2025 Woodland Memorial Hospital
Community Health Implementation Plan

Adopted October 2025

Dignity Health
A member of CommonSpirit

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At-a-Glance Summary

Community Served	A hospital's service area comprises all residents in a defined geographic area and does not exclude low-income or underserved populations. As such, Woodland Memorial Hospital is located in Yolo County and serves the entire county.
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 the hospitals intends to address with strategies and programs are: • Access to Care • Chronic Disease Prevention & Management • Access to Resources • Mental Health & Substance Use
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: **Patient Navigator Program:** Bridging emergency care with lasting wellness, our patient navigators seamlessly connect individuals from the hospital emergency department to a vital network of medical homes regionally and other community-based supports. ***Significant Health Needs Addressed:*** Access to Care and Access to Resources **Substance Use Navigation Program:** Our wellness navigators treat substance use disorder as a medical emergency, facilitating immediate Medication for Addiction Treatment (MAT) and seamless connections to ongoing substance use and mental health services. Rooted in the CA Bridge Model, we offer low-barrier care and champion harm reduction. ***Significant Health Needs Addressed:*** *Access to Care, Access to Resources, and Mental Health/Substance Use*

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the Community Health and Outreach Department at 5400 Data Drive Rancho Cordova, CA 95670 or by email to communityhlth-GSM@commonspirit.org

Our Hospital and the Community Served

About the Hospital

Woodland Memorial Hospital is part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Woodland Memorial is situated in Yolo County, located at 1325 Cottonwood Street in Woodland, CA, and has been providing exceptional care to the community for more than 100 years. The general acute care hospital is a part of Dignity Health and has 765 employees, 122 active medical staff, and 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

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

Financial Assistance for Medically Necessary Care

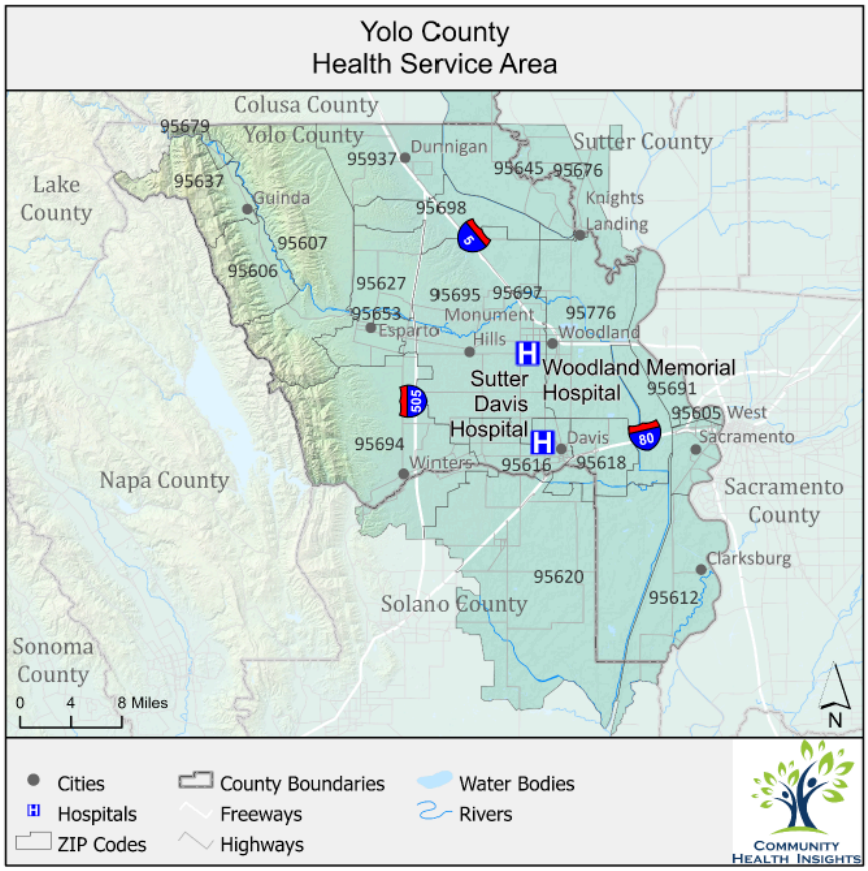
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such

care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

A hospital's service area comprises all residents in a defined geographic area and does not exclude low-income or underserved populations. As such, Woodland Memorial Hospital is located in Yolo County and serves the entire county.



Furthermore, by region 20 ZIP Codes that comprise Woodland Memorial Hospital's primary service area are:

- 95620, 95676, 95605, 95606, 95607, 95612, 95616, 95618, 95627, 95637, 95645, 95653, 95679, 95691, 95694, 95695, 95697, 95698, 95776, 95937

As a result of the collaborative 2025 CHNA completed by Community Health Insights for Dignity Health and other hospitals located in Yolo County, the following four regions and 20 ZIP Codes were identified to be places of concern:

- West Sacramento: 95605 & 95691
- Woodland: 95695 & 95776
- Esparto: 95627
- Knights Landing: 95645
- Madison: 95653
- Dunnigan: 95937

Yolo County – Core Demographic Composition, 2019–2023

Geographic Classification	Rural & Suburban	**Total Population**	217,782
Race & Ethnicity			
		Not Hispanic or Latino	**66.8%**
White	43%	**Native Hawaiian/ Other Pacific Islander**	0.4%
Black or African American	2.5%	**Some Other Race**	0.5%
American Indian and Alaska Native	0.4%	**Two or More Races**	5.4%
Asian	14.5%		
		Hispanic or Latino (of any race)	**33.2%**
Socioeconomic Status			
Median Household Income	$88,818	**Unemployment Rate**	11.5%
Non-High School Graduates	12.8%	**Poverty Among Families w/Children**	9.1%
Limited-English Proficiency	5.3%		
Access to Care			
Uninsured Individuals	4.6%	**Medicaid Beneficiaries**	4.1%

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation plan were identified in the most recent CHNA report, which was adopted in June 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Care	This significant health need will focus on increasing clinical-community linkages and enhancing an individual's ability to obtain necessary health services.	☑
Access to Resources	This significant health need will focus on connecting individuals with basic needs and other community-based resources.	☑
Chronic Disease Prevention & Management	The focus of this significant health need will include promoting active and healthy lifestyles, and preventing or treating chronic conditions, including injury and trauma.	☑
Mental Health & Substance Use	This significant health need will address access to comprehensive mental health and substance use services and other community-based programming.	☑

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

Dignity Health - Yolo County is dedicated to improving community health and delivering community benefits with the engagement of its staff, clinicians and board, and in collaboration with community partners.

The following outlines the approach taken when planning and developing initiatives to address significant health needs. 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 hospitals' leadership teams, 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 hospitals' 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.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

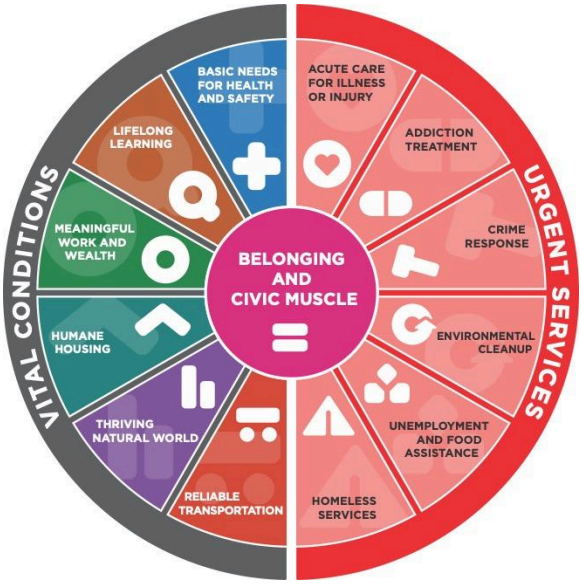
- **Core Strategy 1:** Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2:** Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3:** Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.



What are Vital Conditions?

These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?

These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?

This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

Strategies and Program Activities by Health Need

Access to Care					
Goal I: Increase health literacy and access to quality care.					
Strategy	**Roles, Responsibilities & Resources Committed**		**Planned Actions**		
1.1 Reduce the 30-day all-cause unplanned hospital readmission rate among patients with Medi-Cal by 2.5%.	WMH: Strategy sponsor charged with implementation of all aspects of this strategy including financial and in-kind support		- Leverage patient data to identify common medical conditions, social challenges, payor, and primary care affiliation that correlate with higher readmission rates. This analysis will directly inform the development of targeted interventions to address this disparity. - Strengthen partnerships with Enhanced Care Management providers, Federally Qualified Health Centers and other primary care practices, and payors to enhance coordinated care and improve transitions to effectively reduce readmission rates across our shared patient population. - Conduct patient screening for social determinants of health, then employ the Unite Us platform to bridge gaps in care by addressing identified needs and ensuring their successful resolution through a closed-loop referral process. - Implement strategies to increase patient knowledge and utilization of Cal-AIM benefits, specifically prioritizing enrollment in ECM and arranging for medically-tailored meal delivery prior to discharge. - Provide comprehensive cultural humility training for all staff interacting with patients, designed to enhance awareness of implicit bias and foster skills in culturally sensitive and respectful communication practices that improve patient engagement and satisfaction - Evaluate and revise patient education materials for adherence to California/National Culturally and Linguistically Appropriate Services Standards. - Assess current availability and utilization of professional medical interpreters for all languages spoken by patient population, ensuring 24/7 access.	
Strategy Alignment	**Strategy 1:** Extend Care Continuum	**Strategy 2:** Evidence-informed	**Strategy 3:** Community Capacity	**Vital Condition OR Urgent Service**	*Vital Condition:* Basic Need for Health& Safety; *Urgent Services:* Homeless Services, Food and Assistance

Access to Care – CONTD.				
Goal I: Increase health literacy and access to quality care.				
Strategy	**Description**	**Population of Focus**	**Roles, Responsibilities & Resources Committed**	**Evaluation Measures**
1.2. Provide patient navigation services to ED patients.	An Emergency Department community health worker navigation program that will: • Perform SDOH, assessment, and/or other risk assessments • Support linkages to primary, behavioral health, and specialty care services • Determine resources to support unmet social needs • Support linkages with unmet social needs • Educate patient about Medi-Cal benefits • Schedules post-discharge and appointment transportation (as needed)	Low-acuity ED patients	WMH: Strategy co-sponsor charged with implementation of this strategy, and providing financial /in-kind support Empower Yolo: Strategy co-sponsor contracted to provide patient navigation services.	- Proportion of low acuity ED patients in which an SDOH screening was completed - Proportion of ED patients with an identified social need that accepted navigation services - Proportion of ED patients screened with at least one identified social need - Proportion of SDOH screened ED patients: (1) with a medical home, (2) identified to be unhoused, (3) seeking care of an ambulatory sensitive condition, (4) with a chronic condition, (5) that had an inpatient hospitalization within the last 30 days, (6) that had an ED visit within the last 90 days; (7) with a substance use disorder; (8) which a primary care visits was scheduled pre/post discharge; (9) educated about their Medi-Cal benefits; and (10) that have Medi-Cal in which post-discharge transportation (home and/ or medical appointment) was scheduled.
Evidence-informed Source				
Peretz PJ, Vargas H, D'urso M, Correa S, Nieto A, Greca E, Mucaria J, Sharma M. Emergency department patient navigators successfully connect patients to care within a rapidly evolving healthcare system. Prev Med Rep. 2023 Jun 23;35:102292. doi: 10.1016/j.pmedr.2023.102292. PMID: 37449004; PMCID: PMC10336236.			Shi, M., Fiori, K., & Chambers, E. (2023, April 21). Social Needs Assessment and Linkage to Community Health Workers in a Large Urban Hospital System. Sage Journals . https://journals.sagepub.com/doi/full/10.1177/21501319231166918	
Strategy Alignment	**Strategy 1:** Extend Care Continuum	**Strategy 2:** Evidence-informed	**Strategy 3:** Community Capacity	**Vital Condition OR Urgent Service**	*Vital Condition:* Basic Need for Health& Safety; *Urgent Services:* Homeless Services, Food and Assistance

Access to Care-CONTD.						
Goal I: Increase health literacy and access to quality care.						
Strategy	**Description**	**Population of Focus**	**Roles, Responsibilities & Resources Committed**		**Evaluation Measures**	
1.3. Provide financial and in-kind support to organizations addressing health care disparities in Yolo County	Conducted annually by the hospitals, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on the significant health needs identified in the most recent community health needs assessment.	Medically-needy adults and children residing in Yolo County	WMH: Strategy sponsor charged with administration of the grants program and providing financial support.		- # of grantees - Total grant funds awarded - The process and outcome evaluation measures are unique to each Community Health Improvement grantee. As such, the evaluation measures cannot be identified in advance.	
Strategy Alignment		**Strategy 1:** Extend Care Continuum	**Strategy 2:** Evidence-informed	**Strategy 3:** Community Capacity	**Vital Condition OR Urgent Service**	*Vital Condition:* Basic Need for Health& Safety; *Urgent Services:* Homeless Services, Food and Assistance

Access to Resources					
Goal II: Advance health equity by ensuring basic needs are identified, addressed and met.					
Strategy	**Description**		**Population of Focus**	**Roles, Responsibilities & Resources Committed**	**Evaluation Measures**
2.1. Provide patient navigation services to ED patients	Same as Strategy 1.2				
2.2. Provide financial/in-kind support to Yolo County community organizations addressing basic needs	Conducted annually by the hospitals, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on the significant health needs identified in the most recent community health needs assessment.		Individuals residing in Yolo County with unmet basic needs	WMH:: Strategy sponsor charged with administration of the grants program and providing financial support.	- # of grantees - Total grant funds awarded - The process and outcome evaluation measures are unique to each Community Health Improvement grantee. As such, the evaluation measures cannot be identified in advance.
Strategy Alignment	**Strategy 1:** Extend Care Continuum	**Strategy 2:** Evidence-informed	**Strategy 3:** Community Capacity	**Vital Condition OR Urgent Service**	*Vital Condition:* Basic Need for Health & Safety; *Urgent Services:* Homeless Services, Food and Assistance

Chronic Disease Prevention & Management					
Goal III: Prevent and/or manage chronic disease and risk factors					
Strategy	**Description**		**Population of Focus**	**Roles, Responsibilities & Resources Committed**	**Evaluation Measures**
3.1. Provide financial/in-kind support to Yolo County organizations offering chronic disease prevention and/or management services/programs	Conducted annually by the hospitals, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on the significant health needs identified in the most recent community health needs assessment.		Yolo County adults and child with/at-greater risk for a chronic disease	WMHJ: Strategy sponsor charged with administration of the grants program and providing financial support.	- # of grantees - Total grant funds awarded - The process and outcome evaluation measures are unique to each Community Health Improvement grantee. As such, the evaluation measures cannot be identified in advance.
3.2. Increase chronic disease prevention and management through assessment and education	The Healthier Living program utilizes the Stanford Chronic Disease Self-Management curriculum to equip participants with the self-efficacy and skills needed to better their health. Six week workshops are offered in partnership at medical clinics, food banks, affordable housing developments and other community organizations.		Yolo County adults with/at-risk for a chronic disease	WMH: Strategy sponsor charged with implementation and providing financial support.	- # of six week workshops held - # of new community partners/sites - # of community members in enrolled - Program attrition rate - Pre/Post participant self-efficacy assessment results
Strategy Alignment	**Strategy 1:** Extend Care Continuum	**Strategy 2:** Evidence-informed	**Strategy 3:** Community Capacity	**Vital Condition OR Urgent Service**	*Vital Condition:* Basic Need for Health & Safety

Mental Health & Substance Use

Goal IV: Promote community well-being and improve the proportion of individuals within Dignity Health - Greater Sacramento's service area that have access to/receive behavioral health services.

Strategy	Description	Population of Focus	Roles, Responsibilities & Resources Committed	Evaluation Measures
4.1. Expand Emergency Department (ED) Substance Use Navigation Program	Wellness Navigators based in the ED engage, link and provide continuity of care and treatment for patients with opioid, polysubstance, and alcohol-related conditions. Navigators with the aforementioned patients will provide harm reduction (i.e., naloxone and fentanyl testing strips) education and supplies.	ED patients with a substance use disorder	WMH: Strategy sponsor charged with implementation of this strategy including financial and in-kind support for all uninsured and non-MediCal insured ED patients in need of SUD services California Department of Public Health: Provide harm reduction supplies (i.e., naloxone and fentanyl testing strips) for distribution through Naloxone Distribution Project. MediCal: Provide financial reimbursement for substance use navigation for covered beneficiaries	- Proportion of ED patients with an SUD provided with education. - Proportion of ED patients with an identified (patient record and/or provider referral) to have an SUD. - Proportion of patients in which care navigation (i.e., clinical referrals, community resources, etc.,) was implemented. - Proportion of patients that had a follow-up care appointment scheduled within seven days post ED discharge. - Proportion of ED patients that initiated MAT - Proportion of patients and/or their families provide with harm reduction education and supplies (i.e., overdoses reversal education and training, free naloxone and fentanyl testing strip, substance use navigation, etc.,).
4.2. Provide financial and in-kind support to community -based organizations addressing mental health and substance use	Conducted annually by the hospitals, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on the significant health needs identified in the most recent community health needs assessment.	Nonprofit organizations providing mental health/substance use services in Yolo County.	WMH: Strategy sponsor charged with implementation of the grant program and providing financial support.	- # of grantees - Total grant funds awarded - The process and outcome evaluation measures are unique to each Community Health Improvement grantee. As such, the evaluation measures cannot be identified in advance.

Strategy Alignment	Strategy 1: Extend Care Continuum	Strategy 2: Evidence-informed	Strategy 3: Community Capacity	Vital Condition OR Urgent Service	Urgent Service - Addiction Treatment