St. Joseph Health, Petaluma Valley Hospital

FY18 - FY20 Community Benefit Plan/Implementation Strategy Report

St. Joseph Health
Petaluma Valley

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EXECUTIVE SUMMARY

St. Joseph Health-Petaluma Valley Hospital is a community hospital founded in 1980 by the Petaluma Health Care District, and is located in Petaluma, California. St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds and a campus that is 14.63 acres in size. Petaluma Valley Hospital (PVH) has a staff of 501 employees and professional relationships with more than 260 local physicians. PVH is a Leapfrog A-rated facility, a Joint Commission Stroke-Ready certified hospital, has been designated as a Baby-Friendly® Hospital by Baby-Friendly USA, and as a Blue Distinction® specialty care facility by Blue Cross Blue Shield for maternity services. Major programs and services also include emergency care, outpatient surgery, obstetrical services, and pulmonary rehabilitation.

Part of a larger healthcare system known as St. Joseph Health (SJH), PVH is part of a countywide ministry, St. Joseph Health-Sonoma County (SJH-SC) that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region. The ministry's core facilities are PVH, an 80-bed acute care hospital, and Santa Rosa Memorial Hospital (SRMH), a full service, state of the art 330-bed acute care hospital that includes a Level II trauma center for the coastal region from San Francisco to the Oregon border. Major programs and services include critical care, cardiovascular care, stroke care, women's and children's services, cancer care, and orthopedics. SRMH is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

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

PVH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved. Each year, PVH allocates 10 percent of its net income to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care for the Poor programs. In addition, PVH spends portions of its annual operating budget to operate ongoing community benefit programs targeted at both the economically poor and underserved as well as the

broader community. These programs include a free Mobile Health Clinic, Mobile Dental Clinic, fixed-site Dental Clinic, a House Calls program providing in-home care to chronically ill patients, a *Promotores de Salud* program offering Spanish-language health and nutrition education and health screenings, and school-based programs providing health and nutrition education and peer support groups.

FY18-FY20 CB Plan Priorities/Implementation Strategies

As a result of the findings of our FY17 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, PVH will focus on the following areas for its FY18-FY20 Community Benefit efforts:

- **Access to Resources:** Ensuring access to affordable, quality health care services is important to protecting both individual and population health, eliminating health disparities and promoting overall quality of life in the community. This includes most barriers to accessing health care services and other necessary resources, such as income, lack of adequate insurance, immigration status, transportation, a shortage of providers and specialists, language barriers, and resources being unavailable outside of working hours.
- **Homelessness and Housing Concerns**: Housing is considered a primary social determinant of health, and the lack of housing or affordable housing contributes to and exacerbates multiple adverse health conditions. Our primary focus will be on the condition of homelessness, including the development of permanent supportive housing, providing health care to homeless individuals, prevention of homelessness, and mitigating its impact on communities. We also intend to partner with other community organizations to address issues of housing affordability, availability, overcrowding, and quality.
- **Mental Health and Substance Use**: Covers all areas of emotional, behavioral, and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious mental health conditions, with a particular focus on trauma-informed community-based prevention and resilience in the face of adverse community experiences. Because the co-occurrence of substance use disorders is so prevalent with those confronting mental health challenges, this priority focus area will also include addressing issues pertaining to the misuse of all drugs, including alcohol, marijuana, methamphetamines, opiates, prescription medication, and other legal or illegal substances.

MISSION, VISION, AND VALUES

Our Mission
To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision
We bring people together to provide compassionate care, promote health improvement and create healthy communities.

Our Values
The four core values of St. Joseph Health – Dignity, Service, Excellence, and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry of the Sisters of St. Joseph of Orange, Petaluma Valley Hospital (PVH) lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out "the dear neighbors" and minister to their needs. The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28-bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

PVH is a community hospital founded in 1980 by the Petaluma Health Care District, and is located in Petaluma, California. St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds and a campus that is 14.63 acres in size. Petaluma Valley Hospital (PVH) has a staff of 501 employees and professional relationships with more than 260 local physicians. PVH is a Leapfrog A-rated facility, a Joint Commission Stroke-Ready certified hospital, has been designated as a Baby-Friendly® Hospital by Baby-Friendly USA, and as a Blue Distinction® specialty care facility by Blue Cross Blue Shield for maternity services. Major programs and services also include emergency care, outpatient surgery, obstetrical services, and pulmonary rehabilitation.

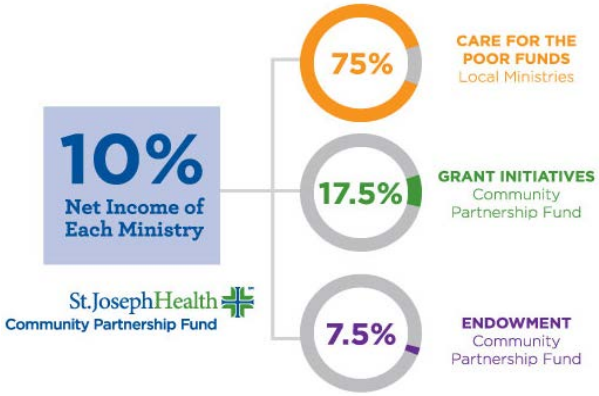
Since joining St. Joseph Health, PVH has established itself as an anchor institution in leading multiple and various community health improvement programs, initiatives, and partnerships aimed at increasing access to care and improving the health and quality of life of the communities we serve. Prominent among these efforts are the provision of free dental care for children at our Mobile Dental Clinic, our Healthy For Life school-based nutrition and health education program, our Your Heart Your Life nutrition education and cooking classes for Spanish-speaking adults, and our House Calls program providing medical care to home bound patients.

ORGANIZATIONAL COMMITMENT

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

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

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



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

Community Benefit Governance and Management Structure

PVH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The

Vice President of Mission Integration and the Community Partnership Manager are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.
The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on CB programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formation of the Santa Rosa Memorial Hospital and Petaluma Valley Hospital Community Benefit Committee. The role of the CB Committee is to support the Board of Trustees in overseeing community benefit issues. The CB Committee is charged with recommending policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and approving the annual Care For The Poor budget.

The CB Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 9 members of the Board of Trustees and 10 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The CB Committee generally meets every other month.

Roles and Responsibilities

Senior Leadership

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

Community Benefit Committee (CBC)

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

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.

- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate emergency department utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community Representatives on the CBC

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

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

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

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

PLANNING FOR THE UNINSURED AND UNDERINSURED

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 PVH has a **Patient Financial Assistance Program** 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.

COMMUNITY

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

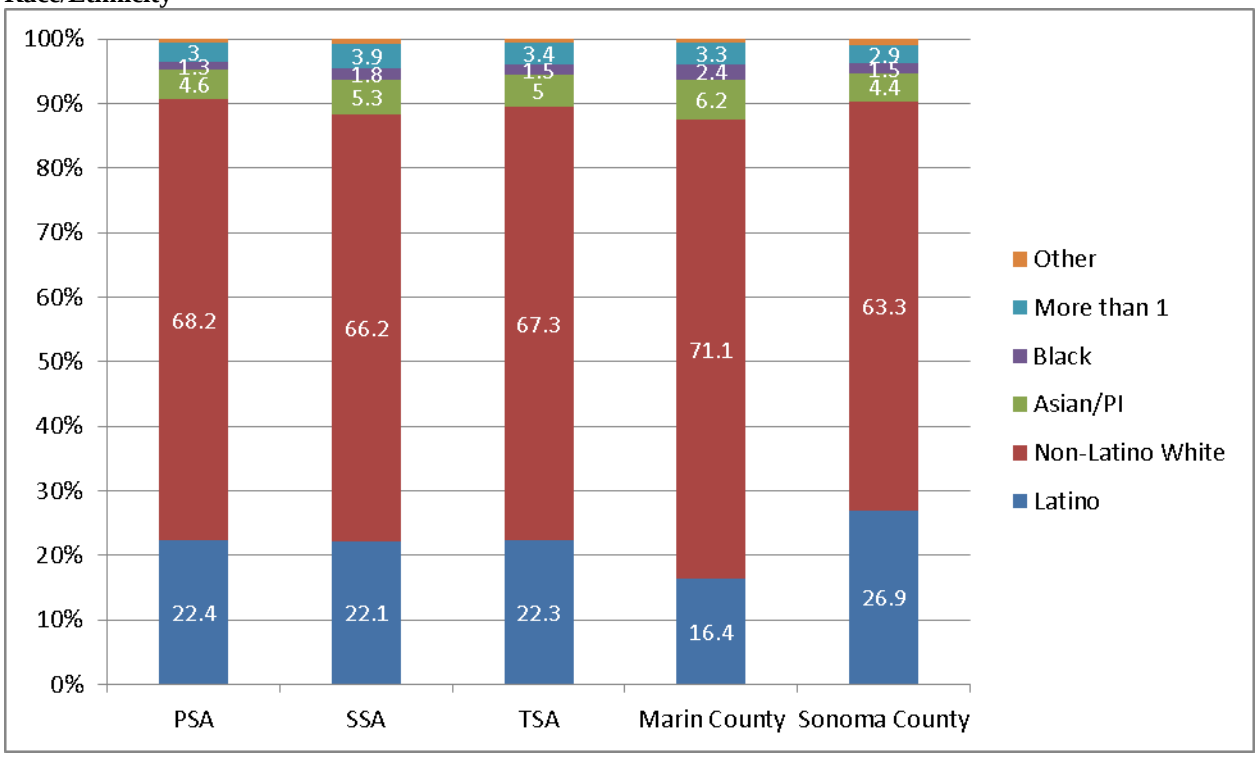
Community Profile
The table and graph below provide basic demographic and socioeconomic information about the Petaluma Valley Hospital Service Area and how it compares to Sonoma and Marin Counties and the state of California. The Total Service Area (TSA) of Petaluma Valley Hospital includes approximately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

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

Service Area Demographic Overview

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

Race/Ethnicity



Hospital Total Service Area

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

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)

- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

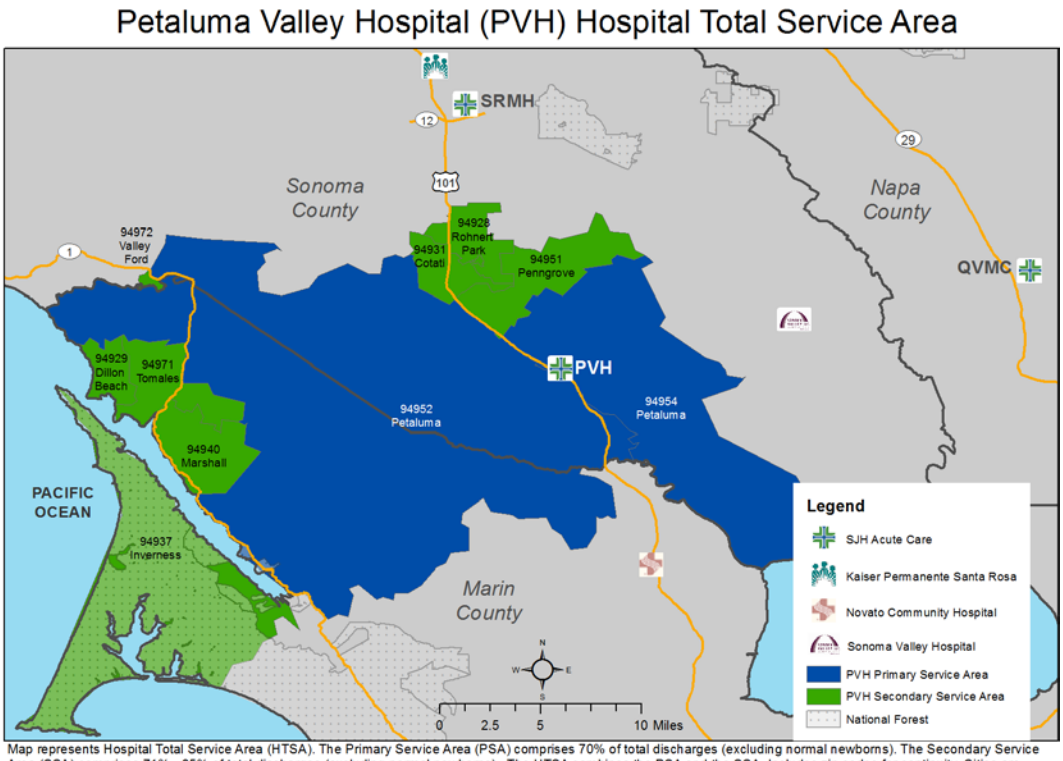
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of the city of Petaluma. The SSA is comprised of the Sonoma County cities of Rohnert Park and Cotati, with a smattering of northwestern Marin towns.

Table 1. Cities and ZIP codes

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

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

Figure 1. PVH Total Service Area



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

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

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

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

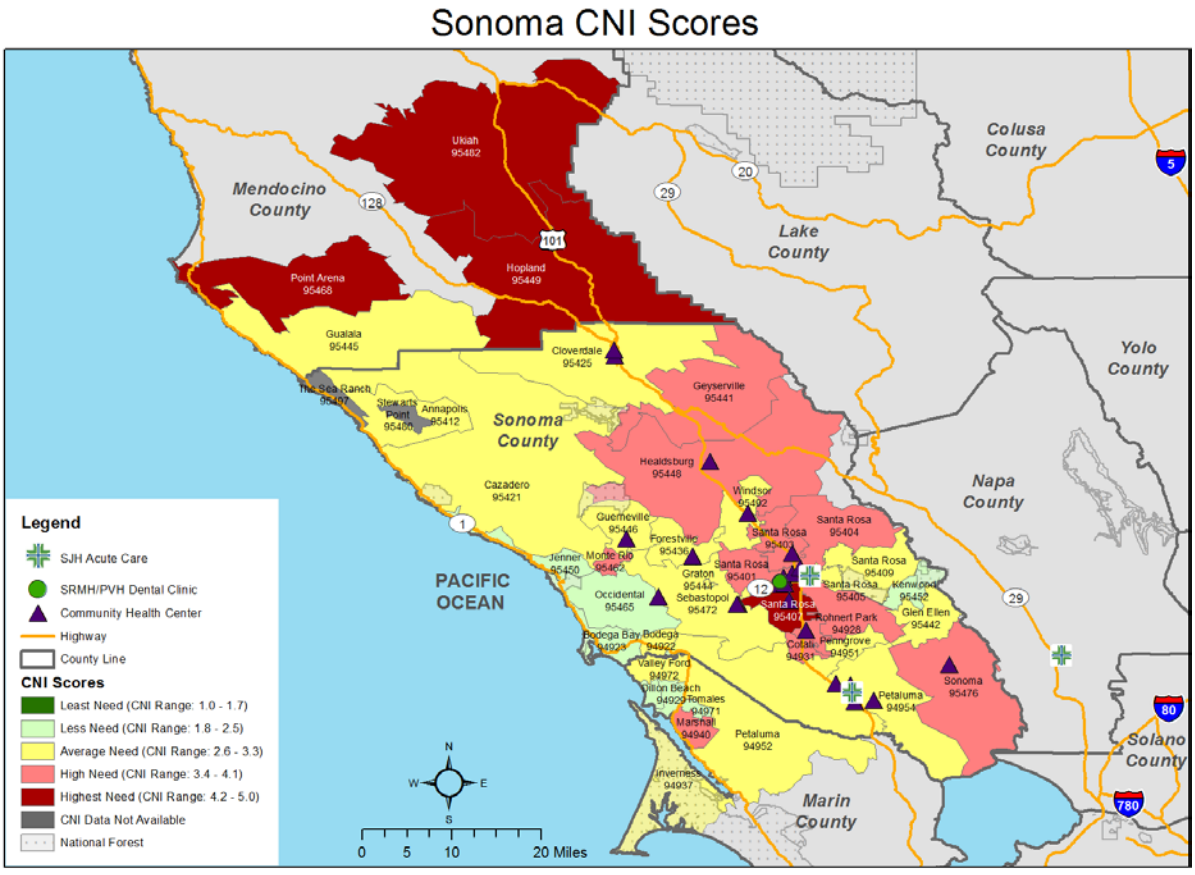
- Income Barriers (Elder poverty, child poverty and single parent poverty);
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

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

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

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

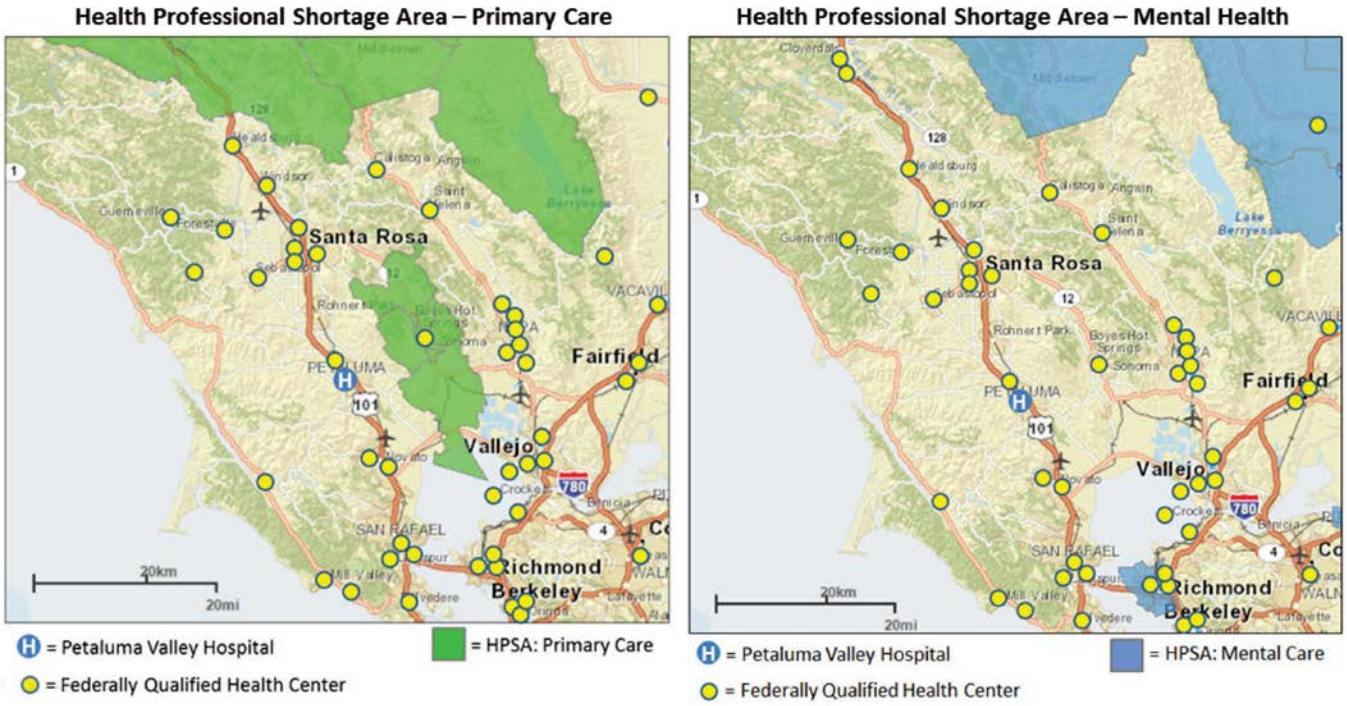


Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); Redwood Community Health Coalition (rchc.net) (accessed Oct. 2016).
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although
PVH is not located in a shortage area parts of the hospital's service area to the north and east are shortage designated, indicating a need for additional primary care physicians. The map below depicts these shortage areas relative to PVH's location.

Figure 3. Petaluma Valley Hospital Health Professions Shortage Area

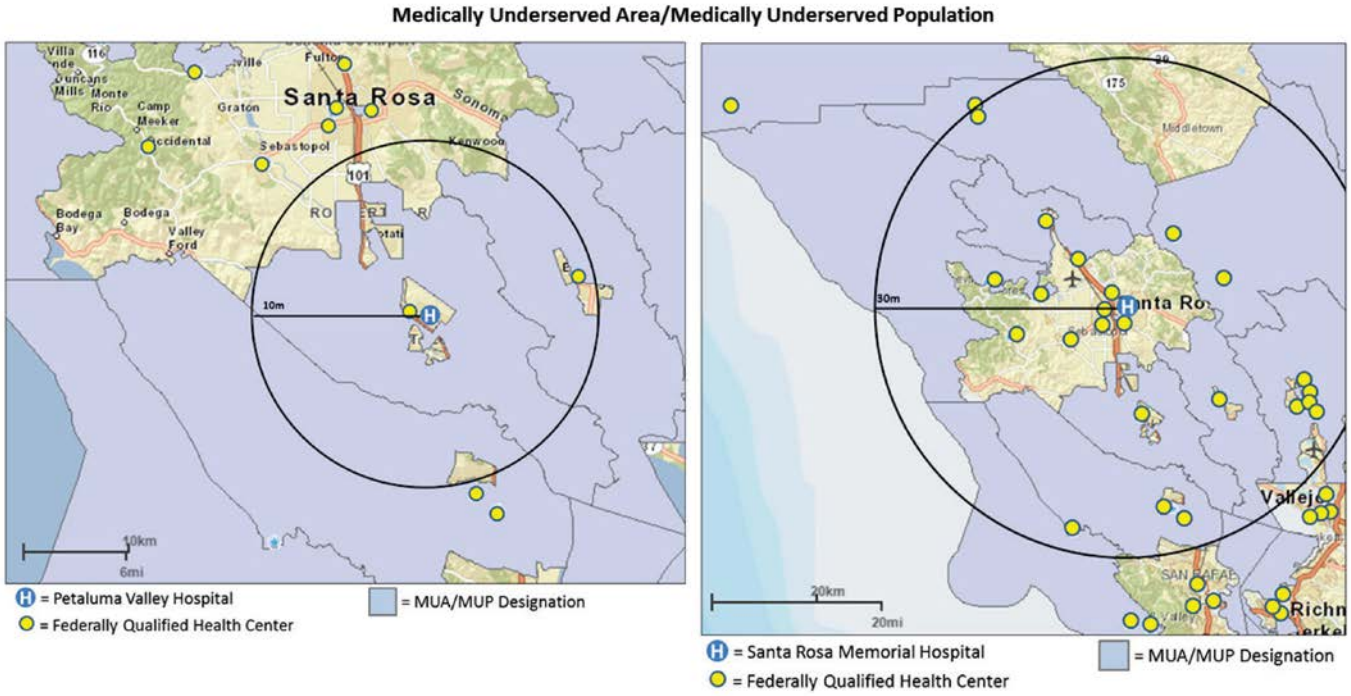


Medical Underserved Area/Medical Professional Shortage Area

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

The map below depicts the Medically Underserved Areas/Medically Underserved within a 30 mile radius from PVH.

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



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

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

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. When data was publicly available,

it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.

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

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

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

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

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

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

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

Secondary Data/Publicly available data

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

Collaborative Partners

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

- Sonoma County Department of Health Services, i.e., County Public Health

- Community Child Care Council (4Cs) of Sonoma County
- First 5 Sonoma County
- Burbank Housing
- Community Foundation Sonoma County
- Sonoma County Sheriff's Office
- City of Santa Rosa Violence Prevention Partnership
- Community Action Partnership of Sonoma
- Sonoma County ACEs Connection
- Sonoma County Economic Development Board
- Sonoma County Permit & Resource Management Department
- Sonoma County Environmental Health & Safety
- Buckelew Programs
- Sonoma County Office of Education
- Sonoma County Community Development Commission
- La Luz Community Center
- Petaluma People Services Center
- Sutter Health
- Kaiser Permanente
- Santa Rosa Community Health Centers
- West County Health Centers
- Petaluma Health Care District
- Petaluma Health Center
- Alliance Medical Center
- Sonoma West Medical Center
- Palm Drive Health Care District
- North Sonoma County Health Care District
- Sonoma Valley Health Care District
- Russian River Area Resources and Advocates
- Community Health Initiative of the Petaluma Area
- Latino Service Providers
- Sonoma County Human Services Department
- Sonoma County Task Force on the Homeless
- Sonoma County Health Care for the Homeless Coalition
- Mendocino County Department of Health & Human Services
- Healthy Mendocino

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a

Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by SRMH. In addition, the findings from the recent Community Building Initiative in Roseland were considered as an additional source.

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

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

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

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

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

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

Identification and Selection of Significant Health Needs

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

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

Prioritization Process and Criteria

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

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

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

- Sustainability of Impact: The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.
- Opportunities for Coordination and Partnership: The likelihood that the ministry could be part of collaborative efforts to address the problem.
- Focus on Prevention: The existence of effective and feasible prevention strategies to address the issue.
- Existing Efforts on the Problem: The ability of the ministry to enhance existing efforts in the community.

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

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

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

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

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

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

Community Health Needs Prioritized

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

The CBC noted that while many adults in Sonoma County are able to obtain insurance coverage and access regular healthcare in the wake of the implementation of the Affordable Care Act (ACA), disparities persist. Specifically, lower income residents have difficulty accessing care, as many remain uninsured due to high premium costs and those with public insurance face barriers to finding providers who accept MediCal. Foreign-born residents who are not U.S. citizens also face stark barriers in obtaining insurance coverage and accessing care. Among those who do have insurance coverage, primary data identified other barriers to accessing care including that there are not enough primary healthcare providers in Sonoma County to meet the high demand. The CBC recognizes this as an ongoing, high-priority need, and one which, given the existing PVH Community Benefit programs (mobile health and dental clinics, fixed-site dental clinic, and in-home care), we are uniquely qualified with appropriate capacity to address.

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

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

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

ranked concerns. Both concerns were raised throughout the community input process and received a high number of votes at the community forum.

Although the data shows a better ratio of population to mental health providers in Sonoma and Mendocino Counties than the state, focus group participants spoke of shortages of providers and services for mental health and substance abuse. In Sonoma County, for instance, many low-income individuals with mental health concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly funded treatment services are significant barriers for many. Furthermore, limited integration of mental health services within the health care system also leads to missing opportunities for early problem identification and prevention. Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health. As a result, the CBC felt that the focus on mental health and substance abuse, i.e., behavioral health, with a particular focus on trauma-informed community-based prevention and resilience in the face of adverse community experiences, was of paramount importance to our ministry and our community.

Needs Beyond the Hospital's Service Program

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

With respect to some of the other needs identified in the CHNA process that were not prioritized for action through this plan, we intend to remain engaged in addressing oral health needs through our ongoing St. Joseph Health Community Dental Clinic and Mobile Dental

Clinic; crime and safety through our continued involvement on the Santa Rosa Violence Prevention Partnership; and insurance and cost of care through our continued involvement on the Covered Sonoma and Sonoma Health Action Community Health Improvement committees. We also intend to incorporate other issues such as early childhood development in our behavioral health strategy as it is such a fundamental determinant of mental health later in life; and economic insecurity in our housing concerns strategy as it is a necessary ingredient in housing affordability. Similarly, with respect to immigration, we lack appropriate expertise or competency to offer a program, but we intend to develop a Medical Legal Partnership with a local Legal Aid organization that will assist residents and patients with immigration issues, among others. And while food and nutrition is not to be directly addressed by our own programming, we anticipate that our ongoing support of local initiatives and organizations involved in cardiovascular disease prevention will include a consideration and inclusion of strategies to address this need.

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

COMMUNITY BENEFIT PLAN

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

Summary of Community Benefit Planning Process

The process used to select the priority community health needs to be addressed by both this SRMH Community Benefit Implementation Strategy as well as the Petaluma Valley Hospital (PVH) Community Benefit Implementation Strategy is described above on pages 15-23. Upon adoption of the CHNA by the SRMH/PVH Community Benefit Committee on June 27, 2017, the Community Benefit Department staff began the process of developing this plan in response to the priority needs identified in the CHNA. These processes was undertaken for the entirety of the combined service areas of SRMH and PVH as St. Joseph Health Sonoma considers these strategies to be interconnected and together are in service to the needs of the entire county and community. This began with the retention of an external consultant to conduct a more detailed study of the behavioral health needs throughout the county. Utilizing this data, the CBC was again tapped in its advisory role to provide its knowledge of the community in developing this

strategy. At the regular meeting of the CBC on August 22, 2017, and again in a smaller subcommittee, the CB staff presented its recommended initial draft of a strategy plan. Incorporating CBC input in subsequent drafts of the plan, staff reviewed the plan and sought input from the SRMH/PVH Population Health Department and the Executive Management Team, as well as from the St. Joseph Health system office staff of the Community Partnership Fund and with staff from the Prevention Institute. This process yielded this final draft plan that was submitted to and approved by the CBC at their meeting on October 24, 2017.

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

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

Goal (anticipated impact): Improve health in the communities served by SRMH and PVH by increasing low-income and vulnerable populations' access to health care and resources.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Percentage of low-income patients who demonstrate health status improvement based on a set of clinical criteria	To be developed during the first quarter of FY18 in consultation with program administrators and clinical staff	To be developed during the first quarter of FY18 in consultation with program administrators and clinical staff	To be developed during the first quarter of FY18 in consultation with program administrators and clinical staff

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Establish new Case Management, Advocacy, Resource Referral, and Education CARE Network program	Number of patients served; number of encounters; percentage demonstrating health status improvement	0	1,000 patients served; 3,000 encounters; 40%	2,000 patients served; 5,000 encounters; 40%
2. SJH Dental programs	Number of patients served; number of encounters; percentage demonstrating health status improvement	9,200 patients served; 14,000 encounters; 75%	9,200 patients served; 15,000 encounters; 75%	9,200 patients served; 16,000 encounters; 75%
3. House Calls program	Number of patients served; number of encounters; percentage	150 patients served; 7,000 encounters;	165 patients served; 7,700 encounters;	175 patients served; 8,000 encounters;

	maintaining health status and comfort as chronic/terminal conditions persist/progress	75%	75%	75%
4. Mobile Health Clinic	Number of patients served; number of encounters; percentage demonstrating health status improvement and/or linkage to medical home for ongoing care	1,500 patients served; 3,200 encounters; 50%	1,600 patients served; 3,500 encounters; 50%	1,700 patients served; 3,800 encounters; 50%

Key Community Partners: Santa Rosa Community Health, Petaluma-Rohnert Park Health Centers, West County Health Centers, Alliance Health Center, Catholic Charities, Community Action Partnership, County of Sonoma Department of Health Services, Petaluma People Services Agency, Redwood Community Health Coalition

2. Initiative/Community Need being Addressed: Behavioral Health

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

Outcome Measure	Baseline	FY18 Target	FY20 Target
A composite metric to measure improvement in community behavioral health and health equity will be developed during the first quarter of FY18 in consultation with community partners, County Behavioral Health leaders, and behavioral health program administrators and clinicians.	A baseline for this metric will also be developed in the first quarter of FY18	Targets for this metric will also be developed in the first quarter of FY18	Targets for this metric will also be developed in the first quarter of FY18

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Convene and support	Number of partners	0; 0	10 partners	25 partners

a Sonoma County Behavioral Health Collaborative (BHC), a strategic local coalition of partners to coordinate services, to advocate for policy change, and to develop and launch community collaborative initiatives to address community determinants of behavioral health	engaged in the BHC; number of meetings of the BHC		engaged; 4 meetings held	engaged; 6 meetings held
2.Develop new and/or advance existing community initiatives focused on trauma-informed care and/or upstream community-based prevention strategies and interventions	Number of community initiatives developed and/or advanced	0	3	6
3.Evaluate the Circle of Sisters program to determine its effectiveness, to assess its ability to include ACEs and trauma-informed elements in its curriculum, and to assess the necessity/desirability of continuing the program	Findings from formal program evaluation.	Program serves 175 student-participants	To be developed based on findings and conclusions from formal program evaluation.	To be developed based on findings and conclusions from formal program evaluation.
4.Establish new CARE Network program to include psychiatric resource liaisons and behavioral health specialists	Number of patients served; number of encounters; percentage demonstrating behavioral health status improvement	0	800 patients served; 2,000 encounters; 40%	1,500 patients served; 4,000 encounters; 40%

Key Community Partners: ACEs Connection, Restorative Justice Collaborative, Sonoma County Human Services Dept., Sonoma County Dept. of Health Services, NAMI Sonoma, Buckelew Programs, CAP Sonoma, Sonoma County Office of Education, Nurse Family Partnership, Sonoma County Wellness Arts

Collaborative, Petaluma Health Care District, Redwood Community Health Coalition and multiple FQHCs, Drug Abuse Alternative Center (DAAC), multiple school districts

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

Goal (anticipated impact): The overall intent of this strategy is to reduce the number of homeless and improve their health. A more precise goal statement and outcome measure will be developed during the first quarter of FY18 in consultation with Sonoma County homeless service providers, affordable housing developers, the Continuum of Care Board, and County Community Development Commission leaders and staff.

Outcome Measure	Baseline	FY18 Target	FY20 Target
To be developed in the first quarter of FY18 as described above	To be developed in the first quarter of FY18 as described above	To be developed in the first quarter of FY18 as described above	To be developed in the first quarter of FY18 as described above

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Mobile Health Clinic targeting homeless clients and shelters	Number of homeless patients served; number of encounters	500 patients served; 1,500 encounters	500 patients served; 1,500 encounters	500 patients served; 1,500 encounters
2.Continue support of expansion of Project Nightingale (homeless medical respite Program)	Expanded number of beds for Project Nightingale patients	26 beds in two locations; 13 low acuity, 13 higher acuity	Expand number of higher acuity beds by 11 at new location in Palms Inn permanent supportive housing project	Maintain new 37-bed capacity and add regular medical case management services for all Project Nightingale patients
3. Promote development of permanent supportive housing (PSH) project(s)	Number of new PSH units/beds created	119 PSH units; 690 PSH beds	10% increase over baseline	30% increase over baseline
4.Convene and support the Health Care for the Homeless Collaborative (HCHC)	Development of new HCHC implementation project	No current HCHC implementation project underway	One HCHC implementation project completed during the year	One HCHC implementation project completed during the year

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

Other Community Benefit Programs

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
1. Community Building	NEIGHBORHOOD CARE STAFF (NCS)	The NCS program serves as the community outreach and engagement arm of the SRMH Community Benefit Department. NCS staff engage community resident leaders and agency partners to address local community health and quality of life issues, facilitate community conversations and planning, support collaborative initiatives, and drive policy and program development emerging from these efforts.	Broader Community
2. Healthy Eating, Active Living	PROMOTORES DE SALUD	The Promotores de Salud program bridges language and culture with the local Latino population, providing health information and referrals, conducting cooking, nutrition and "Your Heart Your Life" classes, and training community volunteer health promoters in heart health.	Broader Community
3. Healthy Eating, Active Living	HEALTHY FOR LIFE	Healthy for Life is a school-based physical activity and nutrition program targeting schools in low-income neighborhoods. The program builds school capacity to support healthy eating and physical activity among its students.	SERVICES FOR THE POOR

Evaluation Plan
The Community Benefit staff conducts annual surveys of program participants and compile and report on quantitative data related to program performance. These reports are reviewed by the CBC and published annually on the SJH Sonoma website.

Appendix

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social or Community Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in

which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines).

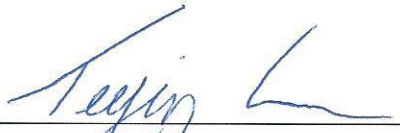
Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.

GOVERNANCE APPROVAL

This Community Benefit Plan/Implementation Strategy Report was approved at the October 24, 2017 meeting of the Santa Rosa Memorial Hospital Community Benefit Committee, a sub-Committee of the Board of Trustees.



Community Benefit Committee Chair's Signature confirming approval of Petaluma Valley Hospital FY18-20 Community Benefit Plan/Implementation Strategy Report

10-24-17

Date