2022

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

Petaluma Valley Hospital

Petaluma, California

To provide feedback on this CB report or obtain a printed copy free of charge, please email Amy Ramirez at amy.ramirez2@stjoe.org

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 FY22, the hospital provided $11,413,837 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.

2022 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. Additionally, in January of 2022, CARE Network became an Enhanced Care Management (ECM) provider through Partnership HealthPlan of California, receiving referrals directly from Partnership HealthPlan for patients who are high utilizers of health and emergency services and/or are experiencing homelessness. The CARE Network ECM team is dedicated full time to serving this highly vulnerable population through complex care management.

Project Nightingale: Recuperative beds for unhoused and medically vulnerable 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.

Committee on the Shelterless (COTS) Recuperative Beds: Recuperative beds for unhoused and medically vulnerable discharged patients as an alternative to lengthy hospital stays or shelter placement. 6 beds at 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 11 PSH units embedded in COTS' Mary Isaak Center for chronically homeless, high utilizers of emergency services. In addition, CHI financially supports a full time Case Manager dedicated to these 11 individuals.

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, Health and Human Services, hospitals, substance use treatment providers, FQHCs, shelters, housing and homeless services and other community-based organizations. 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.)

*PEP Housing Capable Projec*t: Providence CHI invested in this project which was a partnership between PEP Housing and John Hopkins University, focused on low-income seniors experiencing isolation post COVID. Thirty-five adults from PEP Housing participated in this program which provided a registered nurse and occupational therapist to increase activities of daily living and self-sufficiency with the goal of safely aging in place.

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.

2022 Accomplishments

Substance Use Navigators (SUNs): A distinct service of CARE Network, SUNs are embedded into Petaluma Valley and Santa Rosa Memorial Hospitals. Paid for, trained, and monitored by a CA Bridge program grant, these SUNs assist any patient who presents to the Emergency Department with an identified substance use disorder. SUNs are trained to assist physicians with dosing buprenorphine inpatient and arranging for next day treatment at an outpatient medication-assisted treatment program (MAT). Additionally, SUNs champion harm reduction techniques and distribute Naloxone out of the 2 emergency departments for any community member, caregiver, or patient.

Path to Hope: Path to Hope is an annual suicide prevention educational forum series produced by Providence CHI staff. Originally conceived as an in-person conference-style event, it was adapted during COVID to be offered virtually. 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, offer support and education to providers to decrease burnout and isolation, share agency updates and current resources, collectively find solutions to common problems and challenges, and ultimately 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 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.

Mothers 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, connecting to needed mental health and substance use treatment and services, and advocating for patient equity. A special focus is on Latino/a, LGBTQI and other underserved populations.
- Humanidad Therapy & Education Services: Providence financially supports a specialized navigator position in this Latino/a -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 Latino/a, 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. As part of this overall

system capacity-building initiative, this position connects with the other system navigation resources being embedded in other CBOs and conducts 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 access.

- 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 Latino/a, 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.

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.

2022 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 Latino/a population in Sonoma County. Providence has been an annual funder of this conference since its inception several years ago.

¡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 Latino/a 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 Latino/a students.

Enhanced Care Management (ECM): In January of 2022, CARE Network became an ECM provider through Partnership HealthPlan of California, receiving referrals directly from Partnership Health Plan of patients who are high utilizers of health and emergency services and/or are experiencing homelessness. The CARE Network ECM team is dedicated full time to serving this highly vulnerable population through complex care management, and coaching.

Mobile Health Clinic (MHC): The MHC merged with our Promotores de Salud (Community Health Worker) program and implemented regular visits to day labor Centers in North County, providing screenings, readings, education and resources to the day laborers and agricultural workers. Additionally, the MHC visited homeless encampments throughout the County weekly to provide medical and community health worker services.

Operation Access: Operation Access's patients who are in need of vital medical procedures, face staggering structural inequality because of their limited income, immigration status, race, language, and ethnicity. They grapple with discrimination in health care, jobs, education, and housing. They often cannot afford private health insurance coverage, and, because of their immigration status, some patients are not eligible to enroll in Medicare, Medicaid, or to purchase coverage through the Affordable Care Act. Operation Access also serves low-income citizens whose earnings make them ineligible for Medi-Cal, but unable to afford insurance.

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.

2022 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: Community Health Investment financial supports an embedded Santa Rosa Community Health scheduler within the Emergency Department at SRMH 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.

Medical Legal Partnership (MLP): Providence CHI funds an attorney position at Legal Aid of Sonoma County 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., autism). Patient population is primarily low-income Latino/a.

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 Latino/a 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.

Ceres Community Project: Providence's CHI granted funding toward this program which provides medically tailored, organic meals to vulnerable and recuperating community members. The focus of funding for this year was for palliative eligible patients.

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; Petaluma Valley Hospital (PVH), Healdsburg Hospital (HH) and Providence Santa Rosa Memorial Hospital (SRMH) 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 $11,413,837 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 Sonoma County Community Health Investment Manager, Amy Ramirez, is responsible for ensuring

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

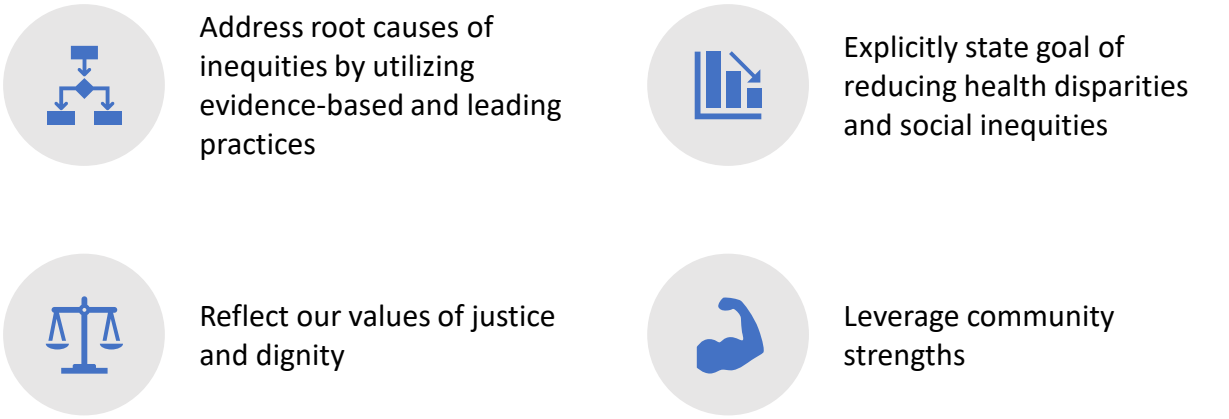
compliance with Federal 501r requirements as well as providing the opportunity for community leaders and hospital leadership, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

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, and external community stakeholders representing subject matter experts and community constituencies.

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)

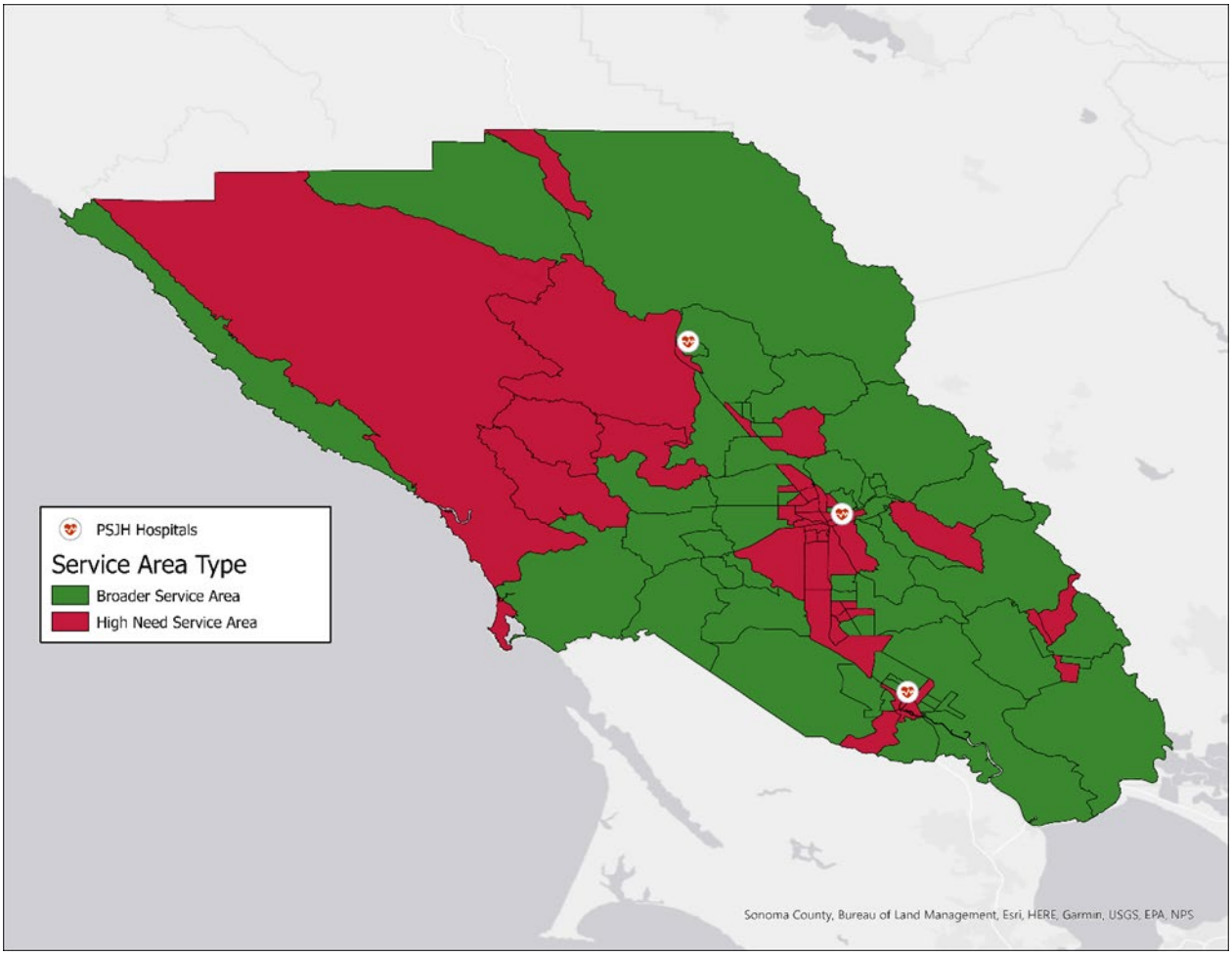
Petaluma Valley Hospital provide access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY22, Petaluma Valley Hospital provided $8,808,649 in Medicaid shortfall. The hospital received $5,150,480 income from the Medi-Cal Hospital Quality Assurance Fee program. If it was not for the Hospital Quality Assurance Fee received, Unpaid cost of MediCal would have been $13,959,129.

OUR COMMUNITY

Description of Community Served

Petaluma Valley Hospital, Healdsburg Hospital, and Santa Rosa Memorial 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. Petaluma Valley Hospital, Healdsburg Hospital, Santa Rosa Memorial 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 asserted that 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 local health centers and community-based organizations 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

2022 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	FY22 Accomplishments
1. Leverage investments to increase safe and affordable housing stock.	BBIPOC & those experiencing health disparities	Providence CHI invested in COTS PSH 11 units for Chronically Homeless and High Utilizers of Emergency Services.
2. Leverage resources through partnerships to expand supportive services.	BBIPOC & those experiencing health disparities	Providence CHI continued to support Nightingale Recuperative Shelter (26 beds). CHI supported 6 COTS recuperative beds, case management and supportive services including a full-time counselor on site at COTS. CARE Network program worked with 1700 patients, 10% of which were identified as experiencing homelessness.
3. Support policies that prevent homelessness and increase access to affordable housing.	At-risk populations	Providence CHI funded a full-time attorney for our medical legal partnership with Legal Aid of Sonoma County. This attorney worked with patients (1=client with 3-day eviction notice, 1=client advocacy for inpatient treatment, 1=tenant/landlord grievance medication, 1=reasonable accommodation ADA housing issue).

Key Community Partners

- Burbank Housing
- Catholic Charities of the Diocese of Santa Rosa
- City of Petaluma
- City of Santa Rosa
- Community Action Partnership of Sonoma County
- Committee on the Shelterless (COTS)
- Community Support Network
- County of Sonoma, Community Development Commission
- Generation Housing (Gen H)
- Health Action 2.0
- Kaiser Permanente, North Bay
- Legal Aid of Sonoma County
- North Bay Organizing Project
- PEP Housing
- Petaluma Health Center
- Petaluma People Services Center
- Providence Supportive Housing
- Reach for Home

- Santa Rosa Community Health
- Sonoma County Continuum of Care
- Sonoma Intersections Coalition
- Sutter Health, North Bay
- West County Community Services
- West County Health Centers

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	FY22 Accomplishments
1. Increase capacity and reduce barriers to address mild-moderate mental health & substance use services.	Broader community	CHI invested in Buckelew Services for a behavioral health navigator for loved ones supporting someone with behavioral health challenges. CARE Network's Substance Use Navigators are access points to treatment at Santa Rosa Memorial and Petaluma Valley Hospital. CHI funded Mothers Care maternal mental health program offering free and timely clinical counseling to new mothers exhibiting mood and anxiety disorders during post-partum well-baby visits.
2. Increase capacity and reduce barriers to provide bilingual/bicultural mental health & substance use services.	Latino/a & undocumented	Humanidad Therapy & Education Services and La Luz Center: Providence financially supported 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 Latino/a, farmworker, and undocumented population in the Boyes Hot Springs area of Sonoma Valley.
3. Advocate for increased access to mental health	Broader community	Providence CHI designed and facilitated the Path to Hope virtual summit provided in both

and substance use care with focused community-based solutions.		English and Spanish. 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.

Key Community Partners

- Alexander Valley Health Center
- Alliance Medical Center
- Buckelew Programs
- California ED Bridge
- Center Point Drug Abuse Alternative Center
- Committee on the Shelterless (COTS)
- Community Development Commission
- County of Sonoma, Department of Health Services
- First 5 Sonoma
- Hanna Institute
- Health Care Foundation of Northern Sonoma County
- Humanidad Therapy and Education Services
- Kaiser Permanente, North Bay
- La Luz Center
- Latino Service Providers
- Mothers Care
- NAMI Sonoma
- Partnership Health Plan
- Petaluma Health Care District
- Petaluma Health Center
- Petaluma People Services Center
- Redwood Community Health Coalition
- Santa Rosa Community Health
- Santa Rosa Fire Department
- Santa Rosa Police
- Santa Rosa Treatment Program
- Social Advocates for Youth (SAY)
- Sonoma County Indian Health Project
- Sonoma County Office of Education
- SOS Community Counseling
- Sutter Health, North Bay
- West County Community Services
- West County Health Centers

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	FY22 Accomplishments
1. Develop Health Equity Playbook by Q1 2021	Latino/a individuals and families	The original plan to develop a Health Equity Playbook was not accomplished in Sonoma County. However, Sonoma County Mobile Health Clinic participated in CHI regional Health Equity work, meeting monthly with the Health Equity workgroup, and implementing breast screenings on the Mobile Health Clinic as a Health Equity Initiative.
2. Partner with FQHC/other for COVID-19 outreach, prevention, testing, and mitigation of spread.	Latino/a individuals and families	Providence CHI's Promotores (Community Health Worker) attended a weekly COVID outreach meeting with local FQHCs, CBOs and Sonoma County Public Health to plan and outreach covid testing and vaccination to the Latino/a community.
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 guidance and representation to low-income patients to help them resolve their legal issues related to social determinants of health.

Key Community Partners

- Buckelew Programs
- California Human Development
- Catholic Charities
- Community Action Partnership of Sonoma County
- Community Foundation Sonoma County
- Corazon Healdsburg
- County of Sonoma, Department of Health Services

- CURA
- First 5 Sonoma
- Hanna Institute
- Health Care Foundation of Northern Sonoma County
- Humanidad Therapy and Education
- Justicewise
- Kaiser Permanente, North Bay
- La Familia Sana
- La Luz Center
- Latino Service Providers
- Latinos Unidos del Condado de Sonoma
- Legal Aid of Sonoma County
- Los Cien
- NAMI Sonoma
- North Bay Organizing Project
- On the Margins
- On The Move
- Petaluma Health Care District
- Petaluma People Services Center
- Santa Rosa Community Health
- Sonoma County Health Action
- Sonoma County Medical Association
- Sonoma County Office of Education
- Sonoma Intersections Coalition
- Sonoma Winegrowers Association
- Sutter Health, North Bay
- United Way of the Wine Country
- West County Community Services
- 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	FY22 Accomplishments
1. Engage high-risk individuals with CARE Network complex care management teams.	Co-occurring socioeconomic and complex medical needs	CARE Network encounters were 829 for FY22.
2. Partner with FQHC / County PH	Un- and underinsured individuals and families	CARE Network partnered with Petaluma Health Center to establish a once-a-week phone appointment with PHC case management to connect post-acute patients with follow up appointments at Petaluma Health Center and Rohnert Park Health Center as well as to case conference on complex patients requiring coordination of care.
3. Engage un- and underinsured youth in dental care through Providence fixed site and mobile dental clinics.	Un- and underinsured youth	Providence Dental Clinic encounters were 120 for FY22. Mobile Dental Clinic encounters were 14.
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 encounters were 16 for FY22.

Key Community Partners

- Alliance Medical Center
- Bellevue Union School District
- Buckelew Programs
- Burbank Housing
- Community Action Partnership of Sonoma County
- Community Child Care Council (4Cs)
- County of Sonoma, Department of Health Services
- Healdsburg Unified School District
- Health Care Foundation of Northern Sonoma County
- Humanidad Therapy and Education Services
- Kaiser Permanente, North Bay

- La Luz Center
- Legal Aid of Sonoma County
- NAMI Sonoma
- North Bay Children's Center
- Operation Access
- Petaluma City Schools
- Petaluma Health Care District
- Petaluma Health Center
- Petaluma People Services Center
- Redwood Community Health Coalition
- Roseland Public Schools
- Santa Rosa City Schools
- Santa Rosa Community Health
- Shoreline Unified School District
- Sonoma Valley Unified School District
- Sutter Health, North Bay
- West County Community Services
- West County Health Centers
- Windsor Unified School District

FY22 COMMUNITY BENEFIT INVESTMENT

In FY22 Petaluma Valley Hospital invested a total of $11,413,837 in key community benefit programs. $11,217,278 was invested in community health programs for the poor. In addition, $1,720,507 in charity care was provided, $8,808,649 in unpaid cost of MediCal, including the Hospital Quality Assurance Fee Program, and $196,559 in community benefits for the broader community. The hospital received $5,150,480 income from the MediCal Hospital Quality Assurance Fee program for FY22. If it was not for the Hospital Quality Assurance Fee received, Unpaid Cost of MediCal would have been $13,959,129. 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.

FY2022 Petaluma Valley Hospital
(July 1, 2021 - June 30, 2022)

CA Senate Bill (SB) 697 Categories	Community Benefit Program Categories	Net Benefit
Medical Care for Vulnerable Populations	Financial Assistance at cost	$1,720,507
	Unpaid cost of Medicaid	$8,808,649
	Unpaid other govt. programs	-
Other Benefits for Vulnerable Populations	Community Health Improvement Services	$159,376
	Subsidized Health Services	$335,365
	Cash and In-Kind Contributions	$182,151
	Community Building	-
	Community Benefit Operations	$11,230
	Total Benefits for Vulnerable Populations	**$11,217,278**
Other Benefits for the Broader Community Populations	Community Health Improvement Services	$16,994
	Subsidized Health Services	-
	Cash and In-Kind Contributions	-
	Community Building	-
	Community Benefit Operations	$179,565
Health Profession Education, Training and Research	Health Professions Education and Research	-
	Total Benefits for the Broader Community	**$196,559**
	Total Community Benefit	**$11,413,837**
Medical Care Services for the Broader Community	**Total Medicare shortfall**	**$16,748,327**

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

Healdsburg Hospital/Petaluma Valley Community Benefit Committee: Providence CHI formed this new governance committee which is comprised of Healdsburg Hospital and Petaluma Valley Hospital staff, community stakeholders who serve as subject matter experts, and hospital board appointed members. In collaboration with members of the Hospitals' Community Board, CHI leadership carefully selected and conducted outreach to community stakeholders that would provide valuable input regarding the department's finances, investments, and strategic plan. Additionally, these committee members are vital to leveraging partnerships and relationships in the service areas of Healdsburg and Petaluma.

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.

2022 CB REPORT GOVERNANCE APPROVAL

This 2022 Community Benefit Report was adopted by the Community Benefit Committee of the Petaluma Valley and Healdsburg Hospitals' Boards of Trustees on November 4, 2022. The final report was made widely available by November 30, 2022.

Sue Campbell 11/4/2022

Sue Campbell Date
Interim Chair, Community Benefit Committee
Petaluma Valley Hospital and Healdsburg Hospital

Contact:

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