St. Joseph Health, Petaluma Valley Hospital

FY20 Community Benefit Report
Progress on FY18-FY20 CB Plan/Implementation Strategies Report

St. Joseph Health
Petaluma Valley

A member of Providence St. Joseph Health

To provide feedback about this *Community Benefit Report*, email:
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EXECUTIVE SUMMARY

St. Joseph Health Petaluma Valley Hospital is a community hospital founded in 1980 by the Petaluma Health Care District. Located in Petaluma, California, St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds and a campus that is 14.63 acres in size. Petaluma Valley Hospital (PVH) has a staff of more than 275 full time employees and professional relationships with more than 260 local physicians. Major programs and services include emergency care, outpatient surgery, a birthing center, and pulmonary rehabilitation.

Part of a larger healthcare system known as Providence St. Joseph Health (PSJH), PVH is part of a countywide ministry, St. Joseph Health Sonoma, that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region. The ministry's core facilities are PVH, an 80-bed acute care hospital, and Santa Rosa Memorial Hospital (SRMH), a full service, state of the art 278-bed acute care hospital that includes a Level II trauma center for the coastal region from San Francisco to the Oregon border. Major programs and services include critical care, cardiovascular care, stroke care, women's and children's services, cancer care, and orthopedics. SRMH is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

PVH provides Sonoma County communities with access to advanced care and advanced caring. The hospital's service area extends from Rohnert Park in the north, Inverness in the south and west, and Petaluma in the east. PVH's Total Service Area includes the cities of Petaluma, Rohnert Park, and Cotati. This includes a population of approximately 133,000 people. The Primary Service Area (PSA) consists of the zip codes that comprise the city of Petaluma, while the Secondary Service Area (SSA) is largely comprised of Cotati, Penngrove, and Rohnert Park. Approximately 95% of the population of the Service Area is in Sonoma County. Compared to the state, the Service Area is older and has a higher percentage of non-Latino Whites. The median income of the TSA is higher than California's average and there is less reported poverty, although the SSA is less affluent than the PSA.

PVH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved. Each year, PVH allocates 10 percent of its net income to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care for the Poor programs. In addition, PVH spends portions of its annual operating budget to operate ongoing Community Benefit programs targeted at both the economically poor and underserved as well as the broader community. These programs include a free Mobile Health Clinic, Mobile Dental Clinic, fixed-site Dental Clinic, a House Calls program providing in-home care to chronically ill patients, a *Promotores de Salud* program offering Spanish-language health and nutrition education and health

screenings, and school-based programs providing health and nutrition education and peer support groups.

Community Benefit Investment

St. Joseph Health, Petaluma Valley Hospital invested $7,178,344 in community benefit in Fiscal Year 2020, ending June 30, 2020 (FY20). In FY20, Medicaid shortfall was $10,187,832.

FY18-FY20 CB Plan Priorities/Implementation Strategies

In FY20 St. Joseph Health Sonoma continued work to implement the following strategies addressing priorities as developed in its FY18-FY20 Community Benefit Implementation Plan.

A. Access to Resources

1) Establish new CARE Network Program:
   - Comprehensive team approach to provide medical care, care coordination, social work supports, and resources navigation to the most vulnerable patient population
   - Integrated behavioral health services would assist all teams
   - Adapt and integrate existing Community Benefit House Calls and Mobile Health Clinic programs with Pop Health's Care Coordination program
   - Pilot a Medical Legal Partnership (MLP) project with Legal Aid of Sonoma County

2) Provide preventive healthcare and education programs
   - Continue existing Dental Programs as delivered to children 0-16
   - Continue existing Mobile Health Clinic provision of primary care in the community
   - Continue community health screenings in conjunction with Mobile Health Clinic and other community partners
   - Continue Growing Together Perinatal Program providing resources for pregnant and parenting families

B. Behavioral Health

1) Expand psychiatric services and clinical support to address behavioral health needs of vulnerable populations.
   - Form a psychiatric team to manage inpatients and outpatients with complex conditions in support of hospitalists and primary care providers
   - Expand capacity of the SJH Outpatient Behavioral Health Program to serve more low-income patients
   - Provide nurse practitioner at Crisis Stabilization Unit to conduct medical clearances on patients
   - Provide emergency department and inpatient psychiatric liaisons to support patients

with behavioral health needs
- Increase the number of available inpatient psychiatric beds by partnering with County government agencies and other community partners to create a regional Psychiatric Health Facility (PHF).

2) Improve access to behavioral health services for high acuity individuals by improving the countywide system of care
   - Convene and backbone a Behavioral Health Working Group of the Committee for Healthcare Improvement (CHI) of Health Action to identify, develop, and implement policies and practices to improve the countywide behavioral health system of care

3) Provide staff leadership and financial support to Petaluma Sober Circle and Sober Sonoma serial inebriate programs.

4) Provide staff leadership and support to align, partner with, and expand upon existing community youth-focused and school-based programs and initiatives addressing behavioral health issues through prevention-focused trauma-informed curricula and approaches.

5) With 3-year funding from St. Joseph Health Community Partnership Fund's Intersections Initiative, form a cross-sectoral *Sonoma Intersections Coalition* to promote policy, systems, and environmental changes addressing housing equity that will lead to improved conditions for community mental health and wellbeing.

C. Homelessness/Housing Concerns

1) Expand access for homeless individuals to medical and other support services that improve quality of life and reduce ED use and hospitalizations.
   - Support the provision of needed respite care for homeless patients after discharge from the hospital (*e.g., Project Nightingale)*
   - Support the Homeless Care Transitions program of Santa Rosa Community Health
   - Provide Mobile Medical Team services at shelters and supportive housing locations
   - Convene and support the Health Care for the Homeless Collaborative (HCHC) to coordinate existing and develop new homeless health care services

2) Research and bring forward models for expanding Permanent Supportive Housing (PSH) throughout the county and region, with Providence St. Joseph Health system and other community partners

3) Play a leadership role on the Continuum of Care Board in re-designing community's system of care for homeless individuals and families

4) Align housing equity efforts of the *Sonoma Intersections Coalition* (above) with existing local housing initiatives and providers/developers

5) Participate in, partner with, and support existing and new homeless and affordable housing projects and initiatives

PROVIDENCE ST. JOSEPH HEALTH

Providence St. Joseph Health (PSJH) was created in 2016 when Providence Health & Services and St. Joseph Health came together with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 111,000 caregivers (all employees) serve in 50 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. The PSJH family includes: Providence Health & Services, St. Joseph Health, Covenant Health in West Texas, Facey Medical Foundation in Los Angeles, Hoag Memorial Presbyterian in Orange County, California, Kadlec in Southeast Washington, Pacific Medical Centers in Seattle, and Swedish Health Services in Seattle.

Bringing these organizations together reflects each of our unique missions, increasing access to health care and bringing quality, compassionate care to those we serve, with a focus on those most in need. By coming together, Providence St. Joseph Health has the potential to seek greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.

It begins with heritage

The founders of both organizations were courageous women ahead of their time. The Sisters of Providence and the Sisters of St. Joseph of Orange brought health care and other social services to the American West when it was still a rugged, untamed frontier. Now, as we face a different landscape – a changing health care environment – we draw upon their pioneering spirit to guide us through these transformative times.

Providence Health & Services

In 1856, Mother Joseph and four Sisters of Providence established hospitals, schools and orphanages across the Northwest. Over the years, other Catholic sisters transferred sponsorship of their ministries to Providence, including the Little Company of Mary, Dominicans and Charity of Leavenworth. Recently, Swedish Health Services, Kadlec Regional Medical Center and Pacific Medical Centers have joined Providence as secular partners with a common commitment to serving all members of the community. Today, Providence serves Alaska, California, Montana, Oregon and Washington.

St. Joseph Health

In 1912, a small group of Sisters of St. Joseph landed on the rugged shores of Eureka, California, to provide education and health care. The ministry later established roots in Orange, California, and expanded to serve Southern California, the California High Desert, Northern California and Texas. The health system established many key partnerships, including a merger between Lubbock Methodist Hospital System and St. Mary Hospital to form Covenant Health in Lubbock Texas. Recently, an affiliation was established with Hoag Health to increase access to services in Orange County, California.

MISSION, VISION, AND VALUES

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision
Health for a Better World

Our Values
Compassion
Dignity
Justice
Excellence
Integrity

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, Petaluma Valley Hospital (PVH), a member of Providence St. Joseph Health, lives out the tradition and vision of community engagement set out hundreds of years ago. Providence St. Joseph Health is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

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programs and services include emergency care, outpatient surgery, a birthing center, and pulmonary rehabilitation.

COMMUNITY BENEFIT INVESTMENT

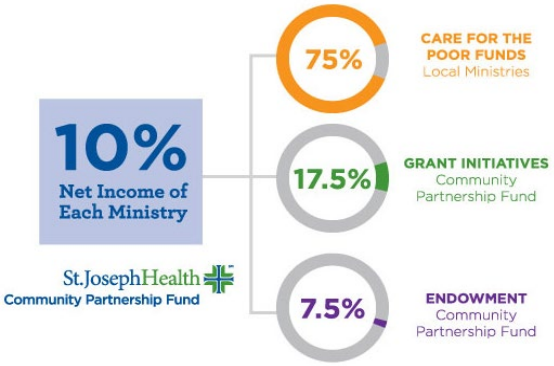
St. Joseph Health, Petaluma Valley Hospital invested $7,178,344 in community benefit in Fiscal Year 2020, ending June 30, 2020 (FY20). In FY20, Medicaid shortfall was $10,187,832.

ORGANIZATIONAL COMMITMENT

PVH dedicate resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved.

In 1986, St. Joseph Health created the St. Joseph Health Community Partnership Fund (SJH CPF) (formerly known as the St. Joseph Health System Foundation) to improve the lives of low-income individuals residing in local communities served by SJH Hospitals.

Each year, SRMH and PVH allocate 10 percent of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospitals Care For The Poor programs. 17.5 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5 percent is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.



Furthermore, SRMH and PVH will endorse local nonprofit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local nonprofit organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

Community Benefit Governance and Management Structure

PVH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and the Community Health Investment Manager are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital

Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on CB programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formation of the St. Joseph Health Sonoma Community Benefit Committee (CBC). The role of the CBC is to support the Boards of Trustees of both SRMH and PVH in overseeing community benefit issues. The CBC is charged with recommending policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and approving the annual Care For The Poor budget.

The CBC has a minimum of eight members including at least three members of the Boards of Trustees. Current membership includes 5 members of the SRMH Board of Trustees, 3 members of the PVH Board of Trustees, and 5 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The CBC generally meets every other month.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance.

Community Benefit Committee (CBC)

- CBC serves as an extension of the Boards of Trustees to provide direct oversight for all charitable program activities and ensure program alignment with *Advancing the State of the Art of Community Benefit* (ASACB) Five Core Principles (Emphasis on Communities with Disproportionate Unmet Health Needs, Emphasis on Primary Prevention, Build a Seamless Continuum of Care, Community Capacity Building, and Collaborative Governance). It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.
- The CBC provides recommendations to the Boards of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.

- Coordinates with clinical departments to reduce inappropriate emergency department utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community Representatives on the CBC

- Promote and take necessary actions to support the achievement of committee goals as specified in the Community Benefit Implementation Strategy Plan and in response to the CHNA;
- Ensure accountability to the CBC's ongoing plans and strategic initiatives;
- Act as ambassadors for the CB Department and help to establish strategic community partnerships;
- Engage diverse stakeholders in CB planning and implementation to assist SJH in achieving its mission in serving those vulnerable populations outlined in the CBIP;
- Recommend to SJH management ongoing opportunities for education, information sharing, and collaboration with outside agencies, individuals, and community workgroups in order to achieve desired goals and outcomes.

The CBC, CEO, and Executive Management Team were involved in the CHNA prioritization process as well as throughout the CB planning process as key informants, advisors, subject matter experts, and ultimately as decision-makers and approvers of the CB plan. This process was informed and shaped by our ministry's Mission Outcomes of Sacred Encounters, Healthiest Communities, and Perfect Care; in fact, this CB Implementation Strategy Plan is one of the primary ways in which achieve these outcomes, particularly in making the community we serve among the healthiest communities in the state.

This CB plan is also aligned with our ministry's overall strategic plan and its goals:

- Be the preferred health partner for those we serve.
- Transform care and improve population health outcomes, especially for the poor and vulnerable.
- Lead the way in improving our nation's mental well-being.
- Extend our commitment to whole person care for people at every age and stage of life.
- Simplify and improve access, including moving clinically appropriate services to digital experiences.
- Engage with partners in addressing the social determinants of health, including education and housing.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as

well as patients who do have insurance but are unable to pay the portion of their bill that insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment. At St. Joseph Health, Santa Rosa Memorial Hospital and Petaluma Valley Hospital, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance or are worried about their ability to pay for their care. Therefore, we have a Financial Assistance Program for eligible patients. In FY20, PVH provided $1,322,526 in free and discounted care following a policy to aid patients earning up to 500% of the federal poverty level. This resulted in 788 patients receiving free or discounted care.

For information on our Financial Assistance Program visit this link:
https://www.stjoesonoma.org/patients-visitors/for-patients/patient-financial-assistance/

Medi-Cal (Medicaid)

St. Joseph Health, Petaluma Valley Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY20, PVH provided $10,187,832 in Medicaid shortfall.

COMMUNITY

Definition of Community Served

PVH provides Sonoma County communities with access to advanced care and advanced caring. The hospital's service area extends from Rohnert Park in the north, Inverness in the south and west, and Petaluma in the east. Our Hospital Total Service Area includes the cities of Petaluma, Rohnert Park, and Cotati. This includes a population of approximately 133,000 people.

Community Profile

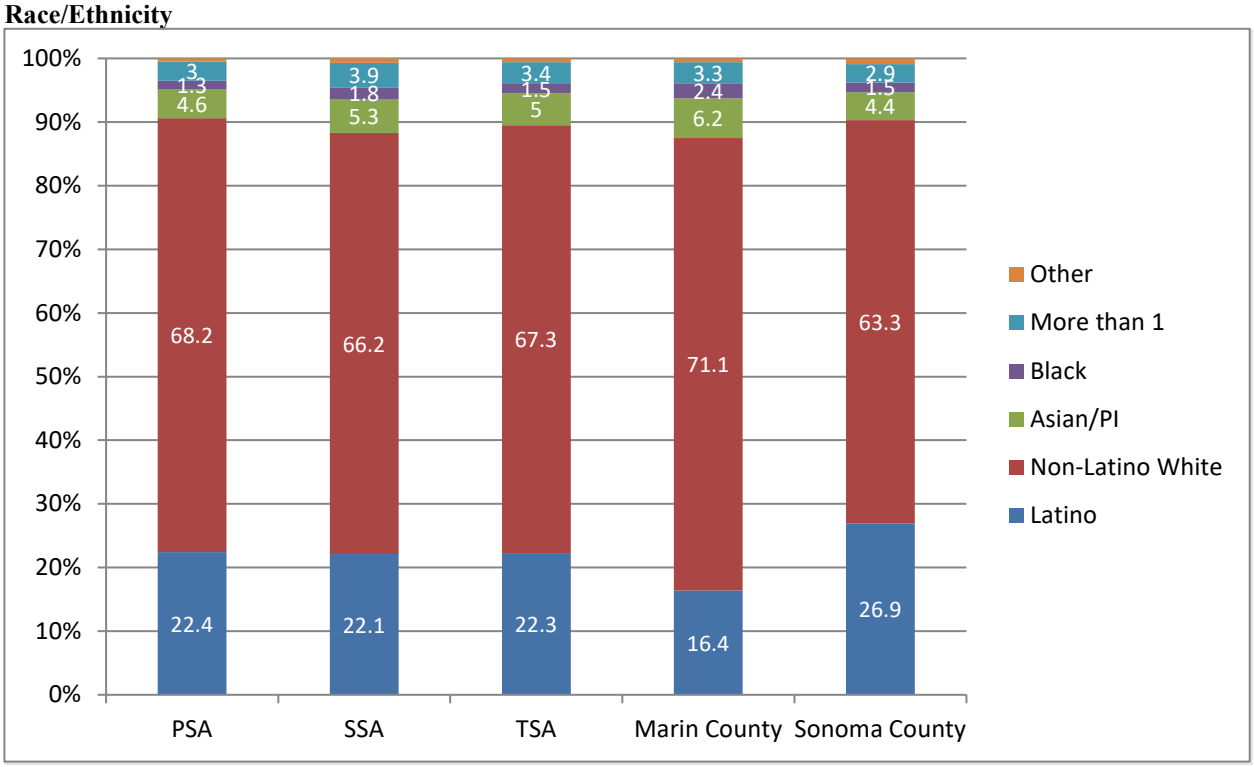
The table and graph below provide basic demographic and socioeconomic information about the Petaluma Valley Hospital Service Area and how it compares to Sonoma and Marin Counties and the state of California. The Total Service Area (TSA) of Petaluma Valley Hospital includes approximately 133,000 people. The Primary Service Area (PSA) consists of the zip codes that comprise the city of Petaluma, while the Secondary Service Area (SSA) is largely comprised of Cotati, Penngrove, and Rohnert Park. Approximately 95% of the population of the Service Area is in Sonoma County, so comparisons to county data will be made to Sonoma but not Marin County. Marin's data is presented here for completeness.

Compared to the state, the Service Area is older and has a higher percentage of non-Latino Whites. The median income of the TSA is higher than California's average and there is less reported poverty, although the SSA is less affluent than the PSA.

Service Demographic Overview

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Total Population	72,538	60,733	133,271	259,572	503,284	38,986,171
Under Age 18	21.5%	18.1%	19.9%	20.3%	20.6%	23.6%
Age 65+	16.1%	12.7%	14.6%	20.0%	16.9%	13.2%
Speak only English at home	75.0%	77.9%	76.3%	76.5%	74.3%	56.2%
Do not speak English "very well"	10.2%	8.4%	9.4%	9.1%	10.9%	19.1%
Median Household Income	$77,319	$60,202	$68,661	$95,860	$63,910	$62,554
Households below 100% FPL	6.3%	7.1%	6.6%	5.3%	7.6%	12.3%
Households below 200% FPL	17.3%	19.8%	18.3%	13.6%	21.6%	29.8%
Children living below 100% FPL	12.9%	9.3%	11.4%	10.8%	15.1%	22.7%
Older adults living below 100% FPL	6.6%	7.9%	7.1%	5.3%	6.8%	10.2%

Race/Ethnicity



Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)

- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

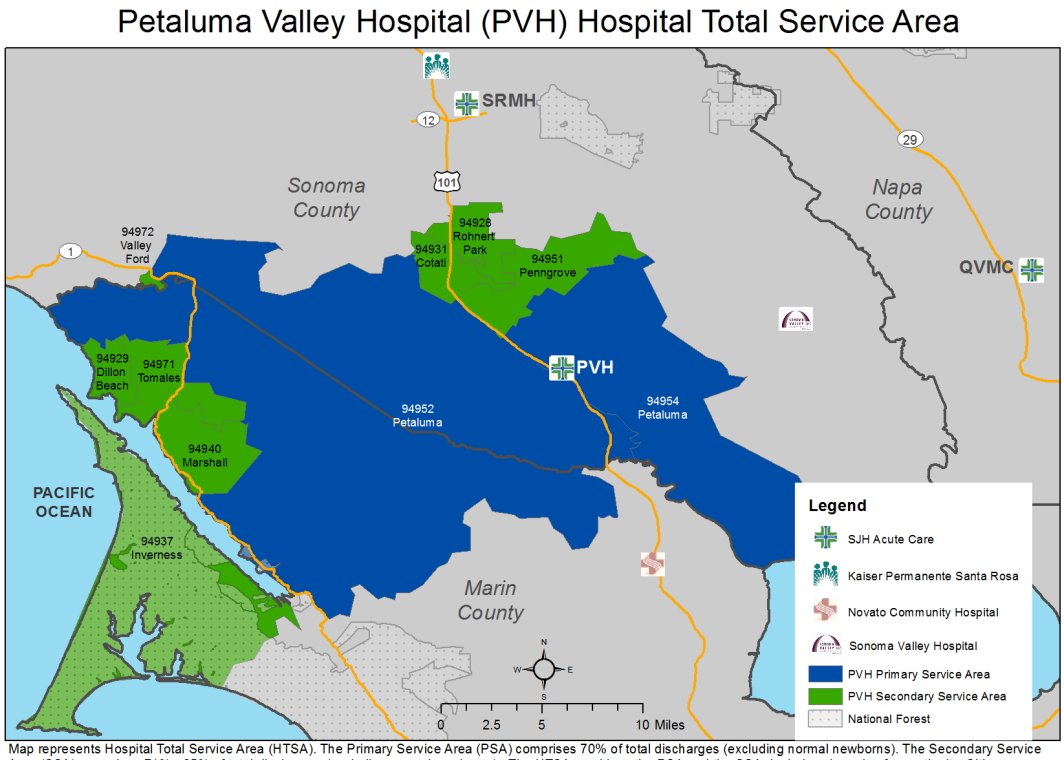
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of the city of Petaluma. The SSA is comprised of the Sonoma County cities of Rohnert Park and Cotati, along with the unincorporated towns of Penngrove, Valley Ford, Inverness, Tomales, Marshall, and Dillon Beach.

Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Petaluma	94954	PSA
Petaluma	94952	PSA
Petaluma	94953	PSA
Petaluma	94955	PSA
Petaluma	94975	PSA
Rohnert Park	94928	SSA
Rohnert Park	94927	SSA
Cotati	94931	SSA
Penngrove	94951	SSA
Inverness	94937	SSA
Dillon Beach	94929	SSA
Valley Ford	94972	SSA
Tomales	94971	SSA
Marshall	94940	SSA

Figure 1 (below) depicts the Hospital's PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. PVH Total Service Area



Map represents Hospital Total Service Area (HTSA). The Primary Service Area (PSA) comprises 70% of total discharges (excluding normal newborns). The Secondary Service Area (SSA) comprises 71% - 85% of total discharges (excluding normal newborns). The HTSA combines the PSA and the SSA. Includes zip codes for continuity. Cities are placed in either PSA or SSA, but not both. SRMH = Santa Rosa Memorial Hospital; QVMC = Queen of the Valley Medical Center.
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Community Need Index (Zip Code Level) Based on National Need

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Need Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

- Income Barriers (Elder poverty, child poverty and single parent poverty);
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

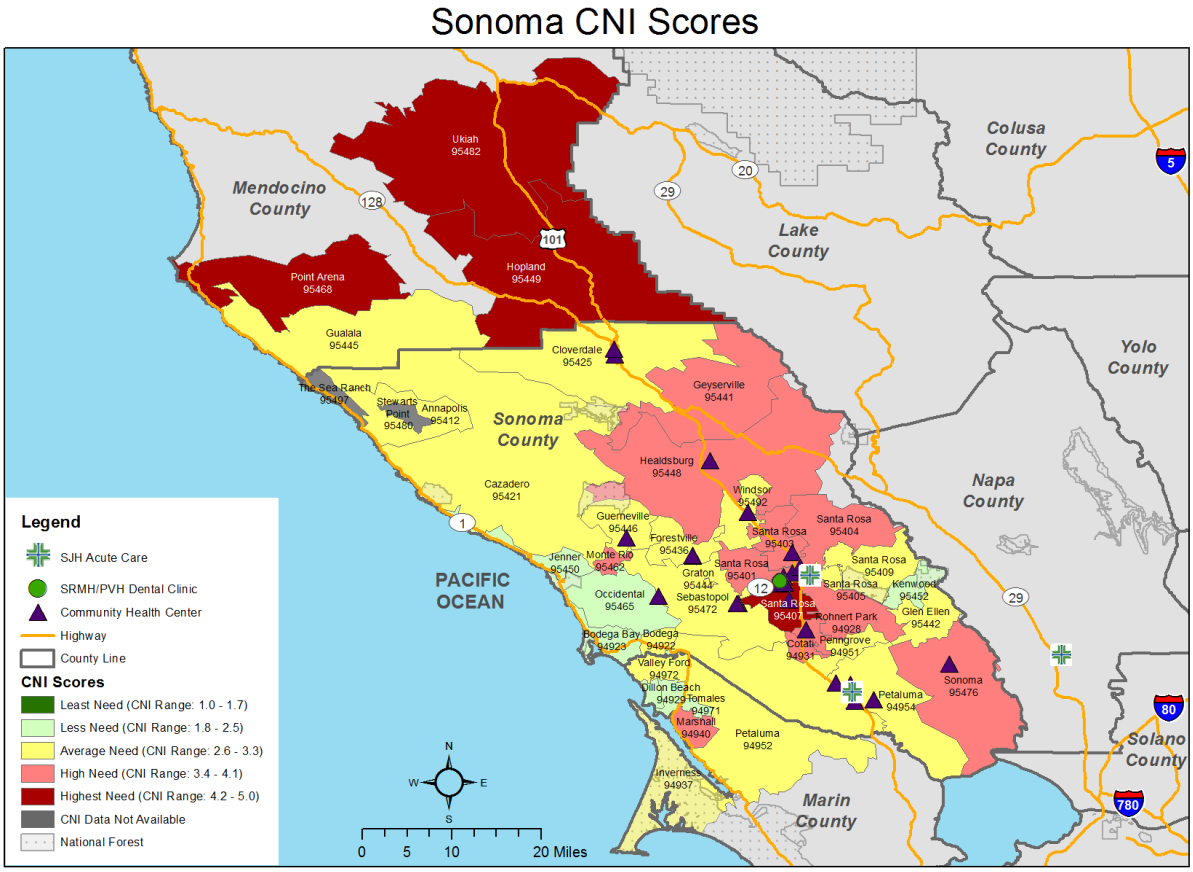
This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections,

pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the ZIP code 95407 on the CNI map is scored 4.2-5.0, making it a Highest Need community.

Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 2. Petaluma Valley Hospital Community Need Index (Zip Code Level)



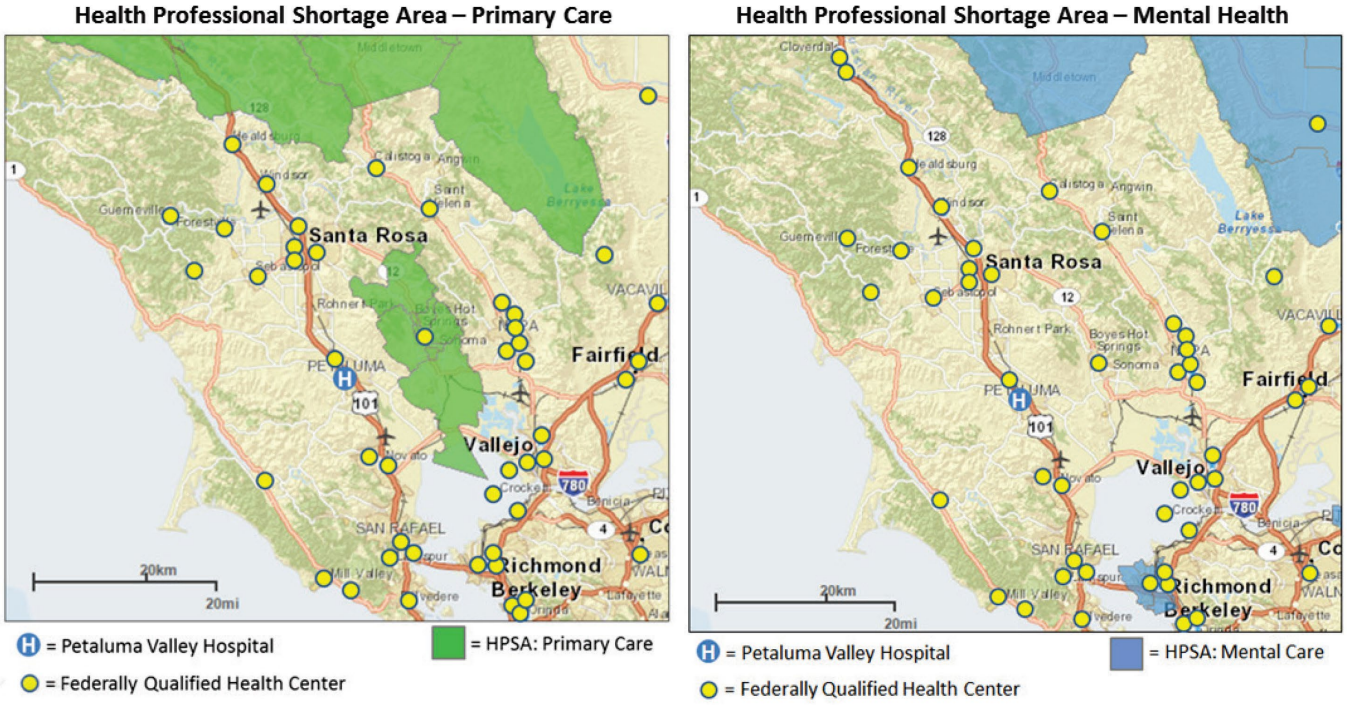
Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); Redwood Community Health Coalition (rchc.net) (accessed Oct. 2016).
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although

PVH is not located in a shortage area parts of the hospital's service area to the north and east are shortage designated, indicating a need for additional primary care physicians. The map below depicts these shortage areas relative to PVH's location.

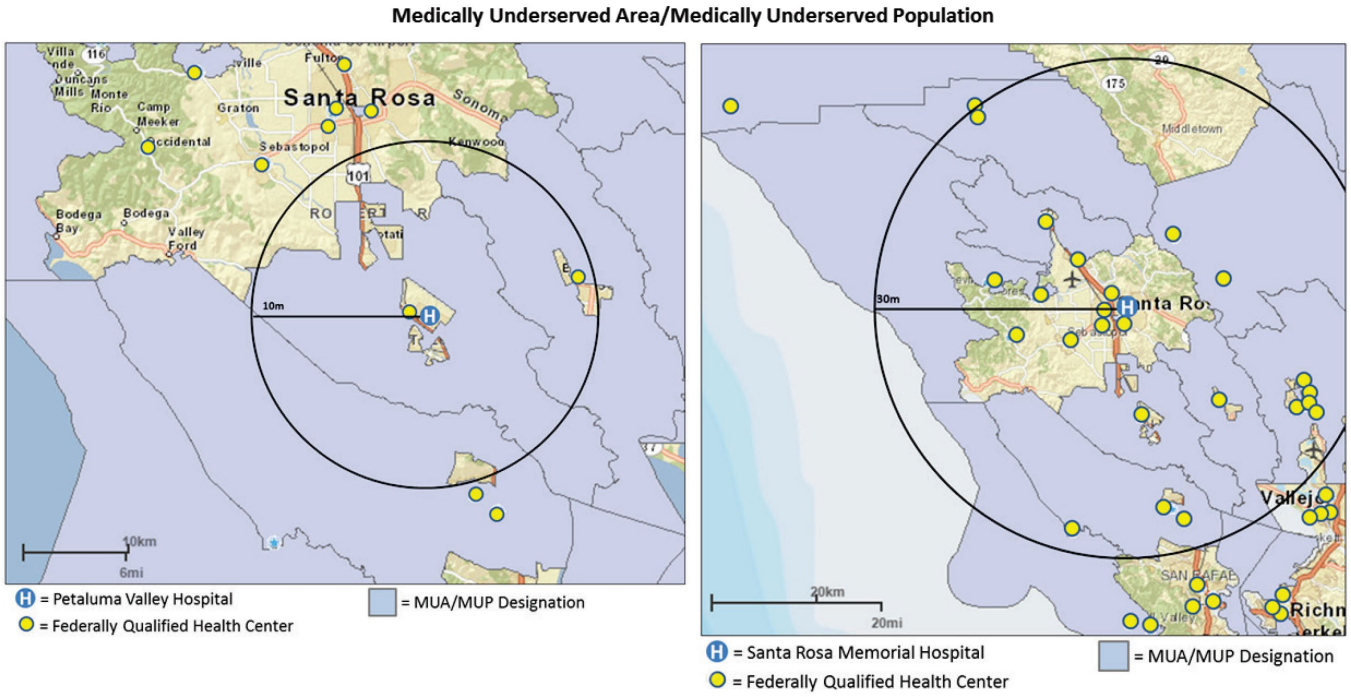
Figure 3. Petaluma Valley Hospital Health Professions Shortage Area



Medical Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. The map below depicts the Medically Underserved Areas/Medically Underserved within a 30 mile radius from PVH.

Figure 4. Petaluma Valley Hospital Medically Underserved Areas/Medically Underserved Population Area



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

The Community Health Needs Assessment (CHNA) process was guided by the fundamental understanding that much of a person and community's health is determined by the conditions in which they live, work, play, and pray. In gathering information on the communities served, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

In addition, we recognized that where people live tell us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. When data was publicly available, it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.

Examples of the types of information that was gathered, by health factor, are:

Socioeconomic Factors – income, poverty, education, and food insecurity

Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden

Health Behaviors – obesity, sugary drink consumption, physical exercise, smoking, and substance abuse

Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:

Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly available data was sought that would provide information about the communities (at the city and zip code level when available), people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area.

Collaborative Partners

Many local government agencies and not-for-profit organizations collaborated with St. Joseph Health in the CHNA process. Among these are the following:

- Sonoma County Department of Health Services, i.e., County Public Health
- Community Child Care Council (4Cs) of Sonoma County
- First 5 Sonoma County
- Burbank Housing
- Community Foundation Sonoma County
- Sonoma County Sheriff's Office
- City of Santa Rosa Violence Prevention Partnership

- Community Action Partnership of Sonoma
- Sonoma County ACEs Connection
- Sonoma County Economic Development Board
- Sonoma County Permit & Resource Management Department
- Sonoma County Environmental Health & Safety
- Buckelew Programs
- Sonoma County Office of Education
- Sonoma County Community Development Commission
- La Luz Community Center
- Petaluma People Services Center
- Sutter Health
- Kaiser Permanente
- Santa Rosa Community Health Centers
- West County Health Centers
- Petaluma Health Care District
- Petaluma Health Center
- Alliance Medical Center
- Sonoma West Medical Center
- Palm Drive Health Care District
- North Sonoma County Health Care District
- Sonoma Valley Health Care District
- Russian River Area Resources and Advocates
- Community Health Initiative of the Petaluma Area
- Latino Service Providers
- Sonoma County Human Services Department
- Sonoma County Task Force on the Homeless
- Sonoma County Health Care for the Homeless Coalition
- Mendocino County Department of Health & Human Services
- Healthy Mendocino

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by SRMH. In addition, the findings from the recent Community Building Initiative in Roseland were considered as an additional source.

The following concerns were identified as important by participants in the community resident and nonprofit/government stakeholder focus groups and the community forum:

Mental Health	Substance Abuse	Housing
Economic Insecurity	Access to Resources	Immigration Status
Oral Health	Obesity	Diabetes
Crime and Safety	Insurance and Cost of Care	Food and Nutrition
Transportation	Homelessness	Early Childhood Development
Health Conditions (heart disease, asthma, cancer)		

Upon completion of the community input process, a selection and prioritization process (described below) resulted in the selection of the following three priority needs for the SRMH and PVH CHNA and CB plan:

Behavioral Health (Mental Health & Substance Abuse)
Homelessness & Housing Concerns
Access to Resources

For a more detailed description of the CHNA process and data collected, please refer to the PVH FY17 CHNA Report on the St. Joseph Health website at this location:

https://www.stjoesonoma.org/documents/Community-Benefit/FY17_CHNA_REPORT_PVH-FINAL.pdf

Identification and Selection of Significant Health Needs

The compiled quantitative community level data and community input (focus group and community forum data) were analyzed to generate a list of significant health needs. The matrix below shows the 17 health needs identified through the selection and initial prioritization processes. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	N.P./ Govt. Stakeholder FG	Community Forum
Mental Health	Health Outcome	47.8	✓	✓	✓	✓
Substance Abuse	Health Behavior	44.7	✓	✓	✓	✓
Obesity	Health Behavior	44.2	✓	✓	✓	
Heart Disease	Health Outcome	44.0	✓	✓		
Oral Health	Clinical Care	43.8		✓	✓	
Access to Resources	Clinical Care	42.3		✓	✓	
Housing Concerns	Physical Environment	41.7	✓	✓	✓	✓
Diabetes	Health Outcome	41.2	✓	✓	✓	
Food and Nutrition	Health Behavior	40.7	✓	✓		✓
Early Childhood Development	Clinical Care	39.0			✓	✓
Insurance and Cost of Care	Clinical Care	36.7	✓	✓		
Homelessness	Socioeconomic	36.2	✓		✓	✓
Economic Insecurity	Socioeconomic	35.0	✓	✓	✓	✓
Asthma	Health Outcome	33.7	✓	✓		
Cancer	Health Outcome	33.5	✓	✓		
Crime and Safety	Physical Environment	33.2	✓	✓	✓	
Immigration Status	Socioeconomic	31.0	✓	✓	✓	✓

Prioritization Process and Criteria

To rank order the list of significant health needs and ultimately select the three health needs to be addressed by SRMH and PVH, a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry.

Step 1: Using criteria that were developed in collaboration with the St. Joseph Health Community Partnership Department and the Community Partnership Manager, each health need was scored on several criteria (seriousness of the problem, scope of the problem, health disparities, importance to the community, potential to affect multiple health issues, implications for not proceeding).

Step 2: A working group of internal stakeholders that included the SRMH and PVH CEO, Vice President of Mission Integration, Community Partnership Manager, and Population Health Medical Director was convened and applied four additional criteria to each need:

- Sustainability of Impact: The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.

- Opportunities for Coordination and Partnership: The likelihood that the ministry could be part of collaborative efforts to address the problem.
- Focus on Prevention: The existence of effective and feasible prevention strategies to address the issue.
- Existing Efforts on the Problem: The ability of the ministry to enhance existing efforts in the community.

Community Benefit Staff participating in the working group also considered a fifth criterion:

- Organizational Competencies: The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

Step 3: Two final criteria were considered by the Community Partnership Manager for each health need.

- Relevance to the Mission of St. Joseph Health: Is this area relevant to or aligned with the Mission of St. Joseph Health?
- Adherence to Ethical and Religious Directives: Does this area adhere to the Catholic Ethical and Religious Directives?

If the answer was "No" to either question, the health need was dropped from further consideration. None of the needs were dropped at this step.

Step 4: The final step of prioritization and selection was conducted by the SRMH Community Benefit Committee, which reviewed the list of identified health needs rank-ordered by the results of the first three steps of the prioritization process. The Committee discussed each need and its relevance to the ministry, the potential for progress on the issue, and the potential role of the ministry in addressing the need. After extensive discussion, the Committee selected three priorities for inclusion in the plan.

Community Health Needs Prioritized

- **Access to Resources:** Ensuring access to affordable, quality health care services is important to protecting both individual and population health, eliminating health disparities and promoting overall quality of life in the community. This includes most barriers to accessing health care services and other necessary resources, such as income, lack of adequate insurance, immigration status, transportation, a shortage of providers and specialists, language barriers, and resources being unavailable outside of working hours.

  The CBC noted that while many adults in Sonoma County are able to obtain insurance coverage and access regular healthcare in the wake of the implementation of the Affordable Care Act (ACA), disparities persist. Specifically, lower income residents have difficulty accessing care, as many remain uninsured due to high premium costs and those with public insurance face barriers to finding providers who accept MediCal. Foreign-born residents who are not U.S. citizens also face stark barriers in obtaining insurance coverage

and accessing care. Among those who do have insurance coverage, primary data identified other barriers to accessing care including that there are not enough primary healthcare providers in Sonoma County to meet the high demand. The CBC recognizes this as an ongoing, high-priority need, and one which, given the existing Community Benefit programs (mobile health and dental clinics, fixed-site dental clinic, and in-home care), we are uniquely qualified with appropriate capacity to address.

- **Homelessness and Housing Concerns**: These two needs were combined by the CBC in recognition of the fact that the two issues, while identified separately in the data collection process, are inextricably linked and cannot be effectively addressed separately, and that while homelessness is the more visible problem, the stress of housing insecurity and the threat of homelessness are equally injurious to community and individual health.
  Housing is considered a primary social determinant of health, and the lack of housing or affordable housing contributes to and exacerbates multiple adverse health conditions.

  Stakeholders noted that 2,835 homeless persons were found during the January 26, 2017 Sonoma County Homeless Count. While this number reflects a declining trend in homelessness in Sonoma County over the past five years, the number is still very large: on any given night, 5.6 people out of every 1,000 residents are homeless, and many of them in much more visible locations than in previous years' counts. The CBC believes it is imperative that we join in our community's efforts to combat these trends as we see this as the most prominent social determinant of health that we must address. Our primary focus will be on the condition of homelessness, including the development of permanent supportive housing, providing health care to homeless individuals, prevention of homelessness, and mitigating its impact on communities. We also intend to partner with other community organizations to address issues of housing affordability, availability, overcrowding, and quality.

- **Behavioral Health**: Mental Health and Substance Use were combined by the CBC in recognition of the fact that mental health and substance use disorders often go hand-in-hand and for many patients are co-occurring conditions. We prefer the term Behavioral Health to refer to these conditions collectively. In addition, the CBC noted that at the conclusion of Step 3 of the prioritization process, these were the first and second highest ranked concerns. Both concerns were raised throughout the community input process and received a high number of votes at the community forum.

  Although the data shows a better ratio of population to mental health providers in Sonoma and Mendocino Counties than the state, focus group participants spoke of shortages of providers and services for mental health and substance abuse. In Sonoma County, for instance, many low-income individuals with mental health concerns do not have access to

the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly funded treatment services are significant barriers for many. Furthermore, limited integration of mental health services within the health care system also leads to missing opportunities for early problem identification and prevention. Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health. As a result, the CBC felt that the focus on mental health and substance abuse, i.e., behavioral health, with a particular focus on trauma-informed community-based prevention and resilience in the face of adverse community experiences, was of paramount importance to our ministry and our community.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We recognize that in choosing to focus on the needs we have prioritized, we will not be addressing directly other needs that are also important in our community. For instance, we recognize that cardiovascular disease is the leading cause of death in our community, and that heart disease, obesity, and diabetes were all among the highest priority community health needs identified in our CHNA process. In not selecting any of these chronic conditions as one of our community benefit priority focus areas, we are aware that other ongoing programs in our ministry and in our community are fully engaged in addressing them. We are committed to continue our involvement with community initiatives such as Hearts of Sonoma and the California Accountable Communities for Health Initiative, financial support for nonprofit organizations such as the Northern California Center for Well Being, and the HeartWorks cardiac rehab program.

With respect to some of the other needs identified in the CHNA process that were not prioritized for action through this plan, we intend to remain engaged in addressing oral health needs through our ongoing St. Joseph Health Community Dental Clinic and Mobile Dental Clinic; crime and safety through our continued involvement on the Santa Rosa Violence Prevention Partnership; and insurance and cost of care through our continued involvement on the Covered Sonoma and Sonoma Health Action Community Health Improvement committees. We also intend to incorporate other issues such as early childhood development in our behavioral health strategy as it is such a fundamental determinant of mental health later in life; and economic insecurity in our housing concerns strategy as it is a necessary ingredient in housing affordability. Similarly, with respect to immigration, we lack appropriate expertise or competency to offer a program, but we intend to develop a Medical Legal Partnership with a local Legal Aid organization that will assist residents and patients with immigration issues, among others. And while food and nutrition is not to be directly addressed by our own programming, we anticipate that our ongoing

support of local initiatives and organizations involved in cardiovascular disease prevention will include a consideration and inclusion of strategies to address this need.

Furthermore, we will continue funding other local nonprofit organizations through grants from our Care for the Poor program managed by the SRMH Community Benefit Department, and we will encourage and endorse local nonprofit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout the SRMH service areas.

COMMUNITY BENEFIT PLAN

PVH anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by PVH in the CB Plan/Implementation Strategy.

Summary of Community Benefit Planning Process
The process used to select the priority community health needs to be addressed by both this Petaluma Valley Hospital (PVH) Community Benefit Implementation Strategy as well as the SRMH Community Benefit Implementation Strategy is described above on pages 18-26. Upon adoption of the CHNA by the SRMH/PVH Community Benefit Committee on June 27, 2017, the Community Benefit Department staff began the process of developing this plan in response to the priority needs identified in the CHNA. These processes were undertaken for the entirety of the combined service areas of SRMH and PVH as St. Joseph Health Sonoma considers these strategies to be interconnected and together are in service to the needs of the entire county and community. This began with the retention of an external consultant to conduct a more detailed study of the behavioral health needs throughout the county. Utilizing this data, the CBC was again tapped in its advisory role to provide its knowledge of the community in developing this strategy. At the regular meeting of the CBC on August 22, 2017, and again in a smaller subcommittee, the CB staff presented its recommended initial draft of a strategy plan. Incorporating CBC input in subsequent drafts of the plan, staff reviewed the plan and sought input from the SRMH/PVH Population Health Department and the Executive Management Team, as well as from the St. Joseph Health system office staff of the Community Partnership Fund and with staff from the Prevention Institute. This process yielded this final draft plan that was submitted to and approved by the CBC at their meeting on October 24, 2017.

Addressing the Needs of the Community:
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH
FY20 Accomplishments

1. Initiative/Community Need being Addressed: Access to Resources

Goal (anticipated impact): Improve health in the communities served by SRMH by increasing low-income and vulnerable populations' access to health care and resources needed to maintain health through direct provision of free or low-cost clinical services and by addressing the community determinants of health experienced by this population with case management services and additional resource assistance.

Outcome Measure	Baseline	FY20 Target	FY20 Results
Numbers of low-income patients who are provided free and low-cost direct health care services throughout the SRMH & PVH service areas.	10,850 patients served; 24,200 encounters	16,000 patients served; 35,000 encounters	15,179 patients served; 29,883 encounters

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
1.CARE Network program	Number of patients served; number of encounters	0 (new program in 2018)	4,000 patients served; 8,000 encounters	1,429 patients served; 2,857 encounters
2. SJH Dental programs	Number of patients served; number of encounters; percentage of patient cases complete	9,200 patients served; 14,000 encounters; 66.2% case complete	9,500 patients served; 15,000 encounters; 67% case complete	8,031 patients served 14,026 encounters; 70% case complete
3. House Calls program	Number of patients served; number of encounters	150 patients served; 7,000 encounters	325 patients served; 7,000 encounters	427 patients served; 4,914 encounters
4. Mobile Health Clinic (MHC)	Number of patients served; number of encounters	1,500 patients served; 3,200 encounters	2,000 patients served; 4,000 encounters	3,133 patients served; 5,927 encounters

5. Open Access	Number of patients linked to medical home for ongoing care by a primary care provider (PCP)	1,292 encounters (6 months of data)	2,500 encounters	2,159 Persons Served; 2,159 Encounters
6. Regional Behavioral Health Integration Project (RBHIP)	Number of community partner meetings/workgroups	0 (new strategy in 2018)	3 workgroups, Community Advisory Group 6 workgroups Behavioral Health Care Coordination & Transition Management Workgroup 2 workgroups, Psychiatry Workforce Subcommittee Sonoma County 3 workgroups, HIE Subcommittee 6 workgroups, Social Determinants of Health Workgroup 3 workgroups, Intensive Outpatient Program Planning Workgroup	3 Workgroups, Community Advisory Group 6 workgroups, Behavioral Health Care Coordination & Transition Management Workgroup 2 workgroups, Psychiatry Workforce Subcommittee Sonoma County 3 workgroups, HIE Subcommittee 6 workgroups Social Determinants of Health Workgroup 6 workgroups, Intensive Outpatient Program Planning Workgroup

7. Health Care for the Homeless Collaborative (HCHC)	Number of community partner meetings/workgroups	6 Community partner meetings per reporting year	6 Community partner meetings, Health Care for the Homeless Collaborative	8 Community partner meetings, Health Care for the Homeless Collaborative
8. Community Partner Connection	Number of community partner meetings/workgroups.	6 Community Partner meetings per reporting year	6 Community partner meetings, Community Partner Connection	12 Community Partner Connection meetings held Note: Bi-monthly Community Partner Connection meeting was re-purposed as a bi-weekly COVID-19 Community Resources meeting in April 2020

Key Community Partners: Santa Rosa Community Health, Petaluma-Rohnert Park Health Centers, West County Health Centers, Alliance Health Center, Catholic Charities, Community Action Partnership, County of Sonoma Department of Health Services, Petaluma People Services Agency, Redwood Community Health Coalition, Redwood Gospel Mission, Santa Rosa Resurrection Parish, First 5 Sonoma County, Burbank Housing, Community Child Care Council of Sonoma County, Santa Rosa Junior College, North Bay Children's Center, Santa Rosa City School District, Roseland Public School District, Sonoma Valley Unified School District, Shoreline Unified School District, Wilmar Union Elementary School District, Latinos Unidos, Latino Service Providers, California Human Development, Northern California Center for Well Being, La Luz, Justicewise

FY20 Additional Accomplishments:

- The Dental Clinic celebrated its 30th anniversary in June 2020.
- The wait time for Dental treatment decreased from 4 weeks in FY19 to 3 weeks in FY20.
- The Dental programs completed full treatment plans on 1,815 patients, representing approximately 70% cases completed.
- *Mighty Mouth* school-based program provided screenings at 39 school sites and provided screenings to 4,266 children, the schoolyear was shortened due to the pandemic.
- The Dental programs provided services to 210 emergency visit patients, many of these during the first 3 months of the pandemic.
- Due to the pandemic, dental services were reduced to urgent and emergent care for a period time, the St. Joseph Health Dental Clinic was one of the few offices to remain open and provide much needed services.
- The Mobile Health Clinic continued to provide outreach to homeless encampments, shelters, respite and permanent supportive housing units.

- RBHIP offered a no-cost training on Suicide Assessment and Intervention: Assess Suicidal Ideation and Effectively Intervene in Crisis Situations with Confidence, Composure and Sensitivity with PESI to 85 participants from our region.
- Designed and developed a Path to Hope, Suicide Prevention Community Forum 2020 to be presented in FY20/21. Due to pandemic, live event will be transitioned to an online event series.
- Community COVID-19 Community Resource online shared resource platform developed: https://drive.google.com/drive/folders/181rPJqHy6Gt1FBm8AJ-yWUgmuDXtSW1C
- Care Network hired a social worker under the Well Being Trust 3 grant and has embedded this social worker into Heritage Medical office to work with our Primary Care physicians and team. This embedded social worker has worked with over 300 patients from the medical group during PCP visits.
- Care Network hired a substance use navigator through the California ED BRIDGE Grant Program who works with all patients at Santa Rosa Memorial Hospital identified with a substance use disorder, focusing especially on patients with opioid disorder.
- Care Network has established a new contract with Uber Health to provide transportation to specialty appointments for our most vulnerable and under-resourced patients.
- Care Network has established a new collaborative weekly meeting with Providence St. Joseph Home Care Network, Palliative, and Open Access Navigators to discuss any shared patients to decrease duplication of services and support patients to the fullest ability. Care Network has been able to assist Palliative and Home Care with vouchers for underinsured patients for transportation and medications. Additionally, Care Network has been able to sponsor Home Care skilled services for undocumented and uninsured patients who otherwise would not qualify for these services.
- SBBH Partnered with La Luz to develop "Supporting our Students" a tech and tutoring program aimed at raising tech literacy for Latinx students and their families during distance learning.
- Community Health Promotions program developed 15 Community Resource fliers, updated in English and Spanish, with new resource information for community providers and case managers to use in their responses to the pandemic.

Addressing the Needs of the Community:
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH
FY20 Accomplishments

2. Initiative/Community Need being Addressed: Behavioral Health

Goal (anticipated impact): Improve mental health, reduce substance use disorders, and advance health equity in the communities served by SRMH through a comprehensive set of approaches that include clinical services, coordination of community collaborative initiatives, and by strategically addressing the upstream community determinants of health (physical/built environment, social/cultural environment, and economic environment) that contribute to mental health and substance use disorders.

Outcome Measure	Baseline	FY20 Target	FY20 Results
The establishment and enhancement of key clinical and community-based programs to address critical, emergent, and upstream behavioral health needs and issues.	The baseline assumption is that insufficient programs existed in the community to meet the level of need.	• Begin implementation of the Regional Behavioral Health Integration (RBHI) project. • Develop program(s) to increase availability of behavioral health clinical resources. • Develop upstream/preventive behavioral health initiatives.	• In partnership with the Redwood Community Health Coalition (RCHC), began implementation of the Regional Behavioral Health Integration (RBHI) project. • In partnership with St. Joseph Health Medical Group and the other hospitals in the PSJH Northern California region, designed and secured funding from the Well Being Trust for a program to embed behavioral health and social work supports in primary care clinics. • Expanded Healthy for Life school-based programs and offerings to the broader school community to provide resources, curriculum, instruction and trainings for students, faculty, staff and community partners on adverse

Outcome Measure	Baseline	FY20 Target	FY20 Results
			childhood experiences (ACEs), building resiliency, and trauma-informed, restorative, and mindfulness practices. • In partnership with Health Action and community leaders launched the Connection, Capacity and Change initiative to support Self-Healing Communities Model, addressing adversity, trauma and community resilience building strategies. • In partnership with Hanna Institute and funding from Well Being Trust initiated the Resilient School Communities project, a framework focused on middle school (grades 5-8) students.

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
1. RBHIP Implementation and completion of Well-Being Trust grant.	Developing systems to strengthen transitions of care and care coordination across disparate entities and health centers.	0	2	RBHIP finalized documentation of workflows for step-up/step-down transitions of care for low income Medi-Cal patients. • Transition of Care meetings supported development and implementation of workflows for referrals to the Non-Congregate Shelter (NCS) and the Alternate Care Site (ACS).

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
	Strengthening the psychiatry workforce and building the capacity of primary care providers to treat patients with mental health needs.	0	2	RBHIP resulted in 20% increase in utilization of psychiatry services from our baseline measurement. Participating health centers reported a total of 2,331 patients seen for psychiatry services at the start of the project (July 1, 2018-December 31, 2018) with an increase to 2,788 patients during the final reporting period of July 1, 2019 through December 31, 2019. Eight primary care providers completed the UC Davis-Irvine Psychiatry Fellowship in December 2019
	Incorporating standard social determinants of health assessment and referrals into mental health/behavioral health visits at community clinics			Total number of patients with ≥1 mental or behavioral health visit and a PRAPARE screening between July 1, 2019 and December 31, 2019 was 1,391.
	Pilot testing Direct Health Information Exchange to facilitate communication	0	1	Connection was successfully tested between the newly implemented EHR for Sonoma County Behavioral Health and

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
	between Sonoma County' Behavioral Health Division, FQHCs, and St. Joseph Health for better continuity of care; and			a provider at the Petaluma Health Center.
	Planning the establishment of an intensive outpatient behavioral health program in Sonoma County that will build upon and may expand the existing St. Joseph Health Program.	0	1	RBHIP Community Partner Needs Assessment for Intensive Outpatient Program Report was completed.
2. Develop program(s) to increase availability of behavioral health clinical resources	Number of programs developed and/or advanced	0	1	As part of the RBHI, 8 primary care providers from community clinics, PVH, and the MHC completed behavioral health training in the UC Psychiatric Fellowship Program. In partnership with St. Joseph Health Medical Group and the other hospitals in the PSJH Northern California region, designed and secured funding

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
				from the Well Being Trust for a program to embed behavioral health and social work supports in primary care clinics. Implementation began in late FY20 with one psychologist and one social worker hired and embedded in a Santa Rosa primary care clinic.
3. Develop upstream/preventive behavioral health initiatives.	Number of programs/initiatives developed and/or advanced	The baseline assumption is that insufficient programs existed in the community to meet the level of need.	1	Established partnerships with 11 local school districts, 32 unique school communities to deliver Healthy for Life (H4L) programing that includes movement, mindfulness and health education to students. Developed an educator mindfulness cohort, resourced and trained participants to serve grades K-12. Trained and facilitated dialogue with school staff and administration on ACEs and resilience building strategies to adopt in school practices. Hosted an educator summit and facilitated professional development sessions, serving Sonoma and Napa county districts on trauma informed practice,

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
				restorative practice and mindfulness with key partners. Hosted a series of seminars with Laura Porter in partnership with Health Action and community leaders to align work plans using the Self-Healing Community model framework. Health Action chapters adopted Self-Healing Community Model (SHCM) into the framework, presented to city officials and convened regular meetings as the Connection, Capacity and Change (CCC) Initiative. During COVID, CCC launched a social media campaign named Connect to Thrive, that highlights Sonoma residents finding ways to meaningfully connect with each other during times of crisis to build resilience. Hosted 20 screenings of the film, "Resilience" to community, internal St. Joseph staff, behavioral health providers, school service

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
				providers (Boys & Girls Club), County Mental Health Board and Health Action groups as a strategy to build awareness and fluency about the long-term effects of childhood adversity and trauma. H4L served 7,250 persons in 28,296 encounters by in FY20

Key Community Partners: Sonoma County Health Action Community Health Improvement Committee, Health Action Cloverdale, ACEs Connection, Restorative Justice Collaborative, Restorative Resources, Sonoma County Human Services Dept., Sonoma County Dept. of Health Services, NAMI Sonoma, Buckelew Programs, CAP Sonoma, Sonoma County Office of Education, Petaluma Health Care District, Redwood Community Health Coalition and multiple FQHCs, Drug Abuse Alternative Center (DAAC), St. Joseph Health Medical Group, Petaluma Police Department, Committee on the Shelterless (COTS), Partnership Healthplan of California, Women's Recovery Services, Kaiser Permanente, Catholic Charities, La Luz, Seeds of Awareness, Hanna Institute, multiple school districts.

FY20 Additional Accomplishments:

- Petaluma Sober Circle serial inebriate project continued with primary funding support from SJH CHI. Since inception in 2017, 216 individuals have entered the program.
- Care Network High Utilizer Team has partnered with Santa Rosa Community Health and Partnership Health Plan to discuss the highest utilizers of our hospital and emergency services. Monthly case conferences are held to discuss these patients and to develop system wide case plans.
- In response to COVID-19, Care Network has been working telephonically with patients discharging from the hospital providing medication, DME front door drop-offs in addition to regular case management services.
- SJH CHI contributed $22,000 to the Women's Recovery Services for facility improvements to their transitional housing project for low-income single mothers in substance use recovery.

Addressing the Needs of the Community:
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan for the combined service areas of SRMH and PVH
FY20 Accomplishments

3. Initiative/Community Need being Addressed: Homelessness & Housing Concerns

Goal (anticipated impact): Reduce the number of homeless individuals and increase the availability of health care services for those suffering from homelessness in the community.

Outcome Measure	Baseline	FY20 Target	FY20 Results
Increase in the amount and level of healthcare services being provided to homeless patients	The baseline assumption is that insufficient programs existed in the community to meet the level of need.	The establishment of some level of new services.	Continued primary care at homeless shelter and permanent supportive housing (PSH) sites through the SJH Mobile Health Clinic. Continued financial support of Project Nightingale homeless respite program and COTS PSH units. Committed $1.5 million towards the development of additional PSH units. Completed an assessment of healthcare and supportive services in permanent supportive housing (PSH) units and sober living environments throughout the County as a precursor to planning for expansion of same.

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
1.Mobile Health Clinic targeting homeless clients and shelters	Number of homeless patients served; number of encounters	176 patients served; 574 encounters (6 months of data)	350 patients served; 1,000 encounters	496 Persons Served; 1,133 Encounters
2.Continue support of Project Nightingale	Continued existence of respite care through Project Nightingale	300 patients served	300 patients served	337 patients served

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY20 Results
(homeless respite program)				
3. Promote development of permanent supportive housing (PSH) project(s)	Number of new PSH units/beds created	119 PSH units; 690 PSH beds	10% increase over baseline	Social work case management support services were funded by SJH CHI for 11 PSH units (13 beds) at COTS' Mary Isaak Center. SJH CHI continued payment of its $1,000,000 pledge (half of which was paid in FY19) to Catholic Charities for the construction of Caritas Village, a multi-year downtown Santa Rosa capital project including PSH, shelter, and clinical services. SJH CHI invested $500,000 in St. Vincent Commons, the acquisition and conversion of a 56-unit motel into a PSH project by St. Vincent de Paul Society. This project will begin serving clients during FY21. SJH CHI made a $250,000 gift to PEP Housing for the development of their 29-unit Linda Tunis Senior Apartments project in Santa Rosa, offering permanent supportive housing to low-income seniors displaced by natural disasters.

Key Community Partners: Continuum of Care, Sonoma County Community Development Commission, Catholic Charities, Santa Rosa Community Health, Petaluma-Rohnert Park Health Centers, West County Health Centers, West County Community Services, COTS, St. Vincent de Paul Society, Providence Supportive Housing, Burbank Housing, Partnership Healthplan of California, Sonoma County Sheriff's Office, Santa Rosa and Petaluma Police Departments, Drug Abuse Alternative Center (DAAC), PEP Housing, Social Advocates for Youth (SAY).

FY20 Additional Accomplishments:

- SJH CHI Manager served as Chair of the 25-member Technical Advisory Committee of Home Sonoma County, the county's Continuum of Care.
- SJH CHI funded an intervention by a trauma-informed practice (TIP) consultant with Burbank Housing, the largest affordable housing developer in the region, to transform their internal and tenant-focused culture into a more TIP model.
- SJH CHI contributed $25,000 to SAY in support of their counseling and housing programs for homeless transition-aged youth (TAY).
- Providence St. Joseph Health initiated a "Housing is Health" program to stimulate an increase in housing and homeless services throughout all the communities served by PSJH. The Northern California region completed a 3-year strategic plan identifying interventions and investments to be made to address the issue.
- SJH CHI, through its Care Network program, funded a full-time case manager position at Catholic Charities who works solely with patients at Santa Rosa Memorial and Petaluma Valley Hospitals to streamline Coordinated Entry (housing) applications and assist daily with shelter placement.
- Care Network continued to play a large role in Project Hope which looks at the top 10 most vulnerable unhoused people in Sonoma County. This collaborative effort between Care Network, SRPD, SRFD, Mayor Tom Schwedhelm, Catholic Charities, Public Defender Kathleen Pozzi, Sonoma County Probation, Sonoma County Jail and Kaiser Permanente develops realistic care plans to house and provide services for this high-risk population.

Other Community Benefit Programs

Initiative/ Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)	FY20 Accomplishments
1. Community Building	SONOMA INTERSECTIONS COALITION (SIC)	The SIC was created in FY19 and continued through FY20 with funding provided by the St. Joseph Health Community Partnership Fund's Intersections Initiative. The purpose of the Initiative is to stimulate engagement by hospitals and their host communities in needed collaborative upstream work to address health equity concerns at the policy, systems, and environmental levels. The SIC is a multi-stakeholder, multi-sectoral collaborative body that is focusing on educating and engaging citizens and policy-makers on issues of housing equity; on training community and service providers on the principles, language, and practice of trauma-informed care; and on organizing a Sonoma County Tenants Union of low-income renters to engage landlords and policy-makers on issues of habitability, safety, affordability and tenant protections.	Low Income and Broader Community	The SIC was formed in FY19. It has a membership of 20, from a multitude of local organizations and agencies. Through its membership affiliations with Legal Aid of Sonoma County, the Hanna Institute, and the North Bay Organizing Project, it developed a housing equity policy platform, a trauma-informed care training, and a tenants union.

Initiative/ Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)	FY20 Accomplishments
2. Healthy Eating, Active Living	PROMOTORES DE SALUD	The Promotores de Salud (Community Health Promotion) program bridges language and culture with the local Latino/a population, organizing community health fairs and health promotion events, conducting health screenings, providing health information and referrals, and training and supporting community volunteer health promotion leaders.	Low Income and Broader Community	1,298 Persons Served; 2,350 Encounters At the outset of COVID, the program developed targeted Spanish-language outreach tools and educational materials for raising awareness and prevention, as well as mobilizing testing and PPE for Latino/a workers.
3. Healthy Eating, Active Living	HEALTHY FOR LIFE (H4L)	Healthy for Life is a school-based physical activity and nutrition program targeting schools in low-income neighborhoods. The program builds school capacity to support healthy eating and physical activity among its students.	Low Income and Broader Community	7,250 Persons Served; 28,296 Encounters During FY20, the program expanded upon various behavioral health curriculum elements that were added in FY19. In response to COVID, additional services were developed, as described in Behavioral Health section above.

FY20 COMMUNITY BENEFIT INVESTMENT

In FY20 Petaluma Valley Hospital invested a total of $7,178,344 in key community benefit programs (excluding Medicare). In FY20, Medicaid shortfall was $10,187,832. Petaluma Valley Hospital applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, and other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet 2. Our Community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY20 COMMUNITY BENEFIT INVESTMENT
PETALUMA VALLEY HOSPITAL

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[1]	Net Benefit
Medical Care Services for Vulnerable[2] Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	$1,322,526
	Unpaid cost of Medicaid[3]	$5,096,859
	Unpaid cost of other means-tested government programs	$53,071
Other benefits for Vulnerable Populations	Community Benefit Operations	$0
	Community Health Improvements Services	$135,535
	Cash and in-kind contributions for community benefit	$479,880
	Community Building	$0
	Subsidized Health Services	0
	Total Community Benefit for the Vulnerable	***$7,087,871***
Other benefits for the Broader Community	Community Benefit Operations	$12,756
	Community Health Improvements Services	$77,717
	Cash and in-kind contributions for community benefit	$0
	Community Building	$0
	Subsidized Health Services	$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$0
	Total Community Benefit for the Broader Community	***$90,473***
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$7,178,344
Medical Care Services for the Broader Community	Unpaid cost to Medicare[4] ***(not included in CB total)***	$18,216,484

[1] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[2] CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[3] Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.
[4] Unpaid cost of Medicare is calculated using our cost accounting system. In IRS Form 990, Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[5] Summary of Accomplishments

The employees, volunteers and physicians of St. Joseph Health Sonoma are the greatest non-financial asset the organization provides for the community. Our team of caregivers is dedicated to providing the best patient-centered health care available in the region and volunteer in their own community on a regular basis.

In FY20, SJH caregivers participated in patient experience workshops and are continually looking for innovative ways to better serve and care for our patients. From quiet hours to friendly greetings, SJH employees, volunteers and physicians embrace our vision outcomes of perfect care, sacred encounters and healthy communities. Our caregivers spend countless hours volunteering in our community. From feeding the homeless with church and nonprofit groups, to staffing medical and health screening services at health fairs and other community events, our caregivers consistently give back. Caregivers volunteer time to serve on nonprofit community boards and they generously donate their hard-earned dollars towards efforts to assure needed services are available to the neediest members of our community and that we have a sound infrastructure of service organizations both now and in the future.

Community partnership is something we believe in and another non-financial benefit we provide the community. Community Benefit and other SJH leaders participate extensively in Sonoma County Health Action, our community's primary collective impact initiative that brings together government, business, nonprofit, education, and health care organizations in a multi-stakeholder coalition to address community determinants of health and health inequities. The SJH chief executive sits on the leadership council of Health Action and many other caregivers play prominent roles on many of its subcommittees and working groups.

We also began a deeper and more focused effort on addressing the systemic challenges of access, behavioral health care, and homelessness. While many of these efforts take the form of leveraging our leadership position in the community to motivate and convene partners to develop collaborative solutions and hence are non-financial, their impact on the upstream social determinants of health will pay long-term dividends that may be difficult to measure financially but are nonetheless extremely valuable in creating healthy communities.

On an organizational level, Providence St. Joseph Health undertook a process to modernize the community benefit function. Part of this effort resulted in a re-naming of the department to Community Health Investment (CHI). We also conducted an audit of existing programs to assure their continued relevancy to the mission and to the CHNA, as well as to discern whether or not we have capable partners in the community that could be providing the same service. This discernment process is ongoing and has resulted in the transition in the House Calls program described above. The main thrust of this process and re-naming is to better focus the efforts of the CHI department on achieving the goals of Health 2.0 and in creating a healthier community.

[5] Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.

Governance Approval

This FY20 Community Benefit Report was approved at the December 1, 2020 meeting of the Petaluma Valley Hospital Community Benefit Committee of the Board of Trustees, as confirmed by the signature below of the Community Benefit Committee Chair.

Debbie Meekins
_____
Debbie Meekins, CBC Chair

12/1/2020
_____
Date