 testing for residents and staff; cooking and delivery meals to staff and residents; and Clinical Leaders sitting and spending time with residents who were infected with COVID-19, so that they were not alone.
- 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 included CommuniCare, UC Davis Department of Agricultural Health and Safety, Empower Yolo, Health Education Council, UC Davis CalAgrAbility Biological and Agricultural Engineering, Yolo County Children Alliance, are some of Puentes de Yolo members lead 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.
- Dignity Health's Chief Medical Officer (CMO) coordinated weekly COVID-19 calls for other CMOs in the community to collaborate on providing the most up to date education and strategizing for how to best provide care for the community.
- Implemented pre-procedure testing at all Division hospitals.

In addition to continuing many of the actions identified above, Woodland Memorial plans to take the following actions in FY21 to continue helping alleviate pandemic-induced needs:

- Adapted our FY21 Community Grants to allow for COVID-19 specific funding.
- Dignity health is supporting new initiatives focused on Homelessness in Yolo County including a Street Medicine Program in partnership with Woodland Clinic Medical Group, Sutter Health and Yolo County; additionally the CommonSpirit Homeless Health Initiative is supporting the East Beamer Way project in Woodland.
- 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.
- Woodland Memorial is strongly encouraging community members to get their flu shot and educating patients regarding the importance especially in light of COVID-19.
- 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 Abuse Services

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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 637 vulnerable and at-risk indigent and Medi-Cal insured residents receiving acute psychiatric care in FY20, who otherwise would not have	☒	☒

	had access to care. The community benefit investment to care for these individuals was nearly $6.7 million.		
Mental Health Crisis Prevention and Early Intervention	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.	☒	☐
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 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.	☒	☒

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 FY20	Planned FY21
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. 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. 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. 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 FY20	Planned FY21
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.	☒	☐
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.	☒	☒

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 FY20	Planned FY21
Farmer's 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.	☒	☒

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 FY20	Planned FY21
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	Beginning in FY20, 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 FY20	Planned FY21
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 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. The Center specializes in high touch chronic disease management with the added components of caregiver respite, transportation, nutrition, education, and socialization.	☒	☒
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.		
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 FY20	Planned FY21
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 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.		

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.

Financial Assistance for Medically Necessary Care

Woodland Memorial 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. A plain language summary of the hospital's Financial Assistance Policy is on the last page of this report. The amount of financial assistance provided in FY20 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Woodland Memorial also includes the Financial Assistance Policy in the reports made publicly available, including the annual Community Benefit reports and triennial Implementation Strategies.

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 FY20, the hospital awarded the grants below totaling $86,885. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Cache Creek Conservancy	Yolo Healthy Parks, Healthy People	$30,085
Yolo Hospice	Community-Based Palliative Care for Vulnerable Populations	$56,800

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.

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 ❑ 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 interaction to support and education to help manage this disease. - Monitoring of symptoms or complications
Community Benefit Category	A2-e community based clinical services – ancillary/other clinical services.
FY 2020 Report	
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)	Increase enrollment of the underserved through outreach and community collaboration, and maintain reduction in number of hospital admissions and readmissions for participants. Establish collaboration between CHAMP®, the new Patient Navigator Program and the hospital's Readmission team to increase 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 works with the care coordinators at the hospitals, patient navigators, and community clinics.
Performance / Impact	514 participants enrolled in the program and none of the patients readmitted to the hospital 30 days post intervention.
Hospital's Contribution / Program Expense	$52,551
FY 2021 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 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.

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 ❑ 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 provide 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.
FY 2020 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, and improve patient/doctor relationships.
Measurable Objective(s) with Indicator(s)	Increase number of underserved assisted through outreach and community collaboration and build awareness of the program among community partners. Continue to provide 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 the Resource Connection staff and community clinics who serve the underserved.
Collaboration	Oncology nurse navigators work with a variety of community partners in terms of finding available services as well as receiving referrals for patients who need assistance
Performance / Impact	452 persons served -- shared by Dignity Health hospitals in Sacramento and Yolo Counties
Hospital's Contribution / Program Expense	$54,644 which is a shared by Dignity Health hospitals in Sacramento and Yolo Counties.
FY 2021 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, 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.

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 to specialty and extended care ❑ Safe and violence-free environment
Program Description	Located on the hospital's campus, a Resource Connection center provides a one stop access point for community services and health education in both Spanish and English including linkages to primary care, health insurance enrollment assistance, health education, case management and community referrals. Beginning in FY18 and continuing through FY20, major emphasis was placed on emergency department navigation.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2020 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 relationship between the Resource Center and case management, emergency department and other staff at the hospital.
Collaboration	The Resource Connection is a partnership between the hospital and community nonprofit, Empower Yolo.
Performance / Impact	637 individuals served and connected to a variety of community resources including primary care.

Hospital's Contribution / Program Expense	$59,512
FY 2021 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 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	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.

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 ❑ Safe and violence-free environment
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
FY 2020 Report	
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 resources are available. Programmatically, ADHC support reduces hospitalization and ED use by 23%.
Intervention Actions for Achieving Goal	Outreach in community and among physicians to increase awareness of, and access to, center services for elderly in need.
Collaboration	YADHC works collaboratively with the others that focus on the same target population such as the Yolo Healthy Aging Alliance, Yolo Hospice, Yolo County Health Council, Yolo County Adult and aging Commission, Senior Link of Yolo County and others.
Performance / Impact	YADHC currently serves 104 families (368 persons) with an average daily attendance of 52 and the waiting list is at 42.
Hospital's Contribution / Program Expense	$490,752
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue to provide care for a growing vulnerable elderly and disabled. To address growing wait list, Dignity Health is actively working to identify an expanded program space as well as piloting a community-based nurse navigation program in collaboration with occupational therapy support.
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 Alliance, Yolo Hospice, Yolo County Health Council, Yolo County Adult and aging Commission, Senior Link of Yolo County and others.

Street Medicine Program

Significant Health Needs Addressed	✓ Access to mental/behavioral/substance abuse service ❑ 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	Street Medicine does not currently exist in Yolo County. Preventative medicine isn't occurring and basic health needs are not being addressed. Simple diagnoses are morphing into health needs that require admission and post discharge services. Improper utilization of ED services was growing. It is the intention of a collaborative consisting of Dignity Health, Woodland Clinic Medical Group, Sutter Health and Yolo County Health & Human Services Agency, to purchase a Mobile Medical Unit, for use by an ongoing provider of community-based healthcare services. The goal overall will be to decrease severity and chronicity of otherwise manageable healthcare conditions for individuals who are typically unserved or underserved throughout Yolo County by providing behavioral, physical, and dental health services.
Community Benefit Category	E1-Cash Donations
FY 2020 Report	
Program Goal / Anticipated Impact	The program is designed to meet the homeless population in their location, providing care and break down access barriers. Increase access to healthcare services and other social support services for the homeless population; develop a more comprehensive referral system to ensure homeless patients receive preventive care and connected with community resources; and decreasing severity and chronicity of otherwise manageable healthcare conditions for individuals who are typically unserved or underserved throughout Yolo County.
Measurable Objective(s) with Indicator(s)	Program was launched in March 2020 in conjecture with Project Roomkey, the objective in FY20 was to serve the homeless patients being quarantined in the Project Roomkey motels.
Intervention Actions for Achieving Goal	Yolo County contracted with CommuniCare to offer COVID-19 testing and immediate back-pack medicine to support homeless population staying in Project RoomKey motels.
Collaboration	This is a partnership between the hospital, Woodland Clinic Medical Group, Sutter Health, and Yolo County HHSA. In FY20 CommuniCare acted as the contractor providing street medicine services.
Performance / Impact	By the close of FY20, 168 were placed in Project RoomKey motels and received services.
Hospital's Contribution / Program Expense	$83,333

FY 2021 Plan	
Program Goal / Anticipated Impact	The overall goal of the program is decreasing severity and chronicity of otherwise manageable healthcare conditions for individuals who are typically unserved or underserved throughout Yolo County. The focus in FY21 will be to finalize and release the RFP in the Fall of 2020; work through the application process to select a contractor with partners; and ultimately have contractor launch the program in early 2021.
Measurable Objective(s) with Indicator(s)	Contractor chosen through RFP process will establish a baseline data collection to establish utilization patterns, comorbidity profiles, and social services penetration. Measures will be reported in a Results Based Accountability (RBA) framework, answering the questions 1) How much did we do? 2) How well did we do it? And 3) Is anyone better off? Specific measures will include, but not be limited to: (a) Demographics: (Age, sex, race, language preferred, length of time homeless, insurance status, those empaneled to medical home, prevalence of comorbidities, primary location for care); (b) Number of Outreach and Engagement Contacts; (c) Number and type of medical service provided; (d) Number and type of mental health service provided; (e) Use of Evidenced Based and Evidence Informed Practices; (f) Numbers of emergency department services provided in the 6-month period following mobile medical visits (Unnecessary ED Visits); (g) Number of Hospital Admissions & Readmissions; (h) Active Connection with PCP/ Medical Home; (i) Improved Health outcomes: HTN Control, A1C, PHQ-9; (j) Patient Experience of Care: (CMS Core Measures)
Intervention Actions for Achieving Goal	In FY21 CommuniCare will continue to provide services to the Homeless Population in the Project RoomKey motels through the end of 2020. An RFP will be developed by partners and released with the hope of launching the full program in early 2021. The program would include: Backpack medicine w/ suburban; and ultimately launch and maintain mobile clinic. Primary Population Served: Homeless. Secondary Population(s): Migrant; Hard to Reach Population; Schools; Special Events. Services provided: Primary Care, Triage, Immunizations, Vaccinations, Case Management, Dental Care and Behavioral Health.
Planned Collaboration	This is a partnership between the hospital, Woodland Clinic Medical Group, Sutter Health, and Yolo County HHSA. Street Medicine partner will be chosen through formal RFP process with Yolo County.

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.

- Healthy Yolo Coalition
  The hospital participates in this collaborative initiative led by Yolo County Public Health Department which is focused on engaging and mobilizing the community in addressing public health issues and identifying strategies to improve the quality of life.

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, Empower Yolo 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	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	**2,558**	**4,247,744**	**2.1%**
Medicaid	**18,589**	**18,750,715**	**9.5%**
Community Services			
A - Community Health Improvement Services	5,833	553,467	0.3%
C - Subsidized Health Services	92	50,125	0.0%
E - Cash and In-Kind Contributions	29	113,320	0.1%
F - Community Building Activities	5	36,836	0.0%
G - Community Benefit Operations	0	124,296	0.1%
Totals for Community Services	**5,959**	**878,044**	**0.4%**
Totals for Poor	**27,110**	**23,876,503**	**12.0%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	4,448	33,044	0.0%
B - Health Professions Education	387	456,174	0.2%
C - Subsidized Health Services	368	490,752	0.2%
E - Cash and In-Kind Contributions	2	1,220	0.0%
F - Community Building Activities	2	9,128	0.0%
Totals for Community Services	**5,207**	**990,318**	**0.5%**
Totals for Broader Community	**5,207**	**990,318**	**0.5%**
Totals - Community Benefit	**32,317**	**24,866,821**	**12.5%**
Medicare	**16,240**	**25,730,670**	**13.0%**
Totals with Medicare	**48,557**	**50,597,491**	**25.5%**

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	Mike Chandler Retired Yocha Dehe Fire Chief
Calvin Handy Retired UC Davis Police Chief	Justin Chatten-Brown, MD Emergency Services Medical Director Woodland 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
Edmundo Castañeda Woodland Memorial President	Laurie Harting Dignity Health Senior Vice President, Operations

Financial Assistance Policy Summary

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Mercy General Hospital 4001 J St, Sacramento, CA 95819 | **Financial Counseling** 916-389-8626
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

Mercy Hospital of Folsom 1650 Creekside Dr, Folsom, CA 95630 | **Financial Counseling** 916-983-7512
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

Mercy San Juan Medical Center 6501 Coyle Ave, Carmichael, CA 95608 | **Financial Counseling** 916-536-3053
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

Methodist Hospital of Sacramento 7500 Hospital Dr, Sacramento, CA 95823 | **Financial Counseling** 916-423-6199
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

Sierra Nevada Memorial Hospital 155 Glasson Way, Grass Valley, CA 95945 | **Financial Counseling** 530-274-6758
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

Woodland Healthcare 1325 Cottonwood St, Woodland, CA 95695 | **Financial Counseling** 530-662-3961 ext. 4559
Patient Financial Services 888-488-7667 | www.dignityhealth.org/woodland/paymenthelp