2021

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

Petaluma Valley Hospital

Petaluma, California

Petaluma Valley Hospital
Providence

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Sonoma County through Petaluma Valley Hospital. Petaluma Valley Hospital (PVH) is a community hospital with 80 licensed beds, founded in 1980 by the Petaluma Healthcare District and is located in Petaluma, CA. The hospital's service area is the entirety of Sonoma County, including 495,319 people.

Petaluma Valley Hospital and Healdsburg Hospital are part of newly formed NorCal HealthConnect, LLC. Both hospitals have a history of serving the health care needs of the Sonoma County community.

Petaluma Valley Hospital 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 vulnerable. In FY21, the hospital provided $3,692,455 in Community Benefit in response to unmet needs.

2020-2022 Petaluma Valley Hospital Community Health Improvement Plan Priorities

As a result of the findings of our 2019 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PVH will focus on the following areas for its 2020-2022 Community Benefit efforts:

PRIORITY 1: HOUSING INSTABILITY & HOMELESSNESS

The cost of living in Sonoma County outpaces the income for many people in the community, making it challenging for families to meet their basic needs. Those most impacted by housing stability and affordability are the Latino/a community due to income inequities; youth experiencing homelessness, especially those identifying as LGBTQ+; and older adults whose fixed income limits their ability to afford local housing prices.

2021 Accomplishments

CARE Network: The CARE Network program offers community-based care management for predominantly low-income and otherwise vulnerable populations. Upon discharge from the hospital or release from the Emergency Department, patients are served by teams of Social Workers and RNs. The program ensures patients and caregivers make a smooth and successful transition from hospital to home, including home visits; assistance with transportation to medical, legal and benefits appointments; diet and medication management; caregiving resources and support; referrals to additional needed resources/services; skilled nursing and senior placement; and coaching designed to teach self-advocacy skills in navigating the healthcare system. CARE Network staff act as an advocate and liaison between the patient and their providers.

Homeless Care Transitions at Santa Rosa Community Health (SRCH): Providence Community Health Investment (CHI) provides annual funding for this intensive outpatient case management team at SRCH focusing on high-utilizer homeless patients.

Embedded Housing Resource Connector: Providence CHI provides annual funding to support this position through Catholic Charities. The position is embedded in SRMH and is available to CARE Network and care management staffs to assist with immediate placement within the County's Coordinated Entry system for emergency and ongoing housing placement.

Project Nightingale: Recuperative beds for unhoused discharged patients as an alternative to lengthy hospital stays or shelter placement. 26 beds at 2 sites in Santa Rosa operated by Catholic Charities and funded in part by Providence in partnership with Kaiser Permanente, Sutter and Partnership HealthPlan of California.

COTS Recuperative Beds: Recuperative beds for unhoused discharged patients as an alternative to lengthy hospital stays or shelter placement. 6 beds at Committee on the Shelterless (COTS) Mary Isaak Center shelter site in Petaluma operated by COTS and funded in part by Providence in partnership with Kaiser Permanente.

COTS Permanent Supportive Housing (PSH): Providence CHI financially supports a social worker/case manager at COTS to provide the social supports to residents in the 11 PSH units that are embedded in COTS' Mary Isaak Center.

Health Care for the Homeless Collaborative (HCHC): Providence CHI staff convene and facilitate this monthly meeting of multiple homeless services providers including Sonoma County Behavioral Health and Human Services, hospitals, substance use treatment providers, FQHCs, shelters, housing and homeless services, etc. HCHC is a forum to address coordination, sharing of information and resources, and the identification and development of new interventions to improve the system of care (e.g., Project Nightingale, Sober Circle, etc.)

Caritas Village: Providence CHI contributed $2,000,000 over the past two-plus years to this Catholic Charities project. Caritas Village will include a housing-focused service center, emergency family shelter, a medical clinic operated by SRCH, and, in subsequent phases, 128 units of permanent affordable housing. Caritas Village is scheduled to open in 2022.

St. Vincent de Paul Commons Permanent Supportive Housing: Providence CHI contributed $750,000 over the past two-plus years to this project to convert an aging motel into a 54-unit permanent supportive housing project that will house up to 75 people who are experiencing homelessness. This project is scheduled to open in 2022.

PEP Housing's Linda Tunis Senior Apartment Permanent Supportive Housing Project: Providence CHI contributed $500,000 over the past two-plus years to this PSH project to convert the former Scottish Rite Masonic Lodge in Santa Rosa into 26 studios for seniors who have been impacted by a federally declared disaster, such as the recent wildfires in Sonoma County. Linda Tunis was a resident of the Journey's End mobile home park who perished in the Tubbs Fire in 2017.

PRIORITY 2: MENTAL HEALTH & SUBSTANCE USE SERVICES

Accessing quality mental health and substance use services can be a challenge for many. Trauma from the recent fires, COVID-19, and the current political climate contribute to the community mental health

needs. There is a need for more mental health and substance use disorder treatment services, as well as more case management services and bilingual and bicultural mental health providers.

2021 Accomplishments

Substance Use Navigators: A distinct service of CARE Network are embedded Substance Use Navigators (SUNs) in 2 Sonoma County Providence hospitals. Paid for by a CA Bridge program grant, these SUNs assist patients with a substance use disorder to get connected with appropriate treatment programs.

Path to Hope: Path to Hope is an annual suicide prevention education forum/series produced by Providence CHI staff. Originally conceived as an in-person conference-style event, it was offered virtually during COVID. The main points of emphasis in Path to Hope are inclusion (especially of LGBTQ+ and differently abled communities), multi-culturalism, peer support and involvement, the importance of culture and art as healing practices, and community building.

Community Transitions of Care (CTOC): CTOC is a multi-stakeholder coalition of area hospitals, FQHCs, County Behavioral Health, criminal justice, and community-based organizations (CBOs) convened and facilitated by Providence CHI staff working together to create a multidisciplinary and integrated approach to address coordination of care challenges throughout the Sonoma County behavioral health system of care.

Community Partner Connection (CPC): This multi-stakeholder coalition is convened and facilitated by Providence CHI staff. Its focus is behavioral health and substance use, and its membership is primarily CBOs working in this space. The CPC provides a forum for open discussion to foster partnerships and connections across disciplines to break down siloes and the fragmented nature of behavioral health and substance use service delivery systems. In doing so, the CPC helps to address barriers to access, to offer support and education to providers to decrease burnout and isolation, to share agency updates and current resources, to collectively find solutions to common problems and challenges, and ultimately to increase shared and overall effectiveness of our system of care.

Petaluma Sober Circle: Serial inebriate program featuring street outreach and alternative direct placement in recovery programs as an alternative to jail or emergency department. Providence CHI is a major funder with Kaiser and Partnership HealthPlan of California. Sober Circle is a collaborative project with Petaluma Health Care District, Petaluma Police Department, Sonoma County Behavioral Health, Center Point DAAC treatment center, Petaluma Health Center (FQHC), and COTS.

Mother's Care: Providence financially supports this maternal mental health program offering free clinical counseling to new mothers exhibiting mood and anxiety disorders during post-partum well-baby visits.

Behavioral Health System of Care Capacity Building: Providence CHI staff designed and funds an integrated approach to increasing access to mild-to-moderate behavioral health services by increasing the capacities of key CBO partners. These include the following:

- Buckelew Programs: Providence financially supports a specialized navigator position in this behavioral health CBO to assist youth and families of adult loved ones with mental health/substance use challenges in navigating the complex system of care, in connecting to

needed mental health and substance use treatment and services, and in advocating for patient equity. A special focus is on Latinx, LGBTQI and other underserved populations.

- Humanidad Therapy & Education Services: Providence financially supports a specialized navigator position in this Latinx-serving behavioral health CBO to assist youth and families of adult loved ones with mental health/substance use challenges in navigating the complex system of care, in connecting to needed mental health and substance use treatment and services, and in advocating for patient equity. A special focus is on Latinx, LGBTQI and other underserved populations.
- NAMI Sonoma: Providence financially supports a Community Engagement Coordinator in this central community information and referral behavioral health CBO. NAMI is the "front door" for many in the community seeking behavioral health services and assistance and, as part of this overall system capacity-building initiative, this position connects with the other system navigation resources being embedded in other CBOs as well as conduct pro-active outreach to underserved communities to draw in those in need of behavioral health services but who otherwise would not come forward and seek them out.
- Humanidad Therapy & Education Services and La Luz Center: Providence financially supports a bilingual mental health clinician from Humanidad to provide individual and group therapy sessions for clients of La Luz Center, a multi-service social services CBO serving the Latinx, farmworker, and undocumented population in the Boyes Hot Springs area of Sonoma Valley.
- Committee on the Shelterless (COTS): Providence financially supports an embedded mental health social worker in COTS' Mary Isaak Center homeless shelter to train and educate shelter staff on dealing with clients experiencing mental health issues, to run groups for clients to surface and discuss their mental health issues, and to connect clients to mental health and social support services.

Healthy for Life & School District Wellness Policy & Practice Development: Providence CHI staff work with local schools and school districts to design and fund programs to improve the physical and mental health and well-being of students, teachers, and staff. These include the following:

- School-based and community wellness program: physical, nutrition, resiliency, and mental health education and training for students, staff and community.
- Education, training and technical assistance for schools and school districts to develop and implement wellness, health, resiliency, equity, Trauma-Informed Care (TIC), Adverse Childhood Experiences (ACEs), and restorative justice awareness, policies and practices.

SOS Community Counseling: Providence CHI financially supports this local mental health CBO to provide teen mental health prevention education and connection to services to SOS counselors at El Molino High School in Forestville (which also serves an isolated and low-income population in the greater Russian River area). In addition, SOS hosted county-wide “think tanks” with teens to better understand how they define mental health, what they see as their greatest needs and their ideas on how best to connect them to services. Data and findings from this effort will inform a messaging campaign in subsequent school years.

PRIORITY 3: HEALTH EQUITY: RACISM AND DISCRIMINATION

Racism and discrimination affect Black, Brown, Indigenous, and People of Color (BBIPOC) from accessing education and job opportunities and affordable housing. Xenophobia and racism negatively affect the mental health and economic security of the Latino/a community in Sonoma County.

2021 Accomplishments

Latino Health Forum: Providence CHI staff sit on the Board of this CBO formed to produce an annual conference focused on the health needs of the local Latinx population in Sonoma County. Providence has been an annual funder of this conference since its inception several years ago.

Mi Futuro is in Healthcare: Providence staff are key organizers with other community partners of this annual event to connect Latinx high school and junior college students with healthcare professionals to encourage them to follow a career path to healthcare.

¡DALE!: ¡DALE! is a youth-led program that includes training, practice, and mentorship to address equity issues within local schools and communities. Co-created with Sonoma County youth, ¡DALE! aims to support the development of high school students who aspire to become leaders and organizers within their school and community.

Sonoma County Equity in Education Initiative: Providence staff participate with other community partners and education leaders in this collaborative initiative to address systemic racism and inequities in the local educational system.

Supporting Our Students (SOS): In response to COVID-related challenges for low-income Latinx families in dealing with home-based virtual learning for their school-aged children, this program was developed by Providence CHI staff with community partners to recruit bilingual university student volunteers to bridge the digital divide and offer virtual technology assistance and tutoring to Latinx students.

Text Food / Text Comida: Providence CHI staff partnered with local CBOs to develop this mobile phone application to link users to sources of food assistance during the pandemic. Anyone with a cellphone can text the number, enter their zip code, and get an up-to-date list of locations that distribute free food in their area.

South Park Community Building Initiative (CBI): The CBI is a funding initiative of the St. Joseph Community Partnership Fund. The CBI funds neighborhood community organizing in the communities where Providence has hospital ministries. The current CBI project is focused on the historically low-income minority South Park neighborhood of Santa Rosa, where a CBI organizer is working with local residents to build power and agency within their local neighborhood.

COVID-19 and Latinx Health Disparities Response (Santa Rosa Community Health): A Providence Population Health system health equity grants program funded this intervention at SRCH. Patients targeted for this intervention receive culturally appropriate supportive services including an assigned care manager who supports and assists the patient with identifying and accessing financial, housing, nutrition, and medical resources.

PRIORITY 4: ACCESS TO HEALTH CARE

Residents of Sonoma County experience barriers to accessing primary and specialty care. There is a need for more affordable health care, case management resources, and culturally responsive and linguistically appropriate health care services. Cost of care, transportation, language, and documentation status are barriers to people receiving the care they need.

2021 Accomplishments

Providence Mobile Health Clinic (MHC): Providence CHI operates this mobile medical clinic to provide free primary care, health screenings, immunizations, and referrals to medical homes and social work supports. The MHC visits locations throughout Sonoma County with a special emphasis on locations with a high concentration of low-income, uninsured, and undocumented residents.

Open Access to Community Care: A distinct service of CARE Network is an embedded resource within the hospital to directly and immediately connect patients without an established medical home to a primary care appointment with Santa Rosa Community Health (SRCH) and other FQHCs. Providence CHI funds this SRCH position who sits in the Emergency Department of SRMH and is available to social workers for immediately linking patients to care at SRCH.

Medical Legal Partnership (MLP): A distinct service of CARE Network is the MLP in partnership with Legal Aid of Sonoma County (LASC). Providence CHI funds an attorney position at LASC who is dedicated to supporting CARE Network patients and other hospital patients in addressing legal issues and impediments to their successful discharge and/or stabilizing their social situations as part of their overall care management.

Providence Fixed-Site Dental Clinic: Providence CHI operates this dental clinic located in southwest Santa Rosa, offering comprehensive dental care for pediatric patients 16 and under provided free of charge (insurance billed when appropriate); emergency dental care for patients of all ages; and specialized dental care for patients with special needs (e.g., autistic patients, etc.). Patient population is primarily low-income Latinx.

Providence Mobile Dental Clinic: An extension of the fixed-site clinic, Providence CHI operates this mobile dental clinic offering similar services in isolated communities as well as regular visits to low-income schools for screening and treatment.

Community Health Promotion: Providence CHI's community health worker (CHW) organizes and offers public health screening and education events throughout the year and throughout the county: cardiovascular screening and testing for hypertension and diabetes; cardiovascular nutrition and health education; referrals to primary care; etc. In addition, the CHW regularly attends the scheduled visits of the Providence Mobile Health Clinic in Windsor, Cloverdale, and Sonoma to offer cardiovascular nutrition and health education to patients identified by the MHC staff. This includes an initial same-day consultation and the development of an ongoing coaching relationship with patients to monitor progress and to assist in behavioral and nutritional modifications needed to stabilize the patients' cardiovascular health indicators.

La Familia Sana: Providence CHI's community health worker sits on the Board of this new nonprofit formed in Cloverdale. Its members are mostly Latinx farmworkers from the remote areas of northern Sonoma County and its mission is to serve this population with health-related education, outreach, and connections to needed social services.

Sonoma Connect | Sonoma Unidos: Providence CHI department is the lead agency on a community project funded by the ACEs Aware initiative of the California Surgeon General to create a "Network of Care" to respond to ACEs and other forms of individual and community trauma. Multiple community partners are involved in building the network that includes expanded ACEs clinical screening, enhanced online resource referral platform, embedded community connection specialists in multiple agencies to assist in service navigation, and community/resident engagement to inform service delivery and design.

Providence

At Providence, we use our voice to advocate for vulnerable populations and needed reforms in health care. We are also pursuing innovative ways to transform health care by keeping people healthy, and making our services more convenient, accessible and affordable for all. In an increasingly uncertain world, we are committed to high-quality, compassionate health care for everyone – regardless of coverage or ability to pay. We help people and communities benefit from the best health care model for the future – today.

Together, our 120,000 caregivers (all employees) serve in 52 hospitals, 1,085 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

Providence across five western states:

- Alaska
- Montana
- Oregon
- Northern California
- Southern California
- Washington

The Providence affiliate family includes:

- Covenant Health in West Texas
- Facey Medical Foundation in Los Angeles, CA.
- Hoag Memorial Hospital Presbyterian in Orange County, CA.
- Kadlec in Southeast Washington
- Pacific Medical Centers in Seattle, WA.
- Swedish Health Services in Seattle, WA.

As a comprehensive health care organization, we are serving more people, advancing best practices and continuing our more than 100-year tradition of serving the poor and vulnerable. Delivering services across seven states, Providence is committed to touching millions of more lives and enhancing the health of the American West to transform care for the next generation and beyond.

INTRODUCTION

Who We Are

Our Mission	We are steadfast in serving all within our communities, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

Part of a larger healthcare system known as Providence; Healdsburg Hospital (HH), Providence Santa Rosa Memorial Hospital (SRMH) and Petaluma Valley Hospital (PVH) serve the communities located in Sonoma County. The health care services provided by these three hospitals include in part, the provision of acute care services, behavioral health, and other facilities for treating the healthcare needs of the community in Sonoma County.

PVH 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. 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.

In addition, Providence hospitals in Sonoma County offer a variety of community-based programs such as a free mobile health clinic, a mobile dental clinic, a fixed-site dental clinic, health promotions, school-based behavioral health, and the CARE Network. These programs and services offered to the community are designed to meet the needs of underserved populations and focus on health equity, primary prevention, health promotion and community building.

Our Commitment to Community

Providence health system 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 vulnerable. During the most recent fiscal year, PVH provided $3,692,455 in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve. Our service area also includes Providence Medical Group, Providence Home Care Network, and multiple urgent care facilities.

Providence hospitals in Sonoma County further demonstrate organizational commitment to the Community Health Needs Assessment (CHNA) through the allocation of staff time, financial resources, and participation and collaboration to address community identified needs. The Northern California Community Health Investment Regional Director, Dana Codron and the Sonoma County.

Community Health Investment Manager are responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders and hospital leadership, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

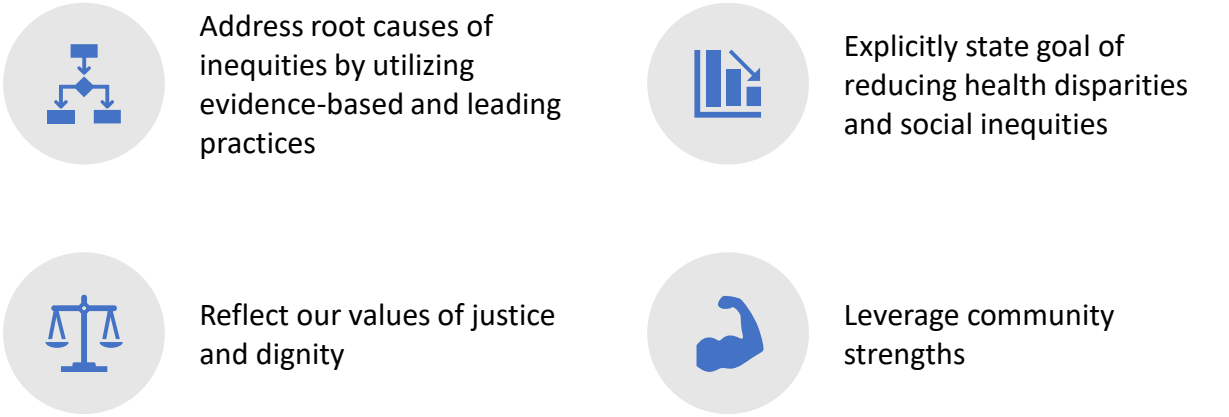
[1] Per federal reporting and guidelines from the Catholic Health Association.

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

Petaluma Valley Hospital (PVH) demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and participation and collaboration with community partners. The Northern California Regional Director of Community Health Investment and the local Community Health Investment Program Manager are responsible for coordinating implementation of State and Federal 501r requirements.

The Community Benefit Committee (CBC) is the board appointed oversight committee of the Community Health Investment department in Sonoma County. The PVH CBC is comprised of Healdsburg Hospital and Petaluma Valley Hospital community board members, internal Providence stakeholders, and staff with the goal of adding key community stakeholder members.

Planning for the Uninsured and Underinsured

Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Petaluma Valley Hospital (PVH) has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way PVH informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click here.

Medi-Cal (Medicaid)

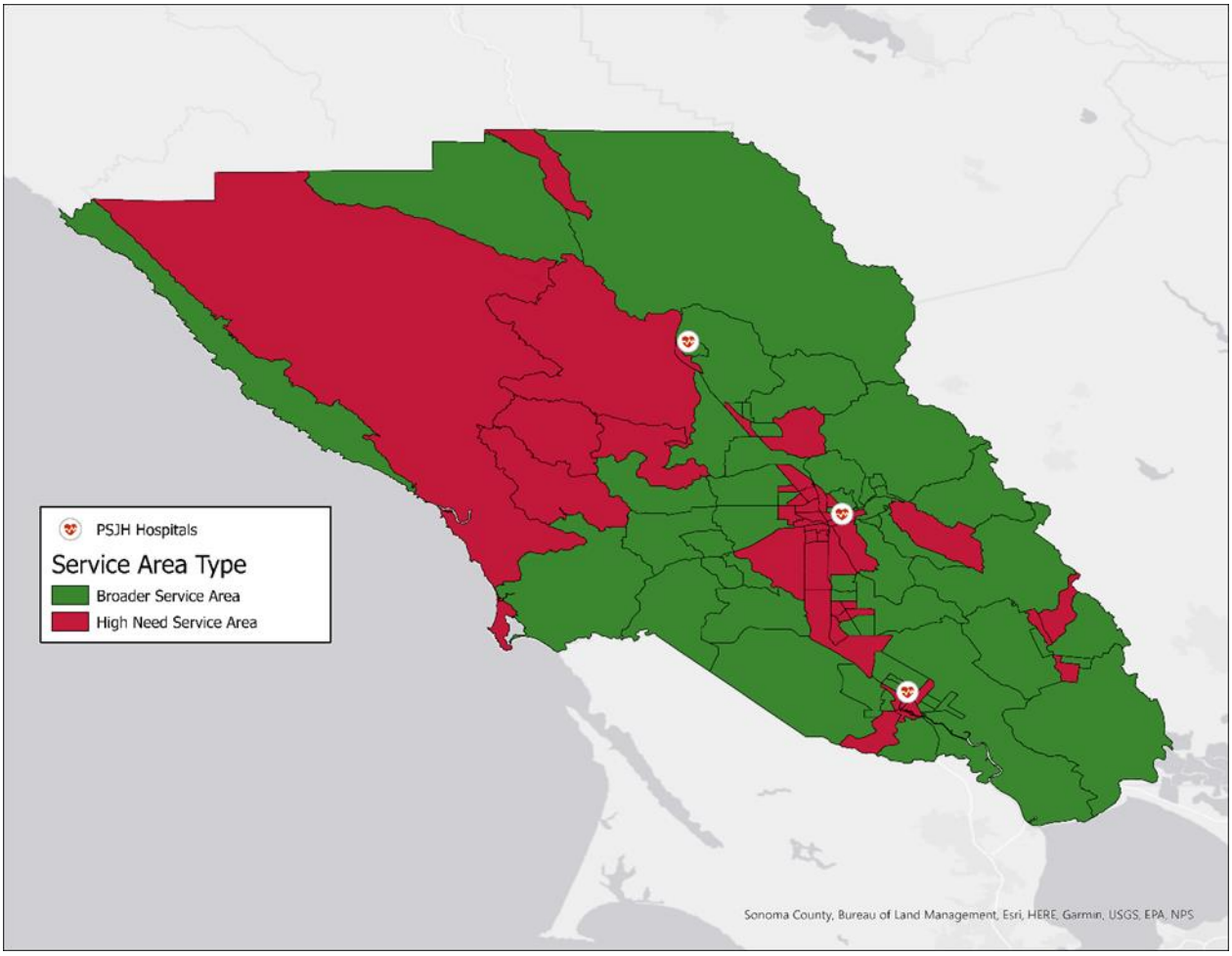
Petaluma Valley Hospital provide access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY21, Petaluma Valley Hospital provided $847,993 in Medicaid shortfall. The hospital received $7,534,217 income from the Medi-Cal Hospital Quality Assurance Fee program. If it was not for the Hospital Quality Assurance Fee received, Unpaid cost of MediCal would have been $8,382,210.

OUR COMMUNITY

Description of Community Served

Healdsburg Hospital, Santa Rosa Memorial Hospital, and Petaluma Valley Hospital provides Sonoma County communities with access to advanced care and advanced caring. The hospitals' service area is Sonoma County and includes a population of approximately 495,000 people.

Figure 2. Healdsburg Hospital, Santa Rosa Memorial Hospital, and Petaluma Valley Hospital



The high need area includes census tracts identified based upon lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of $51,500 or less for family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

For the most part, the age distribution is roughly proportional across Sonoma County geographies, with those between 18 and 34 years slightly more likely to live in a high need area, likely young families and those in and around college towns. Those ages 65 to 84 are less likely to live in a high need area, perhaps due in part to secondary and/or vacation homes.

The male-to-female ratio is approximately equal across geographies.

In Sonoma County, approximately 6% of the population are veterans, roughly in line with the 5% in the state of California.

POPULATION BY RACE AND ETHNICITY

The "other race" population is over-represented in the high need census tracts compared to the county population, whereas those who identify as white are less likely to live in high need communities. Individuals who identify as Hispanic are also over-represented in high need communities, representing nearly 38% of the population in those areas, compared to just under 20% in the broader service area.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Sonoma County Service Area

Indicator	Broader Service Area	High Need Service Area	Sonoma County
Median Income Data Source: American Community Survey Year: 2019	$93,090	$67,310	$81,477
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	25.3%	28.3%	26.9%

The median income in the high need service area is about $14,000 lower than Sonoma County. There is about a $26,000 difference in median income between the broader service area and the high need service area.

Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average about 27% of households in Sonoma County are severely housing cost burdened. In the high need service area, 28% of renter households are severely housing cost burdened. Within Sonoma County there are census tracts in which over 40% of households are experiencing severe housing cost burden.

Full demographic and socioeconomic information for the service area can be found in the 2019 CHNA for Petaluma Valley Hospital.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

Significant Community Health Needs Prioritized

The list below summarizes the rank ordered significant health needs identified through the 2019 Community Health Needs Assessment process:

PRIORITY 1: HOUSING INSTABILITY & HOMELESSNESS

The cost of living in Sonoma County outpaces the income for many people in the community, making it challenging for families to meet their basic needs. Housing is foundational to one's health: people who are stably housed are better able to care for their physical and mental health. Those most impacted by housing stability and affordability are the Latino/a community due to income inequities; youth experiencing homelessness, especially those identifying as LGBTQ+; and older adults whose fixed income limits their ability to afford local housing prices. There is also need for supportive housing, using a Housing First approach, for people with mental health challenges, substance use disorders, and other special needs. There are especially few resources for mixed status families.

PRIORITY 2: MENTAL HEALTH & SUBSTANCE USE SERVICES

Accessing quality mental health and substance use services can be a challenge for many. Trauma from the recent fires, COVID-19, and the current political climate contribute to the community mental health needs. There is a particular need for mild to moderate mental health services, perinatal mental health services, more wraparound case management for families to address mental health, and more substance use disorder treatment services. There is further need for more bilingual and bicultural mental health professionals to serve the Latino/a community, including mixed status families. School-age children and older adults are two additional groups with unmet mental health needs. Major barriers to accessing mental health services include insurance coverage limitations, cost of care, and shortage of providers resulting in long wait times for appointments.

PRIORITY 3: HEALTH EQUITY: RACISM AND DISCRIMINATION

Stakeholders described being at an "inflection point" in acknowledging and addressing racism in the community, with more people talking about the issue. They shared racism keeps people in poverty by limiting education and job opportunities, leading to more Black, Brown, Indigenous, and People of Color (BBIPOC) working in lower-wage jobs, with particular emphasis on the Latino/a community in Sonoma County. Housing discrimination prevents the Latino/a community from accessing good-quality, affordable housing. Racism contributes to inequities in the ways different schools are funded, contributing to the opportunity gap. Stakeholders shared particular concern for the ways in which xenophobia and racist policies negatively affect the mental health and economic security of the Latino/a community.

PRIORITY 4: ACCESS TO HEALTH CARE

Stakeholders discussed the need for more affordable health care, as well as challenges accessing primary and specialty care. They noted a particular need for more case management and navigation resources, especially for Spanish-speaking patients and new parents. Transportation to care is a consistent barrier for many, but especially older adults. Fears of immigration enforcement and changes in public charge rules may prevent mixed status households from applying for Medi-Cal. A lack of culturally responsive and linguistically appropriate health care services and documentation status may prevent the Latino/a community from receiving the care they need.

Needs Beyond the Hospital's Service Program

No single hospital facility can fully address all the health needs present in its community. While Petaluma Valley Hospital will employ strategies to address each of the four significant health needs that were prioritized during the CHNA process, partnerships with community organizations and government agencies are critical for achieving the established goals.

Petaluma Valley will collaborate with Petaluma People Services Center, La Luz Center, West County Community Services, Community Action Partnership of Sonoma County, and a variety of local family resource centers that address the community needs to coordinate care and referrals to address unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Regional Director, Program Coordinator and local Program Manager developed strategies based on insight from stakeholder interviews and caregiver listening sessions, and input and feedback were provided by the Community Benefit Committee. While the strategies were developed to address specific local needs, the strategies were also designed with the intention of leveraging local strengths to scale efforts across the Northern California region.

The 2020-2022 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Petaluma Valley Hospital 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 in the enclosed CHIP.

Addressing the Needs of the Community: 2020-2022 Key Community Benefit Initiatives and Evaluation Plan

2021 Accomplishments

COMMUNITY NEED ADDRESSED #1: HOUSING INSTABILITY & HOMELESSNESS

Population Served

Individuals experiencing or at imminent risk of experiencing homelessness, including older adults

Long-Term Goal(s)/ Vision

A sufficient supply of safe, affordable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs.

Table 2. Strategies for Addressing Housing Instability & Homelessness

Strategy	Population Served	FY21 Accomplishments
1. Leverage investments to increase safe and affordable housing stock.	BBIPOC & those experiencing health disparities	A total of $500,000 was invested in 2021 in projects to create 80 units of permanent supportive housing (St. Vincent's Commons and PEP Housing's Linda Tunis Senior Apartments projects).
2. Leverage resources through partnerships to expand supportive services.	BBIPOC & those experiencing health disparities	A total of $1,250,000 was invested in the construction of the Caritas Center project, a family shelter and homeless services center and a homeless medical clinic. In addition, a social worker position was funded to provide supportive services to the residents of the COTS Mary Isaak Center permanent supportive housing units.
3. Support policies that prevent homelessness and increase access to affordable housing.	At-risk populations	Providence CHI, primarily through its partners in the Sonoma Intersections Coalition, successfully advocated for multiple city and county policies to limit evictions and to preserve housing. In addition, an organizer was funded with North Bay Organizing Project to organize the Sonoma County Tenants Union, empowering renters to protect their rights and preserve their housing.

Key Community Partners

- County of Sonoma, Community Development Commission
- Sonoma County Continuum of Care
- Sonoma County Health Action
- Sonoma Intersections Coalition
- City of Santa Rosa
- City of Petaluma
- Catholic Charities of the Diocese of Santa Rosa
- St. Vincent de Paul Society of Sonoma
- Providence Supportive Housing
- Burbank Housing
- PEP Housing
- Committee on the Shelterless (COTS)
- Community Action Partnership of Sonoma County
- Petaluma People Services Center
- Reach for Home
- West County Community Services
- Legal Aid of Sonoma County
- North Bay Organizing Project

- West County Health Centers
- Santa Rosa Community Health
- Petaluma Health Center
- Generation Housing
- Interfaith Shelter Network
- Kaiser Permanente, North Bay
- Sutter Health, North Bay

COMMUNITY NEED ADDRESSED #2: MENTAL HEALTH & SUBSTANCE USE SERVICES

Population Served

Families and individuals of all ages throughout all geographic sub-regions of Sonoma County, with a particular emphasis on Latino/a population.

Long-Term Goal(s)/ Vision

To ensure equitable access to high quality, culturally responsive, and linguistically appropriate mental health and substance use services, especially for low-income populations.

Table 3. Strategies for Addressing Mental Health & Substance Use Services

Strategy	Population Served	FY21 Accomplishments
1. Increase capacity and reduce barriers to address mild-moderate mental health & substance use services.	Broader community	The Behavioral Health System of Care Capacity Building initiative (described above on pages 5-6) was implemented with multiple community partners to increase access and to directly connect populations in need with behavioral health and social support services.
2. Increase capacity and reduce barriers to provide bilingual/bicultural mental health & substance use services.	Latino/a & undocumented	The Behavioral Health System of Care Capacity Building initiative (described above on pages 5-6) was implemented with multiple community partners to increase access and to directly connect populations in need with behavioral health and social support services. A primary focus of this effort was the Latinx community through partnerships with Humanidad Therapy & Education Services and the La Luz Center.
3. Advocate for increased access to mental health and substance use care with focused community-based solutions.	Broader community	Providence CHI staff convene and facilitate numerous community coalitions that are advocating for increased access, improving behavioral health system of care transitions, and increasing capacity of the local behavioral health system of care to increase access. These are described above on page 5.

Key Community Partners

- Redwood Community Health Coalition
- Santa Rosa Community Health
- West County Health Centers
- Petaluma Health Center
- Alliance Medical Center
- Petaluma Health Care District
- Health Care Foundation of Northern Sonoma County
- County of Sonoma, Department of Health Services
- Sonoma County Office of Education
- Buckelew Programs
- NAMI Sonoma
- Humanidad Therapy and Education Services
- Petaluma People Services Center
- La Luz Center
- West County Community Services
- Social Advocates for Youth
- Mothers Care
- Hanna Institute
- First 5 Sonoma
- Center for Well-Being
- Kaiser Permanente, North Bay
- Sutter Health, North Bay
- Cloverdale Unified School District
- El Molino High School
- Petaluma City Schools
- Old Adobe Union School District
- Two Rock Union School District
- Geyserville Elementary School
- Fitch Mountain Elementary School
- Luther Burbank Elementary
- Roseland School District
- Windsor School District
- Biella Elementary School
- Guerneville Elementary School
- Seeds of Awareness
- Sonoma County Indian Health Project
- Committee on the Shelterless (COTS)
- Center Point Drug Abuse Alternative Center
- Alexander Valley Health Center
- Sonoma Valley Health Center
- SOS Community Counseling
- Santa Rosa Junior College, PEERS Program
- VOICES, Sonoma
- California Parenting Institute
- California Human Development

- Santa Rosa Police Dept
- Petaluma Police Dept.
- Public Defenders Office, Sonoma County
- Probation Dept, Sonoma County
- Wellpath, Sonoma County Jail
- Partnership Health Plan
- Beacon Health Options
- Sonoma County Sheriff Dept.
- Community Development Commission
- Santa Rosa Treatment Program
- Latino Service Providers
- Positive Images
- Sonoma County Resiliency Collaborative

COMMUNITY NEED ADDRESSED #3: HEALTH EQUITY: RACISM AND DISCRIMINATION

Population Served

Families and individuals suffering health inequities and lack of access due to racism and discrimination, including Latino/a, LGBTQ+, elderly, impoverished, etc.

Long-Term Goal(s)/ Vision

To be a community partner in undoing institutional racism and other forms of discrimination that prevent our community members from feeling safe, respected, and heard when accessing health services.

Table 4. Strategies and Strategy Measures for Addressing Health Equity

Strategy	Population Served	FY21 Accomplishments
1. Develop Health Equity Playbook by Q1 2021	Latino/a individuals and families	This projected strategy was not accomplished as originally forecast. As Providence CHI staff became involved with the Sonoma County Latinx Health Task Force, it became apparent that there were immediate and pressing needs that this Task Force addressed. It also became clear that such a health equity playbook ought to be part of the Task Force's work, and so it will hopefully be pursued in the future.
2. Partner with FQHC/other for COVID-19 outreach, prevention, testing, and mitigation of spread.	Latino/a individuals and families	Providence CHI community health promotion staff partnered extensively with FQHCs and Latinx-serving CBOs on multiple strategies and activities aimed at limiting the spread of COVID-19. Among these are the Sonoma County Latinx Health Task Force, La Familia Sana, Centro Laboral de Graton, La Plaza/CURA Project, La Luz Center, Latino

		Service Providers, Lideres Campesinas, Nuestra Comunidad, Petaluma Health Care District, Raizes Collective, and United Women's Group/Grupo de Mujeres Unidas
3. Advocate for policies that address social and economic disparities.	Broader community	Providence CHI invested in the creation of a Medical Legal Partnership with Legal Aid of Sonoma County to provide legal advice and assistance to low-income patients to help them resolve their legal issues related to their social determinants of health.

Key Community Partners

- Sonoma Intersections Coalition
- Justicewise
- On The Move
- Buckelew Programs
- NAMI Sonoma
- Humanidad Therapy and Education Services
- Petaluma People Services Center
- La Luz Center
- West County Community Services
- Corazon Healdsburg
- Sonoma County Health Action
- Community Action Partnership of Sonoma County
- Legal Aid of Sonoma County
- North Bay Organizing Project
- Latinos Unidos del Condado de Sonoma
- La Cooperativa, Campesina
- California Human Development
- Petaluma Health Care District
- Health Care Foundation of Northern Sonoma County
- County of Sonoma, Department of Health Services
- Sonoma County Office of Education
- Kaiser Permanente, North Bay
- Sutter Health, North Bay
- First 5 Sonoma
- Community Foundation Sonoma County
- United Way of the Wine Country
- Los Cien
- Hanna Institute
- Latino Service Providers
- Santa Rosa Community Health Center
- CURA
- La Familia Sana

- Catholic Charities
- Sonoma Winegrowers Association
- Sonoma County Medical Association
- On the Margins
- Youth Voices

COMMUNITY NEED ADDRESSED #4: ACCESS TO HEALTH CARE

Population Served

Families and individuals with low incomes, who are uninsured, who are geographically isolated or home-bound, who are unhoused, or who have any barriers to accessing health care and supportive resources.

Long-Term Goal(s)/ Vision

To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.

Table 5. Strategies for Addressing Access to Health Care

Strategy	Population Served	FY21 Accomplishments
1. Engage high-risk individuals with CARE Network complex care management teams.	Co-occurring socioeconomic and complex medical needs	CARE Network served 98 patients in FY2021.
2. Partner with FQHC / County PH	Un- and underinsured individuals and families	The Open Access to Community Care project directly connected 168 patients to primary care in FY2021. In addition, CARE Network continued to work with the Homeless Care Transitions project at Sana Rosa Community Health in FY2021.
3. Engage un- and underinsured youth in dental care through Providence fixed site and mobile dental clinics.	Un- and underinsured youth	Providence Dental Clinic served 135 patients during FY2021.
4. Engage un- and underinsured youth and adults by providing medical care through the Providence Mobile Health Clinic.	Un- and underinsured youth and adults	The Mobile Health Clinic served 57 patients in FY2021.

Key Community Partners

- Redwood Community Health Coalition
- Santa Rosa Community Health
- West County Health Centers
- Petaluma Health Center
- Alliance Medical Center
- Petaluma Health Care District
- Petaluma People Services Center
- Health Care Foundation of Northern Sonoma County
- County of Sonoma, Department of Health Services
- Operation Access
- Community Action Partnership of Sonoma County
- Legal Aid of Sonoma County
- Buckelew Programs
- NAMI Sonoma
- Humanidad Therapy and Education Services
- La Luz Center
- West County Community Services
- Kaiser Permanente, North Bay
- Sutter Health, North Bay
- Burbank Housing
- Shoreline Unified School District
- Petaluma City Schools
- Sonoma Valley Unified School District
- Santa Rosa City Schools
- Roseland Public Schools
- Bellevue Union School District
- Healdsburg Unified School District
- Windsor Unified School District
- Community Child Care Council (4Cs)
- North Bay Children's Center

FY21 COMMUNITY BENEFIT INVESTMENT

In FY21 Petaluma Valley Hospital invested a total of $3,692,455 in key community benefit programs. $3,568,457 was invested in community health programs for the poor. In addition, $1,800,159 in charity care was provided, $847,993 in unpaid cost of MediCal, including the Hospital Quality Assurance Fee Program, and $123,998 in community benefits for the broader community. The hospital received $7,534,217 income from the MediCal Hospital Quality Assurance Fee program for FY21. If it was not for the Hospital Quality Assurance Fee received, Unpaid Cost of MediCal would have been $8,382,210. Petaluma Valley Hospital applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, 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.

FY2021 Petaluma Valley Hospital
(July 1, 2020-June 30, 2021)

CA Senate Bill (SB) 697 Categories	Community Benefit Program Categories	Net Benefit
Medical Care for Vulnerable Populations	Financial Assistance at cost	1,800,159
	Unpaid cost of Medicaid	847,993
	Unpaid other govt. programs	37,735
Other Benefits for Vulnerable Populations	Community Health Improvement Services	312,126
	Subsidized Health Services	402,688
	Cash and In-Kind Contributions	163,756
	Community Building	-
	Community Benefit Operations	-
	Total Benefits for Vulnerable Populations	3,568,457
Other Benefits for the Broader Community Populations	Community Health Improvement Services	74,936
	Subsidized Health Services	-
	Cash and In-Kind Contributions	-
	Community Building	-
	Community Benefit Operations	49,062
Health Profession Education, Training and Research	Health Professions Education and Research	-
	Total Benefits for the Broader Community	123,998
	Total Community Benefit	3,692,455
Medical Care Services for the Broader Community	**Total Medicare shortfall**	10,282,013

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

CARE Network: The CARE Network program offers community-based care management for predominantly low-income and otherwise vulnerable populations. Upon discharge from the hospital or release from the Emergency Department, patients are served by teams of Social Workers and RNs. The program ensures patients and caregivers make a smooth and successful transition from hospital to home, including home visits; assistance with transportation to medical, legal and benefits appointments; diet and medication management; caregiving resources and support; referrals to additional needed resources/services; skilled nursing and senior placement; and coaching designed to teach self-advocacy skills in navigating the healthcare system. CARE Network staff act as an advocate and liaison between the patient and their providers.

Health Care for the Homeless Collaborative (HCHC): Providence CHI staff convene and facilitate this monthly meeting of multiple homeless services providers including Sonoma County Behavioral Health and Human Services, hospitals, substance use treatment providers, FQHCs, shelters, housing and homeless services, etc. HCHC is a forum to address coordination, sharing of information and resources, and the identification and development of new interventions to improve the system of care (e.g., Project Nightingale, Sober Circle, etc.)

Community Transitions of Care (CTOC): CTOC is a multi-stakeholder coalition of area hospitals, FQHCs, County Behavioral Health, criminal justice, and community-based organizations (CBOs) convened and facilitated by Providence CHI staff working together to create a multidisciplinary and integrated approach to address coordination of care challenges throughout the Sonoma County behavioral health system of care.

Community Partner Connection (CPC): This multi-stakeholder coalition is convened and facilitated by Providence CHI staff. Its focus is behavioral health and substance use, and its membership is primarily CBOs working in this space. The CPC provides a forum for open discussion to foster partnerships and connections across disciplines to break down siloes and the fragmented nature of behavioral health and substance use service delivery systems. In doing so, the CPC helps to address barriers to access, to offer support and education to providers to decrease burnout and isolation, to share agency updates and current resources, to collectively find solutions to common problems and challenges, and ultimately to increase shared and overall effectiveness of our system of care.

Community Health Promotion: Providence CHI's community health worker (CHW) organizes and offers public health screening and education events throughout the year and throughout the county: cardiovascular screening and testing for hypertension and diabetes; cardiovascular nutrition and health education; referrals to primary care; etc. In addition, the CHW regularly attends the scheduled visits of the Providence Mobile Health Clinic in Windsor, Cloverdale, and Sonoma to offer cardiovascular nutrition and health education to patients identified by the MHC staff. This includes an initial same-day consultation and the development of an ongoing coaching relationship with patients to monitor progress and to assist in behavioral and nutritional modifications needed to stabilize the patients' cardiovascular health indicators.

2021 CB REPORT GOVERNANCE APPROVAL

This 2021 Community Benefit Report was adopted by the Community Benefit Committee of the Petaluma Valley and Healdsburg Hospitals' Boards of Trustees on January 28, 2022. The final report was made widely available by February 1, 2022.

Pamela Tuft 1/28/2022

Pamela Tuft Date
Chair, Community Benefit Committee
Petaluma Valley Hospital and Healdsburg Hospital

Contact:

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