

— 2021 - 2023 —

COMMUNITY HEALTH IMPROVEMENT PLAN

Petaluma Valley Hospital

Petaluma, California



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Daniel Schurman at daniel.schurman@stjoe.org.



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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 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, the hospital provided \$7,178,344 in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Petaluma Valley Hospital to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach using quantitative and qualitative data, the CHNA process relied on several sources of information to identify community needs. The community information collected includes state and national public health data, qualitative data from interviews with stakeholders, and hospital utilization data.

Collaborating Organizations

Santa Rosa Memorial Hospital and Petaluma Valley Hospital collaborated to complete the 2021-2023 Community Health Improvement Plan for their shared service area.

PVH Community Health Improvement Plan Priorities

As a result of the findings of our [2020 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PVH will focus on the following areas for its 2021-2023 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.

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.

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.

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.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Part of a larger healthcare system known as Providence, Santa Rosa Memorial Hospital (SRMH) and Petaluma Valley Hospital (PVH) are part of a countywide ministry, Providence Sonoma County, that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County.

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, both SRMH and PVH 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 Sonoma County 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 \$7,178,344 in Community Benefit¹ 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.

SRMH and PVH further demonstrate organizational commitment to the 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, Dan Schurman, is responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for

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

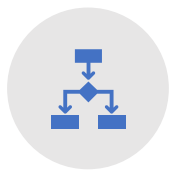
community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

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



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths

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 CBC is composed of Santa Rosa Memorial Hospital and Petaluma Valley Hospital community board members, internal Providence stakeholders and staff, external community stakeholders representing subject matter experts and

community constituencies (i.e., faith based, FQHC's, mental health, homeless services, and education). The Community Benefit Committee reviewed the data collected in the 2020 Community Health Needs Assessment process to identify and prioritize the top health-related needs in Sonoma County for this 2021-2023 CHIP. The committee also oversees and governs budget, investments, populations of focus, and community-wide engagement.

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.

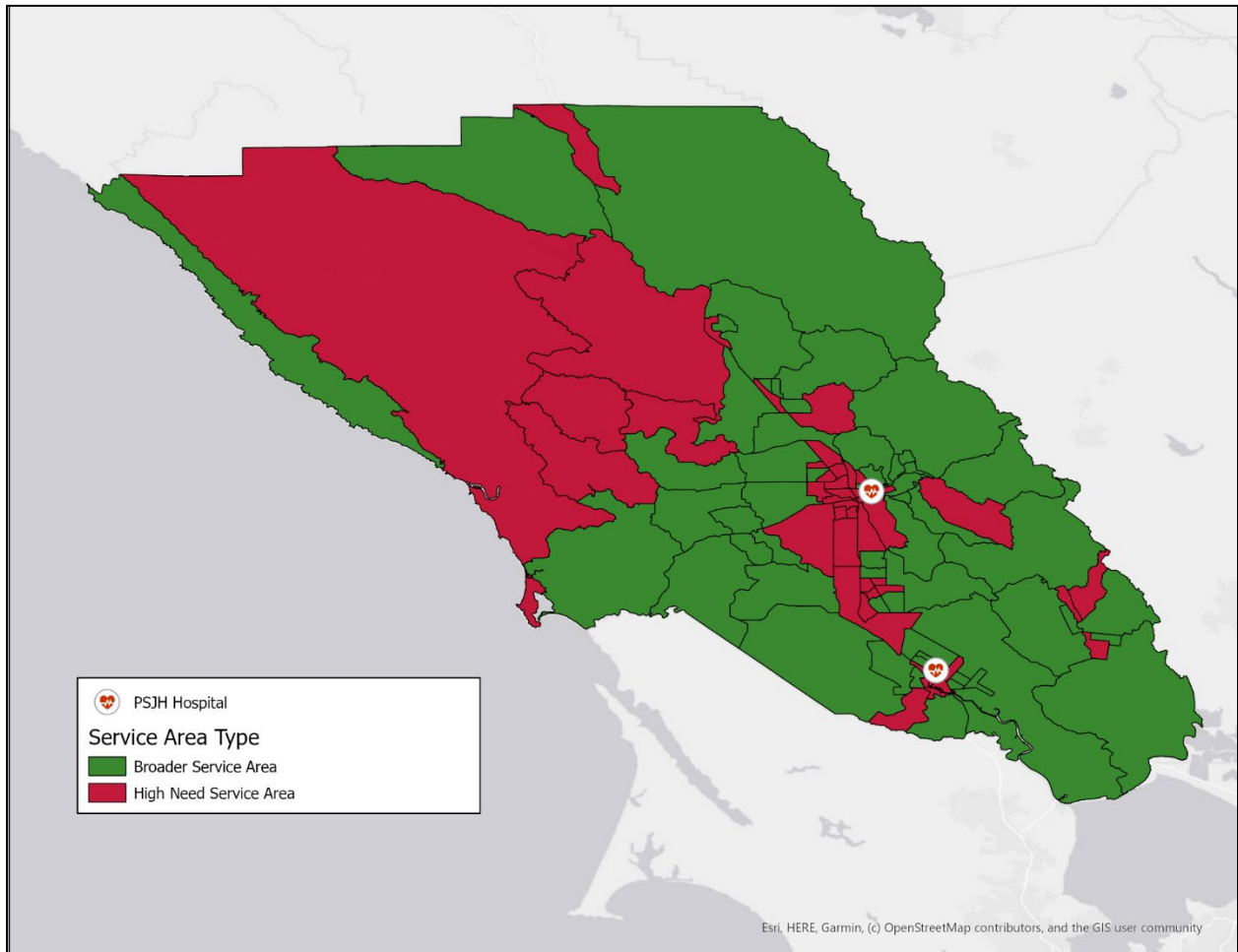
One way PVH informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial 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](#).

OUR COMMUNITY

Description of Community Served

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. Santa Rosa Memorial Hospital and Petaluma Valley Hospital Service Area



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 [2020 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 2020 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 2021-2023 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 2020 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: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: HOUSING INSTABILITY & HOMELESSNESS

Community Need Addressed

The cost of living in Sonoma County outpaces the income. More affordable housing and more supportive housing is needed, especially for the Latino/a and the LGBTQ populations, older adults, individuals living on fixed incomes, and undocumented individuals.

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 and Strategy Measures for Addressing Housing Instability & Homelessness

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Invest in the maintenance and expansion of existing homeless recuperative beds and services.	Individuals experiencing homelessness, including older adults	Number of recuperative beds; dollars invested in support	2020: Project Nightingale (26 beds); COTS' Mary Isaak Center (6 beds); \$285,000 invested in recuperative care programs.	30% increase in number of recuperative beds; \$350,000 invested in recuperative care programs.
2. Leverage resources through partnerships to expand permanent supportive housing (PSH) beds and services.	Individuals experiencing homelessness, including older adults	Number of new PSH units created; amount of investment in PSH creation and supportive services.	828 PSH beds in 2020 countywide; \$175,000 invested in PSH supportive services	10% increase in number of PSH units
3. Expand Providence CARE Network and other transitional services for homeless patients to alleviate or prevent their unsheltered status	Individuals experiencing or at imminent risk of experiencing homelessness, including older adults	Number of individuals receiving CARE Network and other supportive services	In 2020, 2,412 individuals were served by Providence CARE Network (including its partner teams with Santa Rosa Community Health and Catholic Charities).	3,000 individuals served by Providence CARE Network.

Evidence Based Sources

Permanent Supportive Housing:

[Permanent Supportive Housing: Assessing the Evidence](#)

[Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness \(2018\)](#)

Resource Commitment

Petaluma Valley Hospital will commit staff time from its Community Health Investment department, provide grants to local partners, and help leverage resources from the Providence Population Health division.

Key Community Partners

Petaluma Valley Hospital values cross-sector collaboration and believes that nonprofit organizations and local government agencies must work together to solve community-level problems. We plan to collaborate with the following organizations to address this need:

- 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

Community Need Addressed

Accessing mental health or substance use services is a challenge for many in the community; this is especially true for school-age youth, Latino/a individuals and families, undocumented individuals, and older adults. There is a general need for more mild-to-moderate mental health services, perinatal services, wraparound case management, and bilingual/bicultural providers.

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 and Strategy Measures for Addressing Mental Health & Substance Use

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
<p>1. Increase access to mild-to-moderate behavioral health services through navigation assistance, training, organizational culture change, capacity-building, local system of care stakeholder convenings, etc.</p>	<p>Families and individuals of all ages, with a particular emphasis on Latino/a population</p>	<p>Clients served by agencies participating in the Community Behavioral Health Partnership Program</p>	<p>Only partial baseline data are available as the investments in creating the Community Behavioral Health Partnership Program only began late in 2020.</p>	<p>1,000 individuals receiving services through the Community Behavioral Health Partnership Program</p>
<p>2. Increase patients' connections to Medication-Assisted Treatment (MAT) programs using hospital-embedded Substance Use Navigators (SUNs) as part of the CA Bridge program.</p>	<p>Hospital inpatients and emergency department patients with an opioid use disorder</p>	<p>Patients served by SUNs</p>	<p>616 patients served by SUN in 2020</p>	<p>1,200 patients served by SUNs</p>
<p>3. Deliver evidence-based mental health education and training programming (e.g., mindfulness, restorative justice, stigma reduction, suicide awareness and prevention, self-healing communities, etc.) in low-income school districts, in targeted marginal/vulnerable communities, and to behavioral health provider agencies throughout Sonoma County.</p>	<p>Elementary, middle, and high school students and school personnel in low-income school districts; marginalized and vulnerable communities and neighborhoods; and community-based organizations and clinics providing behavioral health services and referrals.</p>	<p>Number of participants in behavioral health-related education and training programs.</p>	<p>In 2019, there were 28,909 encounters in all behavioral health related education and training programs. In 2020, there were 19,283.</p>	<p>15,000 participants in behavioral health-related education and training programs. (Lower target owes to uncertainties about being able to return to former school-based activities post-COVID.)</p>

MAT programs:

[SAMHSA: Use of Medication-Assisted Treatment in Emergency Departments](#)

Resource Commitment

Petaluma Valley Hospital will commit staff time from its Community Health Investment department, provide grants to local partners, and help leverage resources from the Providence Population Health division.

Key Community Partners

Petaluma Valley Hospital values cross-sector collaboration and believes that nonprofit organizations and local government agencies must work together to solve community-level problems. We plan to collaborate with the following organizations to address this need:

- 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

Community Need Addressed

The COVID-19 pandemic highlights racial inequities and disparities at a systemic level. Latino/a and all BBIPOC individuals and families are faced with less favorable housing, educational and employment opportunities.

Population Served

Families and individuals experiencing health inequities and lack of access due to racism and discrimination, including Latino/a, LGBTQ+, elderly, people with low incomes, 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	Strategy Measure	Baseline	2023 Target
1. Partner with FQHCs and other providers/CBOs for mitigation of impacts from COVID-19 in Latino/a communities.	Latino/a community members and families experiencing social, personal and/or financial impacts of COVID-19.	Number of Latino/a individuals and families receiving COVID-recovery-related assistance or referrals.	New project in this CHNA/CHIP cycle; no baseline data available.	500 individuals/families received COVID-recovery-related services/referrals
2. Develop and implement a school-based equity project (iDale!) featuring student leadership, expert mentoring, and a small-grants program to enable student-led equity projects in selected Sonoma County high schools.	High school students in predominantly low-income, racially diverse schools.	Number of projects sponsored, number of students participating.	New project in this CHNA/CHIP cycle; no baseline data available.	8 projects sponsored with 30 total students participating.
3. Institute a Medical Legal Partnership (MLP) program with Legal Aid of Sonoma County to provide legal assistance and representation to underserved and vulnerable patient populations to resolve legal challenges & barriers to addressing their social determinants of health.	Patient populations unable to afford basic legal advice and representation.	Number of patients/clients referred and served through the MLP.	New project in this CHNA/CHIP cycle; no baseline data available.	100 patients/clients will be referred and served through the MLP on an annual basis.

Evidence Based Sources

Medical Legal Partnerships:

[Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership](#)

[Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy](#)

[Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health](#)

Resource Commitment

Petaluma Valley Hospital will commit staff time from its Community Health Investment department, provide grants to local partners, and help leverage resources from the Providence Health Equity Initiative.

Key Community Partners

Petaluma Valley Hospital values cross-sector collaboration and believes that nonprofit organizations and local government agencies must work together to solve community-level problems. We plan to collaborate with the following organizations to address this need:

- 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

Community Need Addressed

Many individuals have trouble accessing health care, especially Spanish-speaking patients, new parents, older adults, and undocumented individuals. More primary and specialty care, transportation to care, and culturally appropriate health care services are needed.

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 and Strategy Measures for Addressing Access to Health Care

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Engage high-risk individuals with CARE Network complex care management teams to ensure access to appropriate and needed care and services.	Patients who have a core diagnosis of CHF, COPD, Sepsis, Stroke, PNE, Diabetes, with an identified SDOH need, or who have an identified Substance Use Disorder.	Number of individuals receiving care management services from CARE Network teams	In 2020, 2,412 individuals were served by Providence CARE Network teams	3,000 patients receiving care management services from CARE Network teams
2. Continue to provide cardiovascular disease (CVD) screening throughout the community to prevent CVD through early detection and prevention and through linkages to primary care and treatment.	Low-income adult community members of the general public, primarily Latino/a populations	Number of individuals screened for CVD risk factors (and referred to primary care or treatment, if needed.)	Number of individuals screened for CVD risk factors: 2019: 646 2020: 699	650 individuals screened for CVD risk factors
3. Provide dental care to un- and underinsured patients through Providence CHI fixed site and mobile dental clinics.	All uninsured and underinsured individuals.	Number of patients receiving dental care	In 2019, the Dental Clinic served 10,032 patients, the Mobile Dental Clinic served 1,445, and the Mighty Mouth school-based program served 5,628. In 2020, the corresponding	11,000 patients receiving dental care through all programs combined. (Uncertainties in resuming school-based

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
			numbers were 7,332, 1,605, and 888.	activities post-COVID may prevent Mighty Mouth program for returning to its same pre-COVID levels.)
4. Provide primary care and linkages to medical homes for un- and underinsured patients through Providence CHI Mobile Health Clinic.	Low-income, uninsured, under-insured, undocumented, unhoused, or other vulnerable populations	Number of patients receiving treatment, services, or referrals from the Providence Mobile Health Clinic	In 2020, 4,971 patients received treatment, services, or referrals from the Providence Mobile Health Clinic. (This number was higher than normal due to increased visits with reduced scope of services in shelters during COVID.)	3,000 patients receiving treatment, services, or referrals from the Providence Mobile Health Clinic
5. Increase access for uninsured patients to specialty treatments, services, and procedures through support of Operation Access (OA).	Low-income, uninsured, and under-insured patients in need of surgery or specialty diagnoses and care that are unable to afford it.	Number of referrals to OA; number of Surgical Procedures and Diagnostic Services performed by OA in Sonoma County	In 2019 in Sonoma County, OA received 643 referrals and performed 594 Surgical Procedures and Diagnostic Services; in 2020, these numbers were 484 and 539, respectively.	750 referrals to OA; 750 Surgical Procedures and Diagnostic Services performed by OA in Sonoma County

Evidence Based Sources

Sealants/FI Varnish/Dental Exams:

[Use of Dental Care and Effective Preventive Services in Preventing Tooth Decay Among U.S. Children and Adolescents](#)

[Evidence-based Clinical Practice Guideline for the Use of Pit-and-Fissure Sealants](#)

[Evidence-Based Dentistry Update on Silver Diamine Fluoride](#)

Dental Screenings in Schools:

[School-Based and School-Linked Dental Sealant Programs](#)

[Effectiveness of school-based dental screening in increasing dental care utilization: A systematic review and meta-analysis](#)

Resource Commitment

Petaluma Valley Hospital will commit staff time from its Community Health Investment department, provide grants to local partners, and help leverage resources from the Providence Health Equity Initiative.

Key Community Partners

Petaluma Valley Hospital values cross-sector collaboration and believes that nonprofit organizations and local government agencies must work together to solve community-level problems. We plan to collaborate with the following organizations to address this need:

- 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

2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Benefit Committee of the Santa Rosa Memorial and Petaluma Valley Hospitals' Boards of Trustees on June 22, 2021. The final report was made widely available by July 15, 2021.



6/22/2021

Victor Jordan
Interim Chief Executive, Northern California Region

Date



6/22/2021

Debbie Meekins
Chair, Community Benefit Committee, Sonoma County

Date



7/2/2021

Justin Crowe
Senior Vice President, Community Partnerships
Providence

Date

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.