Dignity Health
Woodland Healthcare

Woodland Memorial Hospital

2019 Community Health Needs Assessment – Main Report

Acknowledgements

We are deeply grateful to all those who contributed to the joint community health needs assessment/community health assessment conducted on behalf of Woodland Memorial Hospital, Sutter Davis Hospital, and Yolo County Health and Human Services Community Health Branch. Many dedicated community health experts and members of various social-service organizations working with the most vulnerable members of Yolo County served on the steering committee and supported the data collection work. Other service providers gave their expertise as key informants to help guide and inform the findings of this joint assessment. We have a special appreciation for CommuniCare Health Centers and Winters Healthcare for their work and dedication to the CHNA/CHA. We also express our deepest appreciation to the many Yolo County residents that participated as focus group participants or completed the countywide survey. To everyone that supported this important work, we extend our deepest heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the work on behalf of the partners. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California. This joint report was authored by:

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Data and Technical Section of the report can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

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Executive Summary

Purpose

The purpose of this joint community health needs assessment (CHNA)/community health assessment (CHA) was to identify and prioritize significant health needs of the Yolo County community. The priorities identified in this report help to guide health improvement efforts of both Woodland Memorial Hospital, Sutter Davis Hospital and Yolo County Health and Human Services, Community Health Branch.

This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and, in California, Senate Bill 697) that not-for-profit hospitals conduct a CHNA at least once every three years, as well as the Public Health Accreditation Board (PHAB) CHA requirements. The CHNA/CHA was conducted by Community Health Insights (www.communityhealthinsights.com). Multiple other community partners participated in and collaborated to conduct the CHNA, including CommuniCare Health Centers and Winters Healthcare.

Dignity Health Commitment and Mission Statement

The hospital's dedication to engagement with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with our mission. Dignity Health is committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

Community Definition

Yolo County was one of California's 27 original counties when it became a state in 1850, and is home to well over 200 thousand residents. It is located directly west of Sacramento, and sits along both the Interstate 5 and 80 corridors. The county is considered a part of the Greater Sacramento metropolitan area and is located in the Sacramento Valley. Yolo County covers over 1,000 square miles, and a large portion is dedicated to agriculture. The County is known for growing and processing tomatoes. The University of California, Davis, is located in the County and has received world-wide recognition for its research and education. It is also the county's largest employer.

Yolo County was chosen as the geographical area for the CHNA/CHA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County. Community service providers and community members described Yolo County during primary data collection for the CHNA/CHA as "diverse in income, race/ethnicity, and rural and urban status" with many "longtime county residents."

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary and secondary data. Primary data included interviews with 61 community health experts, social-service providers, and medical personnel in one-on-one and group interviews, as well as one town hall meeting. Further, 32 community residents

participated in three focus groups across the county, and 2,291 residents completed the community health assessment survey.

Using a social determinants focus to identify and organize secondary data, datasets included measures to described mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, measures also included indicators to describe health behaviors, clinical care (both quality and access), and data to describe the physical environment.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in the previously conducted health assessments with area hospitals. Data were analyzed to discover which, if any, of the PHNs were present in the area. After these were identified, the health needs were prioritized based on an analysis of primary data sources that identified the PHN as a significant health need (SHN).

List of Prioritized SHNs

The following SHNs were identified and are listed below in prioritized order:

1. Access to mental/behavioral/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 health eating
5. Access to quality primary care health services
6. Access and functional needs
7. Access to specialty and extended care
8. Safe and violence-free environment
9. Pollution-free living environment
10. Access to dental care and preventive services

Resources Potentially Available to Meet the Significant Health Needs

In all, 292 resources were identified that were potentially available to meet the identified SHNs in the Yolo County area. The identification method included starting with the list of resources from previous area health assessments, verifying that the resource still existed, and then adding newly identified resources identified as part of the 2019 assessment.

Conclusion

This CHNA/CHA report details the needs of the Yolo County community as a part of a successful collaborative partnership between Sutter Davis Hospital, Woodland Memorial Hospital, and Yolo County Health and Human Services Community Health Branch. It provides both an overall health and social examination of Yolo County and a deeper examination of the needs of community members living within areas of the county experiencing disproportionately unmet health needs. The work provides a comprehensive profile to guide decision-making for implementation of community-health-improvement efforts. This report also serves as an example of a successful collaboration between healthcare systems and local public health departments to provide meaningful insights to support improved health in the community they serve.

Report Adoption, Availability and Comments

The Community Board voted, approved and adopted the Community Health Needs Assessment for Woodland Memorial Hospital June 25, 2019.

This main report and the data and technical section is widely available to the public on the hospital's web site (https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-

assessment), and a paper copy is available for inspection upon request at Dignity Health, Community Health and Outreach Department, 3400 Data Drive, Rancho Cordova, CA 95670.

Written comments on this report can be submitted by email to DignityHealthGSSA_CHNA@dignityhealth.org

Introduction and Purpose

A critical first step to community health improvement planning is a deep understanding of the community's needs. Both nonprofit hospitals nationwide and local public health departments conduct community health assessments to guide community benefit investment and inform community prevention efforts as part of a strategic community health improvement focus.

California state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years. Nationally, state, local and tribal health departments are pursuing "public health accreditation" from the national Public Health Accreditation Board (PHAB), and a community health assessment (CHA) is a crucial component of this. Though titled differently, CHNAs and CHAs are one and the same, both focusing on important key components, including a systematic collection and analysis of data; information on health status, health needs, and other key social determinants of health; community engagement and input; collective participation; and identification of community assets and resources.

The definition of a community health need is similar for the CHNA and the CHA. Federal regulations define a *health need* accordingly from CHNAs: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)".[1] Meanwhile, PHAB refers to health needs as "those demands required by a population or community to improve their health status".[2] Both CHNAs and CHAs guide the development of community health improvement efforts aimed at addressing the identified needs. Hospital CHNAs refer to these as implementation plans, while public health agencies call them community health improvement plans or CHIPs. Given the similarities between the CHNA and CHA processes, national experts are calling for nonprofit hospitals and public health departments to work together on local health assessments and community health improvement efforts.[3]

This report documents the processes, methods, and findings of a collaborative CHNA/CHA conducted on behalf of a partnership between Sutter Davis Hospital (Sutter Health), Woodland Memorial Hospital and Yolo County Health and Human Services Community Health Branch. Other partners involved included CommuniCare Health Centers and Winters Healthcare. A steering committee consisting of 14 various community health experts guided the CHNA/CHA process. The collaboration between the hospitals and the county emphasized a team approach to addressing the key components of the CHNA/CHA. Each partner was committed to the process, engaged in regular meetings, provided timely feedback to analysis, and willingly shared expertise to support the successful completion of the report. The CHNA/CHA was conducted over a period of eight months, beginning in February 2018 and concluding October 2018. This CHNA/CHA report meets the requirements of the Patient Protection and Affordable Care Act (and in California of Senate Bill 697). In addition, this report meets the requirements set out by PHAB for conducting a CHA as a part of a local health department needs assessment.

[1] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.
[2] Public Health Accreditation Board (2011, September). Acronyms and Glossary of Terms, Version 1.0.
[3] Burnett, K. (2012, February). Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A review of scientific methods, current practices and future potential. Public Health Institute on behalf of Center for Disease Control and Prevention.

Organization of This Report

This report follows federal guidelines issued on how to document a CHNA/CHA. First, it describes the prioritized listing of significant health needs identified through the assessment, along with a description of the process and criteria used in identifying and prioritizing these needs. Next, it details the methods used to conduct the CHNA/CHA, including how data were collected and analyzed. Third, it details the community served by partners and how the community was identified. Fourth, it provides a description of how partner organizations solicited and considered the input received from persons who represented the broad interests of the community served. Next it identifies and describes resources potentially available to meet these needs. Finally, it gives a summary of the impact of actions taken by each hospital (Sutter Davis Hospital and Woodland Memorial Hospital) to address significant health needs identified in the hospital's previous assessment.

A detailed methodology section titled "Woodland Memorial 2019 Community Health Needs Assessment – Data and Technical Section" contains an in-depth description of the methods used for collection and analysis of data and compiling the results to identify and prioritize significant health needs. This section can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

Findings

Prioritized Significant Health Needs (SHN)

The analysis of data included both primary and secondary to identify and prioritize the significant health needs within the Yolo County area. In all, 10 significant health needs were identified. After these were identified they were prioritized based on an analysis of primary data sources (key informant interviews, focus groups, and the countywide community survey) that mentioned the health need as a priority health need. The findings are listed below and displayed in Figure 1.

1. Access to mental/behavioral/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 health eating
5. Access to quality primary care health services
6. Access and functional needs
7. Access to specialty and extended care
8. Safe and violence-free environment
9. Pollution-free living environment
10. Access to dental care and preventive services

This prioritization was based on three measures of community member input. The first measure reports the percentage of key informant interviews or focus groups that mentioned themes associated with a given health need. Key informants and focus group participants were also asked to identify the top three health needs in the area. The second measure reports the percentage of these top three priority health needs identified across all key informant interviews and focus groups associated with one of the above identified health needs. The final measure came from the community survey, where respondents were asked to identify the top three health issues, individual behaviors, and environmental issues influencing health issues in the community. The top five responses to each of these three questions were identified. The percentage of these responses associated with each of the health needs above was then calculated as the final measure for prioritization. Values for these measures for each of the health needs are shown in Table 1.

Table 1: Community Member Measures Used for Health Need Prioritization

Health Need	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Three Priority	Percentage of Times Health Need Identified as a Top 5 Priority Health Need in Survey Responses
Access to Mental/ Behavioral/ Substance Abuse Services	100.0%	27.1%	33.3%
Injury and Disease Prevention and Management	100.0%	20.8%	33.3%
Access to Basic Needs such as Housing, Jobs, and Food	100.0%	27.1%	20.0%
Active Living and Healthy Eating	81.8%	6.3%	40.0%
Access to Quality Primary Care Health Services	90.9%	8.3%	13.3%
Access and Functional Needs	90.9%	8.3%	0.0%
Access to Specialty and Extended Care	81.8%	2.1%	6.7%
Safe and Violence-Free Environment	63.6%	0.0%	0.0%
Pollution-Free Living Environment	18.2%	0.0%	20.0%
Access to Dental Care and Preventive Services	54.5%	0.0%	0.0%

Each of these three measures were then rescaled so the health need with the highest value ended up with a value of one, the health need with the lowest value ended up with a value of zero, and all other health needs had values proportional to these. These rescaled values were then summed to create an index that was used to prioritize the health needs. The values for the health need prioritization index are shown in Figure 1.

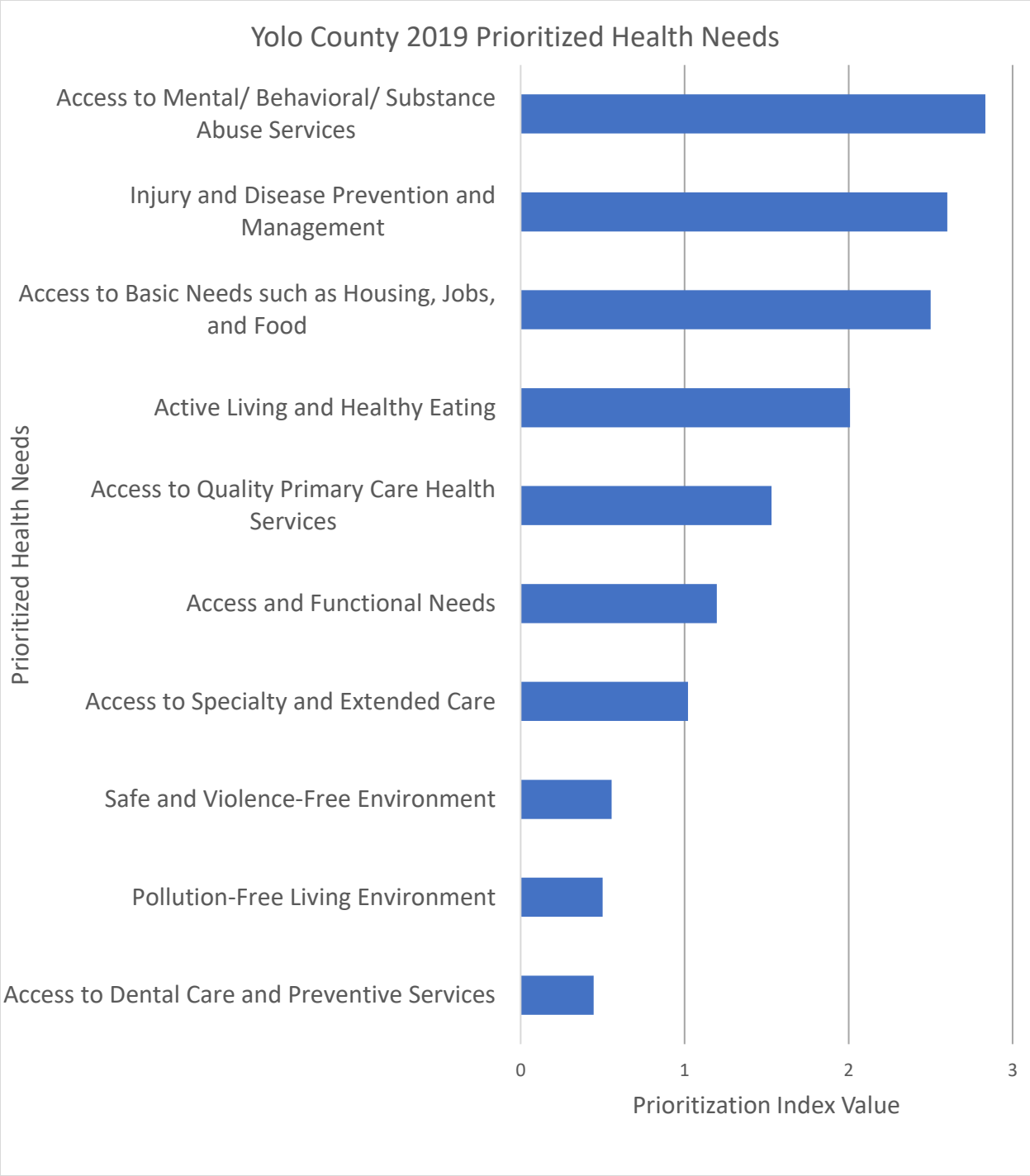

Figure 1: Prioritized, significant health needs for Yolo County

The significant health needs are described below. Those secondary data indicators used in the CHNA/CHA that performed poorly compared to a benchmark are listed in the table below each of the significant health needs. Qualitative themes that emerged during analysis are also provided in the table, followed by survey questions for which the survey responses compared poorly against standard benchmark comparisons. For a full listing of all quantitative indicators, qualitative themes and survey questions per potential health need refer to the data/technical section.

1. Access to Mental, Behavioral, and Substance Abuse Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur concurrently. Adequate access to mental, behavioral, and substance abuse services helps community members obtain additional support when needed.

Quantitative Indicators	Qualitative Themes	Survey Questions

- Life Expectancy at Birth
- Liver Disease Mortality
- Poor Mental Health Days
- Poor Physical Health Days
- Drug Overdose Deaths
- Excessive Drinking
- Health Professional Shortage Area (HPSA) Mental Health
- Liver Cancer Mortality
	- Lacking in access to appropriate, timely and adequate behavioral/mental health treatment and prevention
	- Lack of mental health resources for the community
	- Many using emergency department (ED) for mental healthcare
	- Lack of psychiatrists in the county
	- High substance abuse issues in the county
	  o Alcohol, meth, and opioid usage
	  o Opioid on the rise in the last few years
	- Substance abuse and homelessness in the county
	- High presence of homelessness in Woodland, Davis, West Sac, and by the river
	- Hard to find housing for individuals who are mentally ill and homeless
	- Lack of prevention and early intervention work for mental health
	- Lack of support for adults as parents directly impacting the children in the family
	- Need for mental healthcare and support for the aging population – struggle with anxiety and depression – become "shut-ins"
	- Need community opportunities to stay connected for the aging population and the community in general
	- Need support for dementia caregivers and other caregivers (mental health, etc.)
	- Need mental health day-care programs
	- Increased access to care for mental health and substance abuse treatment as a Medi-Cal enrollee
		- Have you ever been told you have cancer?
		- Have you ever been told you have mental illness?
		- Have you ever been told you have a drug or alcohol problem?
		- Have you needed behavioral health care in past 12 months?

2. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury and around infectious disease control (e.g., sexually transmitted infection (STI) prevention, influenza shots) and intensive strategies around the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

Quantitative Indicators	Qualitative Themes	Survey Questions
- Alzheimer's Mortality - Chronic Lung Disease (CLD) Mortality - Diabetes Mortality - Liver Disease Mortality - Unintentional Injury Mortality - Drug Overdose Deaths - Excessive Drinking - Adult Obesity - Adult Smokers - Motor Vehicle Crash Deaths - Prenatal Care - Liver Cancer Mortality - ED visits for Falls Persons over age 65	- Prevention efforts for chronic disease especially diabetes and obesity - Assistance understanding and navigating community resources before crisis - Prevention of STIs - Prevention of cannabis smoking, especially in youth and pregnant mothers - Need senior services – day-care centers, resources for medication management, preventing isolation, fall prevention, Alzheimer's, and dementia prevention - Fear of accessing community preventive services in the undocumented population - Access to fresh fruits and vegetables to live healthfully - Lack of a resource team for early detection of social needs in youth - West Sac isolated from county hub – hard to get many county-based preventive programs - Over usage of the ED for primary care – focus should be on prevention - Increased awareness needed regarding dating violence	- Have you ever been told you have asthma/lung disease/Chronic Obstructive Pulmonary Disease (COPD)/emphysema? - Have you ever been told you have an autoimmune disease (Lupus, Type 1 diabetes)? - Have you ever been told you have cancer? - Have you ever been told you have diabetes? - Have you ever been told you have mental illness? - Have you ever been told you have a drug or alcohol problem?

3. Access to Basic Needs, Such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[4] says that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health.

Quantitative Indicators	Qualitative Themes	Survey Questions

- Premature Age-Adjusted Mortality
- Years of Potential Life Lost
- HPSA Medically Underserved Area
- Unemployment Rate
- Median Household Income
- Housing Units with No Vehicle
- Third-Grade Reading Level
	- Lack of affordable housing
	- Low housing inventory in the county
	- Lack of employment opportunities in the county
	- Homelessness in adults, especially veterans, and teens
	- Food insecurity and obesity
	- Lack of affordable child care – dual-income families due to high housing and living costs
	- Limited food banks
	- Businesses closing – vacant lots and buildings
	- Lack of housing drastically increasing homelessness in the county, displacing many seniors
	  o Much of the new housing geared at families who are not low-income or seniors on fixed incomes.
	  o "Not in my backyard" mentality
	- Drastic lack of services for migrants in rural areas of county – Knights Landing, Esparto, Madison, Winters
	- High amount of poverty in areas of the county
	- Presence of youth sex workers in the county
	- Need overall safety-net services for families
		- Have you ever been told you have asthma/lung disease/COPD/emphysema?
		- Do you have health insurance?

4. Active Living and Healthy Eating

Physical activity and eating a healthy diet are extremely important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold.

[4] McLeod, S. (2014). *Maslow's Hierarchy of Needs*. Retrieved from: http://www.simplypsychology.org/maslow.html

Quantitative Indicators	Qualitative Themes	Survey Questions
- Diabetes Mortality - Cancer Female Breast - Adult Obesity	- Food insecurity issues - Lack of grocery stores and access to affordable high-quality foods - Limited food banks in the county - Much of what is available too high in sodium, fat, sugar, and chemicals - Contributes to high rates of diabetes, obesity, and youth obesity - Parks for physical activity have many individuals with mental illness or experiencing homelessness – creates perception of being unsafe - Sports and organized activities for youth too expensive - Food deserts – Woodland, Winters, and West Sacramento	- Have you ever been told you have cancer? - Have you ever been told you have diabetes?

5. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

Quantitative Indicators	Qualitative Themes	Survey Questions
- Life Expectancy at Birth - CLD Mortality - Diabetes Mortality - Liver Disease Mortality - Cancer Female Breast - HPSA Medically Underserved Area - Prenatal Care - Liver Cancer Mortality	- Lack of access to care - Need timely care at the local health clinics, area clinics are full – sometimes a week or more for an appt. o The "hurry up and wait" game - Transportation to care a major barrier - Overuse of ED for primary care appointments - Lack of integration of care between major county hubs – Woodland, West Sacramento, and Davis - Medication management and cost of medication is unaffordable - Need more medical caseworkers – basic needs a big barrier to primary care access - Need for trauma-informed care at the primary care level - Language and cultural barriers to primary care access and quality - Hesitation of local primary care providers (esp. at local community clinics) to work on	- Have you ever been told you have cancer? - Have you ever been told you have diabetes? - Have you ever gone to the ER because it was more convenient?

Quantitative Indicators	Qualitative Themes	Survey Questions
	"pain management" cases due to opioid epidemic - Need more patient navigation – especially for seniors - Lacking 24/7 pharmacies in Yolo County - Constant changes to government-funded care creates barriers to care	

6. Access and Functional Needs – Transportation and Physical Disability

The sixth-highest-priority significant health need for Yolo County was access to meeting functional needs, which includes indicators related to transportation and disability. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to assure that all community members have access to necessities for a high quality of life.

Quantitative Indicators	Qualitative Themes	Survey Questions
- Housing Units with No Vehicle	- Lack of adequate and affordable transportation a major issue in the county - Medical care services not organized around major transportation lines - Outlying rural areas lack access to services and healthy food – including transportation - For seniors – helping assist with navigation of the transportation system, and helping reduce fear of using public transportation - Lack of transportation causing increased isolation - Hard to get primary care appointments - – patients use ambulances to get to appointments - Lack of transportation primary reason given for missing medical appointments	- Have you ever been told you have a physical disability?

7. Access to Specialty and Extended Care

Specialty care is devoted to a particular branch of medicine and often focuses on the treatment of a particular disease. Primary and specialty care go hand-in-hand, and without access to specialists such as endocrinologists, cardiologists, and gastroenterologists, community residents are left to manage chronic diseases such as diabetes and high blood pressure on their own. In addition to specialty care, extended care refers to care needed in the community that supports overall physical health and wellness and that

extends beyond primary care services, such as skilled nursing facilities, hospice care, in-home healthcare, and the like.

Quantitative Indicators	Qualitative Themes	Survey Questions

- Life Expectancy at Birth
- Alzheimer's Mortality
- CLD Mortality
- Diabetes Mortality
- Liver Disease Mortality
- Liver Cancer Mortality
	- Lack of specialty care and testing centers (labs) in the county
	- Lack of specialty care providers for diabetes care, especially dialysis centers in the county
	- Disconnect between hospital and post-discharge care to prevent readmissions
	  o Need vocational care
	  o Need home care
	- Transportation major issue for access to specialty care with patients having to travel to major hubs of the county or outside the county for services
	  o Kaiser patients must drive outside of the county for specialty care
	- Long-term dementia care is needed
	- Need board and care homes for seniors
	- Homeless hospice care needed
	- Lack of palliative care programs in the county
	- Shortage of vision and dental providers for Medi-Cal patients
		- Have you ever been told you have cancer?
		- Have you ever been told you have diabetes?

8. Safe and Violence-Free Environment

Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, clothing) is physical safety. Feeling unsafe affects, the way people act and react to everyday life occurrences and can have significant negative impacts on physical and mental wellbeing.[5]

Quantitative Indicators	Qualitative Themes	Survey Questions
- Life Expectancy at Birth - Motor Vehicle Crash Deaths - Poor Mental Health Days - Hospitalizations due to Self-Inflicted Injuries Youth	- Countywide community violence issues - Commercially and sexually exploited youth - Human trafficking - Child neglect - Gang and youth violence visible in the county - High presence of vandalism, graffiti	- Have you ever been told you have a drug or alcohol problem? - Have you ever been told you have mental illness?

[5] Lynn-Whaley, J., & Sugarmann, J. (July 2017). *The Relationship Between Community Violence and Trauma*. Los Angeles: Violence Policy Center.

9. Pollution-Free Living Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.[6]

Quantitative Indicators	Qualitative Themes	Survey Questions
- CLD Mortality - Cancer Female Breast - Adult Smokers - Air Particulate Matter - Drinking Water Violations	- Smoking rates for tobacco were decreasing but now on the rise - Cannabis usage a major issue in the county - Impact by area fires especially in Winters/Guinda - Air quality issues due to pesticide usage – high asthma rates o Especially true in migrant farm workers' areas	- Have you ever been told you have asthma/lung disease/COPD/emphysema? - Have you ever been told you have cancer?

10. Access to Dental Care and Prevention

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Poor oral health impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

Quantitative Indicators	Qualitative Themes	Survey Questions
- Dentists per Population	- Lack of Denti-Cal (Medi-Cal) providers in the county - Lack of providers results in pulling of teeth during dental emergencies - Many people needing dental care cannot wait and seek care in ED - Access especially lacking in outlying rural areas	- Have you been to a dentist in the last 12 months?

Health Disparities: Populations and Locations

A health disparity is defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[7] The figure

[6] See Blum, H. L. (1983). *Planning for Health*. New York: Human Sciences Press

[7] Modified from: Center for Disease Control and Prevention. (2008) Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Service.

and table below describe populations and geographical locations in Yolo County identified via qualitative data collection that were indicated as experiencing health disparities.

Interview participants were asked two separate questions:

1. What specific groups of community members experience health issues the most?
2. What specific geographic locations struggle with health issues the most?

Interview results were analyzed by counting the total number of times all key informants and focus group participants mentioned a particular group as one experiencing disparities. Figure 2 displays the results of this analysis. In addition, locations consistently mentioned by participants as being disproportionately affected by disparities were also noted and are detailed in alphabetical order in Table 2.

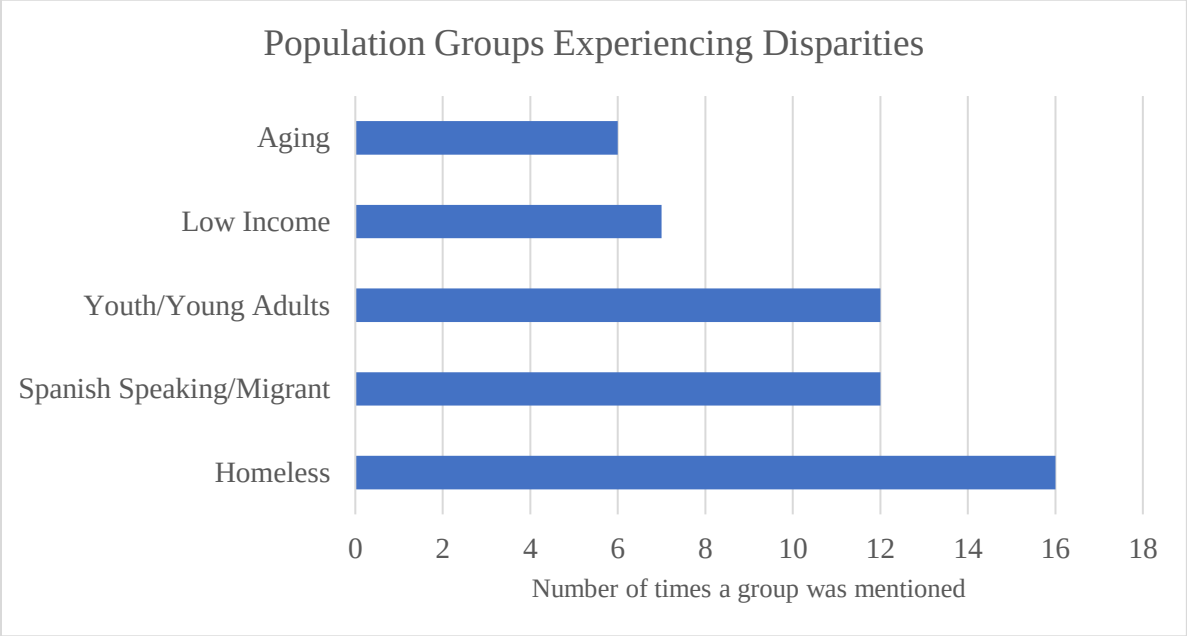

Figure 2: Specific populations experiencing health disparities for Yolo County

Other population groups mentioned included Russian and rural communities, families struggling with domestic violence, those struggling with substance abuse, and tribal community members.
Table 2 displays geographic locations across Yolo County mentioned as areas of the county experiencing social and health disparities. Data presented was collected from key informant interviews where participants were asked to identify and describe areas of the county where disparities existed by location. In most cases, participants were provided with a map of the county to draw and write on for recording the detailed data contained in Table 2. The attributes in Table 2 come directly from the written maps or key informant interview notes.

Table 2: Geographic Locations Experiencing Disparities

What specific geographic locations struggle with health issues the most?	
Geographic Locations	**Attributes of Locations**
Davis	Homelessness, substance abuse treatment needed, domestic violence, lack of affordable housing, adult day-care services needed, high sexually transmitted diseases (STD)/sexually transmitted infections (STI) rates, widespread financial insecurity, disparities in income among community groups
Dunnigan	Lack of access to social and health services, especially healthcare access, transportation issues, low socioeconomic status (SES), transportation barriers to accessing services, large aging population, high prevalence of substance abuse, lack of adequate housing, high prevalence of smoking and unhealthy eating, isolation
Esparto/Madison	High prevalence of obesity, large Spanish-speaking population, large migrant population, migrant camps, need for transportation, lacking access to food
Guinda	Low-income, many homebound residents, tribal communities, rural area of county, high rates of food insecurity, lack of prenatal services, isolation, area greatly impacted by fires
Knights Landing	Large Spanish-speaking population, low socioeconomic status, lack of access to care, need for transportation, isolation, language barriers for care
West Sacramento	Highly diverse area with a large Russian-speaking population, high lung cancer rate, widespread homelessness, especially along the river, mental health issues, substance abuse (methamphetamine), many child maltreatment cases, poverty, large recent-immigrant population, lack of choices for healthcare, food desert, lack of adequate transportation, no hospital for care
Winters	Large Spanish-speaking population, few services available, large migrant population, migrant camps, isolation, impacted by fires
Woodland	Prevalence of STD/STIs, homelessness, lower income, lack of access to care, high prevalence of substance abuse issues, large aging population, teen dating violence, teen pregnancy, HIV, child abuse and sexual assault, high obesity rates, diabetes, lack of access to healthy foods in many areas, need for transportation to access services, need for stronger safety-net systems for families, low SES and urban poverty, need services for the aging population

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA/CHA methodology because, after the county has been assessed more broadly, they allow for a focus on those portions of the county likely experiencing the greatest health disparities.

Geographic Communities of Concern were identified using a combination of primary and secondary data sources. A general description of this process is provided here. (refer to the data/technical section for an in-depth description). Three secondary data factors were considered in determining if ZIP Codes within the service area would be identified as geographic Communities of Concern: 1) whether they were

identified as Communities of Concern in the 2016 CHNA, 2) if they intersected census tracts with the highest 20% of Community Healthy Vulnerability Index (CHVI) scores in the service area, and 3) if they consistently had among the highest mortality indicator values in the county. ZIP Codes with any of these three criteria were combined with the list of geographic locations consistently mentioned in initial area-wide primary data (detailed in Table 2) to result in a final set of geographic Communities of Concern. (Population experiencing disparities were identified based on the results of primary data and were detailed previously in Figure 2).

Analysis of both primary and secondary data revealed seven ZIP Codes that met the criteria to be classified as Communities of Concern. Four ZIP Codes were identified as primary Communities of Concern, while three ZIP Codes were identified as secondary. These three ZIP Codes were labeled as secondary Communities of Concern for two reasons: 1) they were identified by local experts of geographic areas of the county with vulnerable populations and 2) they have small population census counts. These are noted in Table 2, with the census population provided for each, and they are displayed in Figure 3.

Table 3: Identified Communities of Concern for Yolo County

ZIP Code	***Community/Area***	***Population***
Primary Communities of Concern		
95605	West Sacramento	14,677
95691	West Sacramento	37,743
95695	Woodland	40,121
95776	Woodland	23,169
Secondary Communities of Concern		
95627	Esparto	3,892
95645	Knights Landing	1,810
95653	Madison	7,27
Total Population in Communities of Concern		**122,139**
Total Population in Yolo County*		**214,481**
Percentage of Yolo County*		**57%**

*County population used here is the total population of the ZIP codes included in the analysis (95605, 95606, 95607, 95612, 95616, 95618, 95627, 95637, 95645, 95653, 95679, 95691, 95694, 95695, 95697, 95698, 95776, 95937); Total estimated population for the county itself was 212,605 for the same time period. (Source: 2013–2017 American Community Survey 5-year estimates; U.S. Census Bureau)

Figure 3 displays the ZIP Codes that are Communities of Concern for Yolo County. ZIP Codes in pink are primary Communities of Concern, while ZIP Codes in blue are secondary.

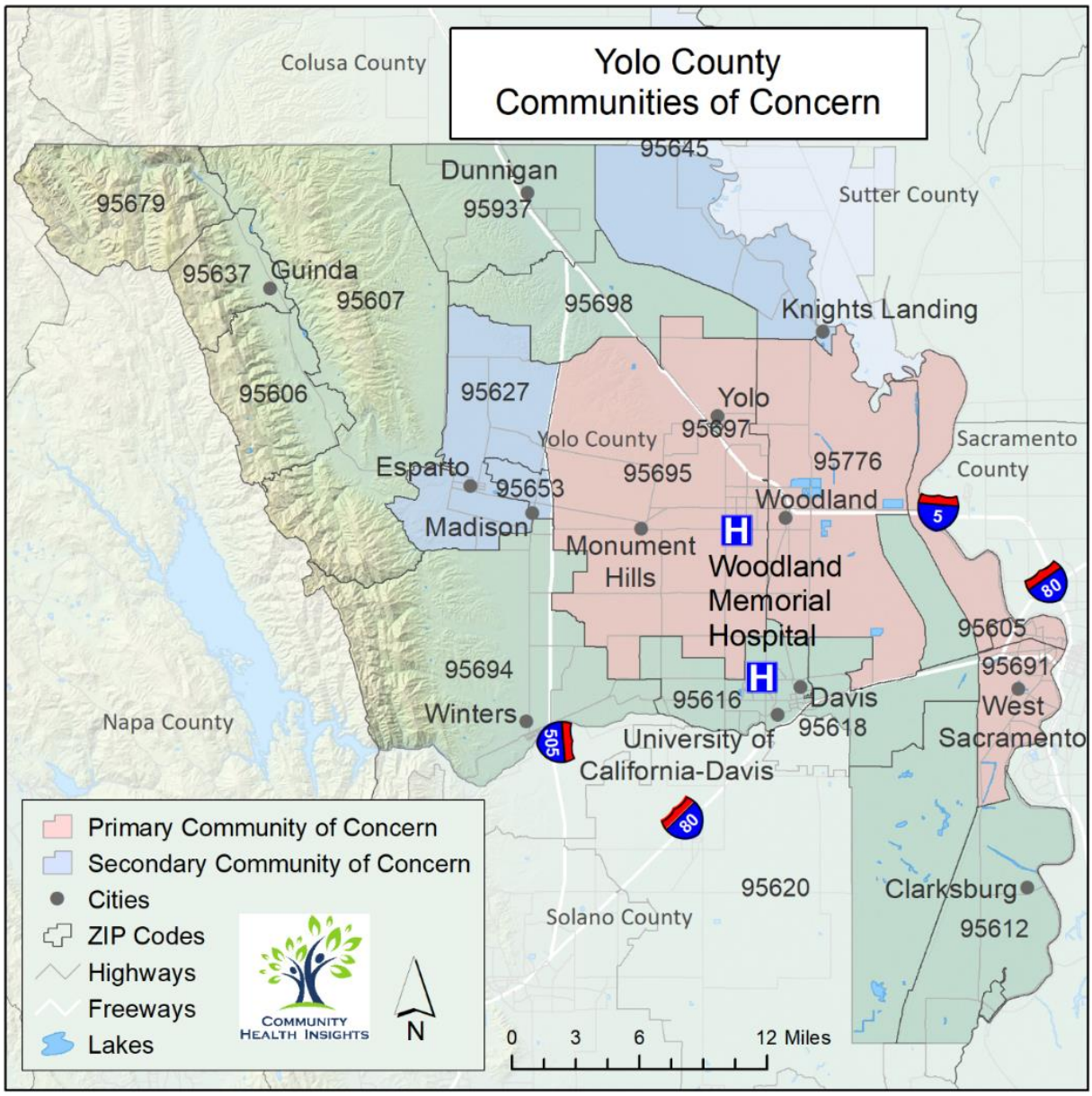

Figure 3: Communities of Concern for Yolo County

Method Overview

Conceptual and Process Models

The data used to conduct the CHNA/CHA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[8] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. For a detailed overview of methods see the data/technical section.

[8] See http://www.countyhealthrankings.org/

Public Comments from Previously Conducted CHNA

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. The 2016 CHNA was made public for Woodland Memorial Hospital. The community was invited to provide written comments on the CHNA report and Implementation Strategy both within the documents and on the web site where they are widely available to the public. The email address of DignityHealthGSSA_CHNA@dignityhealth.org was created to ensure comments were received and responded to. No written comments have been received.

Data Used in the CHNA/CHA

Data collected and analyzed included both primary and secondary data. Primary data included eight interviews with 61 community health experts as well as three focus groups conducted with a total of 32 community residents. In addition, a countywide survey was conducted with 2,291 responses from Yolo County residents (detail of CHNA/CHA participants can be seen in the data/technical section).

Secondary data included four datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at sub-county levels were used to identify portions of Yolo County with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. A set of socioeconomic indicators was also collected to help describe the overall social conditions within the service area. Health-outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health-factor indicators included measures of 1) health behaviors, such as diet and exercise, tobacco, alcohol, and drug use; 2) clinical care, including access and quality of care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) the physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 84 different health-outcome and health-factor indicators were collected for the CHNA/CHA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within Yolo County. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in the previously conducted CHNAs for the two area hospitals (not previous CHAs). Data were analyzed to discover which, if any, of the PHNs were present in the area. After these were identified, PHNs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA/CHA, including primary and secondary data collection, analysis, and results, see the data/technical section.

Description of Community Served

Yolo County was one of California's 27 original counties when it became a state in 1850, and is home to well over 200 thousand residents. It is located directly west of Sacramento, and sits along both the Interstate 5 and 80 corridors. The county is considered a part of the Greater Sacramento metropolitan area and is located in the Sacramento Valley. Yolo County covers over 1,000 square miles, and a large portion is dedicated to agriculture. The County is known for growing and processing tomatoes. The University of California, Davis, is located in the County and has received world-wide recognition for its research and education. It is also the county's largest employer.

Yolo County is governed by a board of supervisors and contains four incorporated cities: Davis, West Sacramento, Winters, and Woodland. While Davis is the largest in terms of population, Woodland serves

as the County Seat. West Sacramento is home to the Port of West Sacramento, an inland port some 80 nautical miles from San Francisco. The port exports many of the agricultural products grown in the County. The Yolo Causeway connects Davis and Sacramento along Interstate 80, and crosses the Yolo Bypass, a large floodplain and wildlife area that received national attention in the late 1990's as a national model for public/private restoration projects.

Community service providers and community members described Yolo County during primary data collection for the CHNA/CHA as "diverse in income, race/ethnicity, and rural and urban status" with many "longtime county residents." A map of Yolo County is shown in Figure 4. Yolo County was selected as the geographical area for the CHNA/CHA because it is the statutory service area of the public health department and the primary service area of the two hospitals participating in the joint assessment.

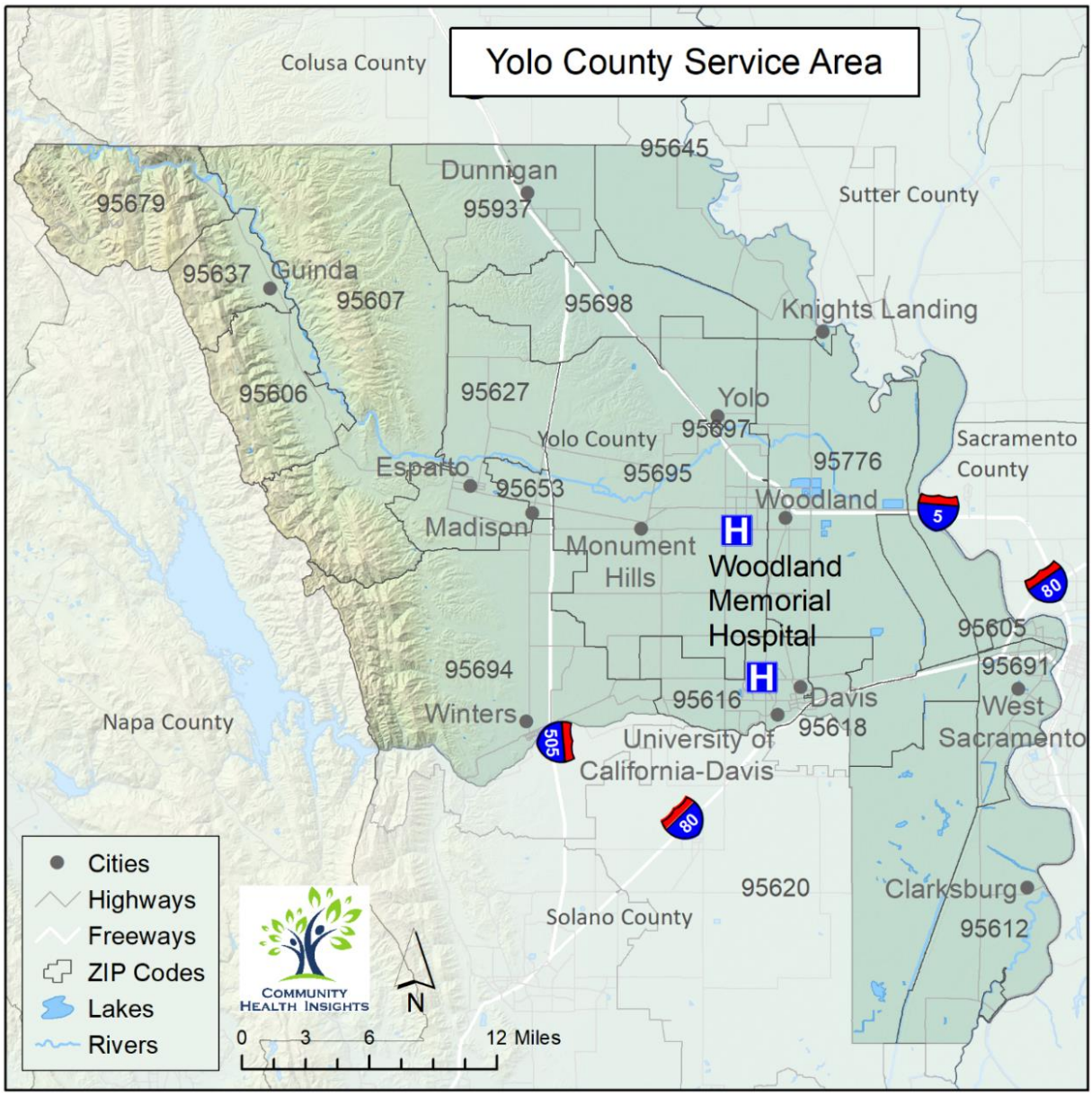

Figure 4: Yolo County service area

Population characteristics for each ZIP Code in Yolo County are presented in Table 4. The data provided below help give a deep understanding of how the county's communities differ based on various social determinants of health. Data provided are compared to the state and county rates, and ZIP Codes that deviated when compared to the county benchmark are highlighted. Cells where ZIP Code data were not available are denoted with a double hash mark (--).

Table 4: Population Characteristics for Each ZIP Code in Yolo County

ZIP Code	Total Population	% Minority	Median Age	Median Income	% Poverty	% Unemployed	% Uninsured	% No HS Graduation	% Living in High Housing Costs	% with Disability
95605	14,595	60.4%	31.7	$42,266	22.6%	14.9%	14.1%	25.7%	45.0%	16.4%
95606	129	66.7%	47.8	--	27.9%	13.8%	0.0%	19.4%	0.0%	38.0%
95607	499	29.3%	59.3	$70,038	10.2%	8.2%	10.6%	11.9%	14.3%	10.8%
95612	964	34.5%	41.5	$72,863	5.1%	0.9%	3.1%	3.3%	18.4%	10.4%
95616	49,093	46.8%	23.3	$46,170	33.9%	6.3%	5.8%	3.2%	44.9%	6.1%
95618	27,926	43.9%	29.2	$81,382	22.2%	5.3%	4.3%	3.8%	39.0%	6.2%
95620	21,685	51.8%	34.4	$72,583	13.7%	8.6%	9.8%	22.0%	37.4%	9.8%
95627	3,873	58.9%	33.1	$58,796	10.8%	8.8%	9.3%	24.1%	28.5%	13.8%
95637	349	69.6%	33.3	$51,641	29.5%	14.2%	0.0%	15.3%	46.3%	8.6%
95645	2,091	66.2%	34.0	$38,917	21.6%	12.6%	16.1%	36.6%	49.0%	13.8%
95653	657	82.3%	41.3	$68,750	3.2%	23.4%	19.3%	29.5%	24.7%	20.9%
95679	20	0.0%	--	--	0.0%	--	0.0%	0.0%	0.0%	50.0%
95691	36,932	49.7%	34.5	$66,519	13.7%	7.7%	10.0%	13.1%	38.7%	11.7%
95694	9,828	51.4%	38.8	$62,083	8.9%	9.8%	14.5%	23.0%	34.5%	10.2%
95695	39,144	51.2%	38.5	$55,386	12.4%	9.7%	12.2%	18.7%	36.4%	14.2%
95697	430	80.9%	35.2	$75,708	8.1%	4.3%	17.9%	22.0%	6.8%	19.3%
95698	232	32.8%	45.8	$38,984	5.6%	0.0%	0.0%	34.2%	21.0%	13.4%
95776	23,260	66.2%	30.6	$66,870	13.5%	5.9%	12.6%	21.3%	39.6%	8.0%
95937	1,400	67.7%	40.2	$50,824	14.0%	14.4%	8.4%	24.9%	31.9%	19.2%
Yolo County	209,671	51.9%	30.9	$57,663	19.3%	7.9%	9.4%	14.4%	39.5%	10.1%
California	38,654,206	61.6%	36.0	$63,783	15.8%	8.7%	12.6%	17.9%	42.9%	10.6%

(Source: 2012–2016 American Community Survey 5-year estimates; U.S. Census Bureau)

Community Health Vulnerability Index

Figure 5 displays the Community Health Vulnerability Index (CHVI) for Yolo County. The CHVI is a composite index used to help explain the distribution of health disparities within the county. Like the Community Need Index or CNI[9] on which it was based, the CHVI combines multiple sociodemographic indicators to help identify those locations experiencing health disparities (displayed in Table 5). CHVI values indicate a greater concentration of groups supported in the literature as being more likely to experience health-related disparities (refer to the data/technical report section for further details as to the CHVI construction). CHVI indicators are as follows:

Table 5: Community Health Vulnerability Index Indicators

Percentage Minority (Hispanic or Nonwhite)	Percentage Families with Children in Poverty
Percentage 5 Years or Older Who Speak Limited English	Percentage Households 65 Years or Older in Poverty
Percentage 25 or Older Without a High School Diploma	Percentage Single Female-Headed Households in Poverty
Percentage Unemployed	Percentage Renters
Percentage Uninsured	

[9] Barsi, E. and Roth, R. (2005) The Community Need Index. *Health Progress*, Vol. 86, No. 4, pp. 32–38.

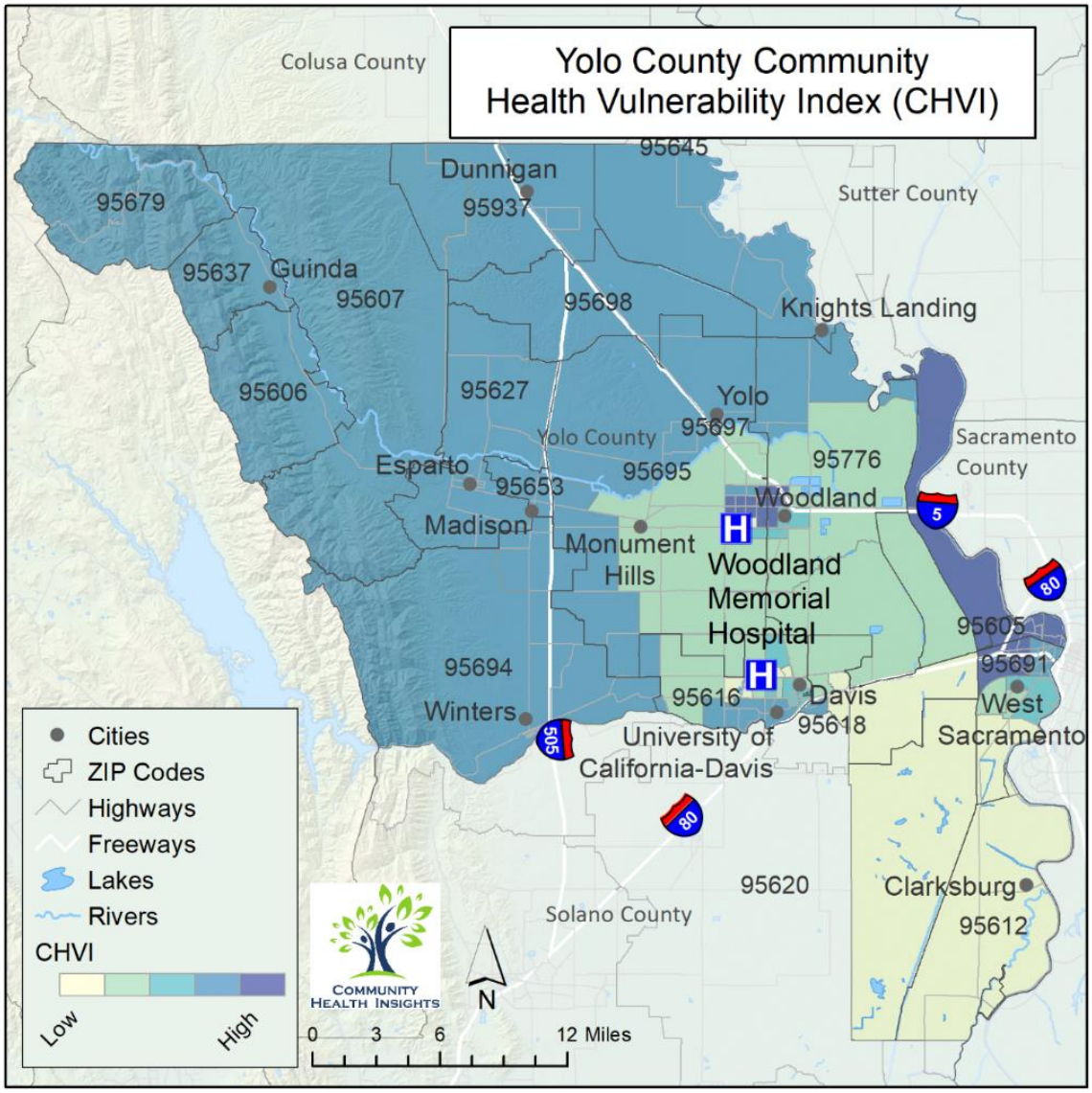

Figure 5: Community Health Vulnerability Index (CHVI) for Yolo County

The census tracts with the highest overall CHVI scores (greatest vulnerability) included the main area of central Woodland, the area of West Sacramento that follows the Sacramento River north, and portions of the City of Davis[10]. Further, outlying rural areas in the northwestern portion of the county also had high CHVI scores.

Resources Potentially Available to Meet the SHNs

In all, 292 resources were identified in the Yolo County area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2016 hospital-based CHNAs, verifying that the resource still existed, and then adding newly identified resources into the 2019 CHNA/CHA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 6. For more specific

[10] The City of Davis includes many college students (approximately 40,000) which could make data related to poverty upwardly skewed.

examination of resources by significant health need and by geographic locations, as well as the detailed method for identifying these, see the data/technical section.

Table 6: Resources Potentially Available to Meet Significant Health Needs in Priority Order for Yolo County

Significant Health Need (in priority order)	Number of Resources
Access to mental/behavioral/substance abuse services	48
Injury- and disease-prevention and management	18
Access to basic needs such as housing, jobs, and food	77
Access to active living and healthy eating	32
Access to quality primary healthcare services	42
Access to meeting functional needs (transportation and physical mobility)	11
Access to specialty and extended care	19
Safe and violence-free environment	36
Pollution-free living environment	4
Access to dental care and preventive services	5

Impact/Evaluation of Actions Taken by Hospital since 2016 CHNA

Regulations require that each hospital's CHNA report include: "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."[11]

Priority Health Need Addressed: Active Living and Healthy Eating	
Farmer's Market	
Program Description	Working with multiple agencies, local farmer's and community partners, the hospital hosts a weekly farmers' market running June through the end of August. The market purposely establishes basic price points, ensuring the locally sourced foods are accessible, affordable and beneficial to both the local food economy, the community as a whole and those touched with food insecurities which includes CalFresh.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Access to Behavioral Health Services ❑ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ❑ Access to High Quality Health Care and Services ✓ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	6,300 persons served
Dignity Health Contribution / Program Expense[2]	$44,668 expense

[11] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

Priority Health Need Addressed: Access to Behavioral Health Services	
Enhanced Mental Health Crisis & Follow- Up	
Program Description	This strategic partnership addresses the limited access to behavioral health services by improving communication and collaboration abilities of the nonprofit agencies involved. The project facilitates direct referrals to lower levels of care which increases the number of individuals served and decreases delays in service; moreover, it improves the quality of services by providing comprehensive follow-up services designed to increase the efficacy of treatment and decrease recidivism due to a recurrence of symptoms.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Active Living and Healthy Eating ✓ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ❑ Access to High Quality Health Care and Services ✓ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	343 persons served between FY16-FY18 across all three partners. In FY18, a new partner was introduced to the program, Davis Community Meals & Housing, allowing services to expand to the homeless population as part of the collaboration.
Dignity Health Contribution / Program Expense[2]	$198,909 expense

Priority Health Need Addressed: Disease Prevention, Management and Treatment	
Congestive Heart Active Management Program (CHAMP)	
Program Description	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
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Active Living and Healthy Eating ❑ Access to Behavioral Health Services ❑ Safe, Crime, and Violence Free Communities ✓ Access to High Quality Health Care and Services ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	942 persons served between FY16-FY18 and less than 6% were readmitted to the hospital 30 days post intervention.
Dignity Health Contribution / Program Expense[2]	$175,138, which is a shared expense by Dignity Health hospitals in Sacramento and Yolo counties.

Priority Health Need Addressed: Disease Prevention, Management and Treatment	
Healthier Living	
Program Description	Provides residents with chronic diseases knowledge, tools and motivation needed to become proactive with their health. Healthier Living workshops are open to anyone with any ongoing health condition, as well as those who care for persons with chronic health conditions. The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Active Living and Healthy Eating ❑ Access to Behavioral Health Services ❑ Safe, Crime, and Violence Free Communities ❑ Access to High Quality Health Care and Services ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	820 persons served between FY16-FY18
Dignity Health Contribution / Program Expense[2]	$48,445 expense

Priority Health Need Addressed: Access to High Quality Health Care and Services	
Resource Connection / Patient Navigator Program	
Program Description	Located on the hospital's campus, the Resource Connection center provides a one stop access point for community services and health education in both Spanish and English including linkages to primary care, health insurance enrollment assistance, health education, case management and community referrals. In the second half of FY18, a major emphasis was placed on emergency department navigation to assist individuals in establishing a medical home.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Active Living and Healthy Eating ❑ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ✓ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	621 persons served FY16-FY18. Persons served includes those connected to community resources from the Resource Connection Program as well as those served through the Patient Navigator Program. Numbers include patient navigation efforts which started in May 2018.
Dignity Health Contribution / Program Expense[2]	$135,554 expense

Priority Health Need Addressed: Access to High Quality Health Care and Services	
Oncology Nurse Navigator	
Program Description	The program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit around their diagnosis and treatment options. The program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	8,539 persons served between Dignity Health hospitals in Sacramento and Yolo counties.
Dignity Health Contribution / Program Expense[2]	$175,138, which is a shared expense by Dignity Health hospitals in Sacramento and Yolo counties.
Yolo Adult Day Health Center (YADHC)	
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.
Fiscal Years Active	✓ FY 2016 ✓ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	✓ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ❑ Safe, Crime, and Violence Free Communities ❑ Basic Needs (Food Security, Housing, Economic Security, Education)
Program Performance / Outcomes[1]	1,512 persons served through the YADHC between FY16-FY18.
Dignity Health Contribution / Program Expense[2]	$1,908,340 expense

Priority Health Need Addressed: Basic Needs	
Haven's House	
Program Description	A partnership between Woodland Memorial, Sutter Davis, and the Yolo Community Care Continuum, Haven House is a medical respite transitional program that utilizes a four-bed house and offers respite for homeless individuals upon discharge from the hospital.

Fiscal Years Active	❑ FY 2016 ❑ FY 2017 ✓ FY 2018
Secondary Health Needs Addressed	❑ Active Living and Healthy Eating ✓ Access to Behavioral Health Services ✓ Disease Prevention, Management and Treatment ✓ Safe, Crime, and Violence Free Communities ✓ Access to High Quality Health Care and Services
Program Performance / Outcomes[1]	In FY19, the program will provide temporary shelter as well as linkage to supportive services to patients who have been cleared from a local hospital yet remain medically fragile and do not have a safe place to go. Woodland Memorial committed $65,000 in FY18 to launch the program.
Dignity Health Contribution / Program Expense[2]	$65,000 expense

All program outcomes and expenses are reflective of the timeframe (fiscal years) indicated by the boxes checked in the 'Fiscal Years Active' section of the table for each program.

Collaboration

During FY16-FY18, Woodland Memorial Hospital utilized collaborative strategies to assess current strengths, weaknesses and gaps, and engaged non-traditional partners in community health programs to increase access to expanded services and increase the continuum of care beyond hospitals walls for its patients and community it serves.

Collaborative programs and partnerships across these various initiatives include:

- Yolo Food Bank
- RISE, Inc.
- Nutritional Education and Counseling
- Commit2Fit
- Inpatient Mental Health Services
- Cristo Rey
- CommuniCare Capacity Building
- Yolo Crisis Nursery
- Multiple Sclerosis Support Group
- Migrant Center Visits
- Human Trafficking Community Response Program
- Baby & Me

Community Grants

The theme for Dignity Health's Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Dignity Health hospitals; leveraging resources that address priority health issues, and utilize creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of 3 community partners. Program/Project responds to two or more of the following priority health needs:

1. Active Living and Healthy Eating
2. Access to Behavioral Health Services
3. Disease Prevention, Management and Treatment
4. Safe, Crime and Violence Free Communities
5. Access to High Quality Health Care Services
6. Basic Needs (including homelessness)

In FY 2016 through FY 2018, the Woodland Memorial Hospital awarded 3 grants totaling $231,626. The table below highlights the grantees.

Community Grants						
Lead Grant Recipient	**Priority Health Need(s) Addressed**	**Project Name**	**Fiscal Years Funded**			**Amount**
			FY16	FY17	FY18	
Suicide Prevention of Yolo County	Access to Behavioral Health Services	Enhanced Mental Health Crisis Services and Follow-Up	$67,851	$81,058		$148,909
Yolo Community Care Continuum*	Access to Behavioral Health Services	Enhanced Mental Health Crisis Partnership and Follow-Up			$50,000	$50,000
Yolo Crisis Nursery	Access to Behavioral Health Services Active Living and Healthy Eating	Prevention Wraparound and Peer Parent Partner Services			$32,717	$32,717
*Lead organization changed in FY 18 from Suicide Prevention of Yolo County to Yolo Community Care Continuum.			**Total Amount:**			**$231,626**

Conclusion

This joint CHNA/CHA report details the needs of the Yolo County community as a part of a successful collaborative partnership between Sutter Davis Hospital, Woodland Memorial Hospital, and Yolo County Health and Human Services Community Health Branch. It provides both an overall health and social examination of Yolo County, as well as a deeper examination of the needs of community members living within areas of the county experiencing disproportionate burdens. The work provides a comprehensive profile to guide decision-making for implementation of community health improvement efforts. This report also serves as an example of a successful collaboration between local healthcare systems and county public health to not only meet state and federal reporting/accreditation requirements but also provide meaningful insights to support improved health in the community they serve.