

2024 - 2026

COMMUNITY HEALTH IMPROVEMENT PLAN

Healdsburg Hospital

Healdsburg, CA



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

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Sonoma County through Healdsburg Hospital. Healdsburg Hospital is a critical-access hospital founded in 1905 and located in Healdsburg, CA. The hospital's service area is the entirety of Sonoma County, including about 492,000 people.

Healdsburg Hospital dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. The Community Health Needs Assessment (CHNA) is an opportunity for Healdsburg 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: state and national public health data, and qualitative data from interviews with community key informants and listening sessions with community members.

Healdsburg Hospital Community Health Improvement Plan Priorities

As a result of the findings of our [2023 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Healdsburg Hospital will focus on the following areas for its 2024-2026 Community Benefit efforts:

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

Publicly available data, along with Providence hospitalization data, show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care. Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members and caregivers all shared that lack of behavioral health and substance use services was a major barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox were also commonly voiced needs. Data showed particular concern for youth.

ACCESS TO HEALTH CARE AND DENTAL SERVICES

Fewer people saw a primary care doctor or dentist over the past year in 2022. This trend coupled with qualitative data expressing lack of primary, medical and dental providers highlighted lack of appropriate level of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

HOMELESSNESS AND HOUSING INSTABILITY

Over 25% of Sonoma County is experiencing severe house cost burden, spending 50% or more of their household income on housing. Additionally, over 2800 individuals were found to be experiencing homelessness in 2022. Most Key Informants identified the need for additional permanent supportive housing, housing accepting housing vouchers, affordable housing and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

AGING ISSUES

There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. Older adults experiencing homelessness and housing instability as well as mental health issues due to isolation is on the rise in Sonoma County. A lack of providers with experience with geriatric conditions is of concern.

RACISM AND DISCRIMINATION

While the need area “Racism and Discrimination” was not voted as a top priority by our Community Benefit Committee, the Committee and Community Health Investment department recognize that racism and discrimination was a crosscutting theme and root cause among all prioritized needs areas and will be specifically addressed in each prioritized need area as outlined by our Community Health Improvement Plan.

INTRODUCTION

Who We Are

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

Healdsburg Hospital is a critical-access hospital founded in 1905 and located in Healdsburg, CA. The hospital has 43 licensed beds, and a staff of roughly 300 employees. Major programs and services offered to the community include 24/7 emergency department, critical care, acute rehab, behavioral health, women’s health, and orthopedics. The hospital is certified as a Medicare Critical Access Hospital (CAH) provider and is also a certified stroke center.

Our Commitment to Community

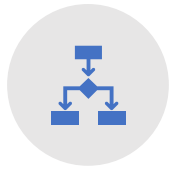
Healdsburg Hospital dedicates resources to improve the health and quality of life for the communities we serve. For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: <https://www.providence.org/about/annual-report>.

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

Planning for the Uninsured and Underinsured

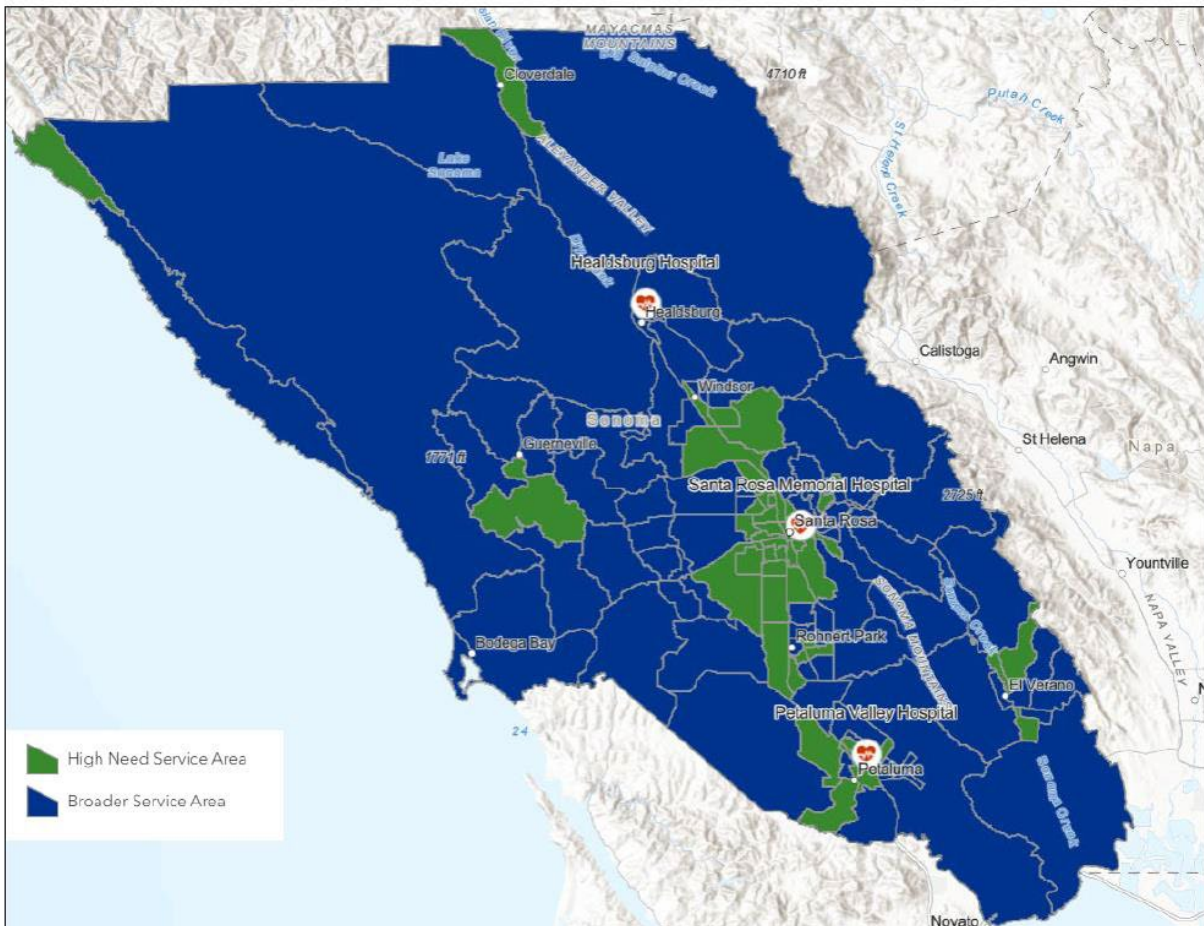
Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Healdsburg Hospital has a Financial Assistance Program (FAP) that provides free or discounted services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

One way Healdsburg Hospital 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

Healdsburg Hospital’s service area is Sonoma County and includes a population of approximately 492,000 people.



To facilitate identifying health disparities and social inequities by place, we designated a “high need” service area and a “broader” service area, which together make up the Sonoma County Service Area. Based on work done by the Public Health Alliance of Southern California and their [Healthy Places Index \(HPI\)](#) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.¹

¹ The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in [Limited English](#)

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The following population demographics for Sonoma County are from the 2021 American Communities Survey 5-year estimates. 50.9% of people living in Sonoma County are female, and 49.1% are male. The high need service area predominantly houses a younger population, with individuals under the age of 55 being more prevalent. Conversely, the broader service area tends to host a higher proportion of older adults aged 55 and above. This demographic distribution may be attributed partially to the prevalence of secondary and/or vacation homes.

POPULATION BY RACE AND ETHNICITY

In Sonoma County, there are noticeable disparities in the distribution of racial and ethnic groups across different census tracts. The 'other race' population is notably overrepresented in high-need census tracts compared to the county's overall population. Conversely, individuals who identify as white are less likely to reside in high-need communities.

Additionally, there is a significant overrepresentation of individuals identifying as Hispanic in high-need communities, constituting nearly 38% of the population in those areas, compared to just under 20% in the broader service area. In Sonoma County, approximately 6.5% of the population are veterans, slightly higher than the 4.8% in the state of California.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Sonoma County Service Area

Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
Median Income Data Source: 2021 American Community Survey, 5-year estimate	\$117,926	\$77,152	\$90,867	\$83,226
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2021 American Community Survey, 5-year estimate	25.4%	27.9%	25.0%	26.3%

Household median incomes includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

[Households](#) (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

The broader service area has a median income of \$117,926, which is \$27,059 greater than Sonoma County and \$40,774 greater than the high need service area.

Severe housing cost burden is defined as renter households that are spending 50% or more of their income on housing costs. About 25% of households in Sonoma County are severely housing cost burdened, which is slightly lower than the state of California overall.

In the high need service area, about 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 [2023 CHNA](#) for Healdsburg Hospital.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

In our Community Needs Assessment Process, we employed a mixed-methods approach, integrating both quantitative and qualitative data. Data was collected from various reliable sources, including the American Community Survey, Behavioral Risk Factor Surveillance System, local public health databases, and public health datasets focusing on health behaviors, morbidity, and mortality.

To ensure active community engagement, we collaborated with On the Margins, Inc. to facilitate three listening sessions. These sessions were specifically designed to gather insights from individuals with chronic conditions, diverse backgrounds, low-income backgrounds, and those who are medically underserved. Additionally, we conducted 14 key informant interviews with representatives from organizations serving these populations. Through these interviews, our aim was to delve deeper into understanding community strengths and opportunities.

Some key takeaways include the following:

- Lack of affordable housing with increased barriers for those with disabilities, older adults, and the BBPIOC community.
- Limited access to and availability of behavioral health and substance use services.
- Limited access to primary and specialty medical care providers.
- Economic insecurities with increased barriers related to racism and discrimination.
- Strengths included community resiliency and community-based organization collaboration.

Significant Community Health Needs Prioritized

The list below summarizes the rank-ordered significant health needs identified through the 2023 Community Health Needs Assessment process:

BEHAVIORAL HEALTH AND SUBSTANCE USE



Publicly available data, along with Providence hospitalization data, show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care. Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members, and caregivers all shared that lack of behavioral health and substance use services was a major barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox were also commonly voiced needs. Data showed particular concern for youth.

HOMELESSNESS AND HOUSING INSTABILITY



Over 25% of Sonoma County is experiencing severe housing cost burden, spending 50% or more of their household income on housing. Additionally, over 2800 individuals were found to be experiencing homelessness in 2022. Most Key Informants identified the need for additional permanent supportive housing, housing accepting housing vouchers, affordable housing, and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

ACCESS TO HEALTH AND DENTAL CARE



Fewer people saw a primary care doctor or dentist over the past year in 2022. This trend coupled with qualitative data expressing lack of primary, medical and dental providers highlighted lack of appropriate level of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

AGING ISSUES



There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. Older adults experiencing homelessness and housing instability, as well as mental health issues due to isolation, is on the rise in Sonoma County. A lack of providers with experience with geriatric conditions is of concern.

RACISM AND DISCRIMINATION



While the need area “Racism and Discrimination” was not voted as a top priority by our Community Benefit Committee, the Committee, and Community Health Investment department recognize that racism and discrimination was a crosscutting theme and root cause among all prioritized needs areas and will be specifically addressed in each prioritized need area as outlined by our Community Health Improvement Plan as indicated by.

Needs Beyond the Hospital’s Service Program

While hospitals play a vital role in addressing community health needs, it is recognized that no single facility can comprehensively tackle all health challenges within its locality. At Healdsburg Hospital, we remain steadfast in our mission by fostering collaborations with community organizations to augment our efforts.

The following community health needs identified in the ministry CHNA will not be addressed and an explanation is provided below:

- **Economic Insecurity:** Economic insecurity affects many other needs, including educational opportunities, food resources, employment, transportation, and physical and mental health. While Economic Insecurity was an identified significant need, Providence Community Health Investment Sonoma County lacks an effective method of intervention. However, systemic

impacts of economic insecurity are identified and addressed through the chosen priority need areas outlined in this document.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2024-2026 Community Health Improvement Plan (CHIP) is designed to address the needs identified and prioritized through the 2023 Community Health Needs Assessment (CHNA). We recognize the greatest needs of our community will change over time, and we are dedicated to adapting our efforts accordingly. Our commitment remains steadfast in supporting, strengthening, and serving our community in alignment with our Mission, utilizing our expertise, and maximizing the impact of Community Benefit resources.

The Healdsburg Hospital CHIP process was led by the Senior Manager of Community Health Investment and the Community Health Investment staff with review and approval from the Community Benefit Committee. Strategies outlined in the CHIP encompass a diverse array of approaches, including direct service programming goals, support for community organizations, and collaborative commitments aimed at addressing the identified priority need areas.

While Racism and Discrimination was not designated as a standalone priority area, the Community Benefit Committee made a deliberate decision to incorporate strategies addressing the needs of the Black, Brown, Indigenous, and People of Color (BBIPOC) community and those most likely to experience discrimination within each priority area. This acknowledgment underscores our commitment to addressing health disparities and promoting equity across all facets of our community health initiatives.

Addressing the Needs of the Community: 2024- 2026 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: BEHAVIORAL HEALTH AND SUBSTANCE USE

Long-Term Goal(s)/ Vision

To reduce substance use disorders (SUD) and mental health conditions through evidence-based and community-led prevention, treatment, and recovery support services that are equitable, high-quality, culturally responsive, and linguistically appropriate, especially for populations with low incomes.

Table 2. Strategies and Strategy Measures for Addressing Behavioral Health and Substance Use

Strategy	Population Served	Strategy Measure	Baseline	2026 Target
1. Leveraging partnerships between the Mobile Health Clinic and behavioral health community-based organizations (CBOs) Providence Program: Mobile Health Clinic	Unhoused, rural communities, seniors, undocumented, and BBIPOC population experiencing behavioral and substance use disorders	# of outreach sites in conjunction with behavioral health outreach programs	2 sites in North County	Add 1 additional site in collaboration with CBOs
2. Connect patients to Medication-Assisted Treatment (MAT) programs through substance use navigation Providence Program: CARE Network	Hospital emergency department and admitted patients experiencing substance use disorders	Number of encounters # of patients connected to MAT treatment	2023 = 264 encounters 2023 = Estimated 84 patients connected to MAT	15% increase in encounters 15% increase in patients connected to MAT program
3. Provide comprehensive case management to high-risk and severe and persistent mental illness population through Enhanced Care Management (ECM) Providence Program: CARE Network (CN)	Patients identified by CN or referred through Partnership HealthPlan as having a behavioral health diagnosis and are at risk of homelessness	# of patients enrolled in ECM % of enrolled ECM patients screened for depression with the PHQ-9	2023 = 34 patients enrolled 5% screened with PHQ-9 (Q4 2023)	Work in coordination with care partners and organizations to increase county-wide ECM enrollment by 10% 90% of patients screened
4. Administer county-wide community grants to CBOs addressing behavioral health and substance use disorder*	Vulnerable populations, unhoused, rural communities, seniors, undocumented, BBIPOC, uninsured/underinsured	25% of grant funds invested in programs to address behavioral health (BH) and	2023 = 20% of grant dollars invested in BH and SU	25% of grant dollars invested in BH and SU

		substance use (SU)		
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* Indicates a strategy focused on addressing Racism and Discrimination

Evidence Based Sources

- Emergency Department Access to Buprenorphine for Opioid Use Disorder
- Bridge to Treatment
- CalAIM ECM Fact Sheet

Resource Commitment

Healdsburg Hospital is dedicated to addressing the behavioral health and substance use needs of our community through various programs and initiatives.

Mobile Health Clinic

The Providence Mobile Health Clinic will allocate staff time to provide essential services to populations facing challenges in accessing healthcare. These services will be tailored to meet the unique needs of individuals struggling with behavioral health and substance use disorders.

We recognize the importance of collaboration in expanding access to behavioral health and substance use services. Therefore, our Mobile Health Clinic will actively seek opportunities to partner with both internal and external providers in the community. By leveraging existing relationships and trust within the community, we aim to enhance and diversify the range of services available.

CARE Network’s Enhanced CARE Management Team

The CARE Network's Enhanced Care Management (ECM) team remains committed to providing comprehensive case management to individuals grappling with behavioral health and substance use disorders. This includes both acute care interventions, such as Substance Use Navigation and Medication Assisted Treatment Connection, as well as outpatient support. ECM, a statewide Medi-Cal benefit, offers wrap-around care management to address the complex social and medical needs of its members. In Sonoma County, ECM extends its outreach to populations experiencing homelessness, behavioral health issues, substance use disorders, and other social determinants of health that hinder quality of life and overall health outcomes.

Key Community Partners

- Alexander Valley Health Center
- Alliance Medical Center
- Buckelew Programs
- California ED Bridge
- Community Support Network
- County of Sonoma, Department of Health Services

- Health Care Foundation of Northern Sonoma County
- Kaiser Permanente, North Bay
- La Familia Sana
- Mother’s Care
- NAMI Sonoma
- Partnership Health Plan of California
- Santa Rosa Community Health
- Sonoma County Indian Health Project
- Sutter Health, North Bay
- West County Health Center

COMMUNITY NEED ADDRESSED #2: ACCESS TO HEALTH AND DENTAL CARE

Long-Term Goal(s)/ Vision

To improve access to equitable and culturally responsive health care and preventive resources for people with low incomes and those underinsured by deploying programs to assist with navigating the health care system. This will ease the way for people to access the appropriate level of care at the right time.

Table 3. Strategies and Strategy Measures for Addressing Access to Health and Dental Care

Strategy	Population Served	Strategy Measure	Baseline	2026 Target
1. Engage high-risk individuals with CARE Network’s (CN) complex care management and Enhanced Care Management teams to increase access to health care Providence Program: CARE Network	High risk individuals with complex socioeconomic and chronic conditions, especially patients with an identified social determinant of health need, including substance use disorder	# of individuals enrolled with CN	2023 = 1,129 individuals were served by CARE Network teams	Increase enrollment to 1,500 patients enrolled per year
2. Provide Community Health Worker services, including screenings, education, navigation, and	Low-income adult community members of the public, primarily	# of encounters	2023 = 319 encounters in North County	Commit to continue the provision of these services to the benefit

advocacy for BBIPOC and vulnerable populations* Providence Program: Promotores de Salud	Latino/a populations			of the community
3. Provide dental care to un- and underinsured patients through Providence Mobile Dental Clinic* Providence Program: Dental – Mighty Mouth	Uninsured and underinsured adults including unhoused and those who identify as having developmental disabilities, MediCal pediatric population	# of mobile dental sites in North County	2023 = 3 sites	Add 1 site in North County
4. Provide primary care and linkages to medical homes for un- and underinsured patients through Providence Mobile Health Clinic with the goal of reducing avoidable emergency department visits* Providence Program: Mobile Health Clinic	Low-income, uninsured, under-insured, undocumented, unhoused, or other vulnerable populations	# of mobile health sites in North County	2023 = 3 sites in North County	Add 1 site in North County

* Indicates a strategy focused on addressing Racism and Discrimination

Evidence Based Sources

- [The Six Pillars of Community Health Workers](#)
- [Effect of Oral Health on the Community](#)
- [Mobile Health Clinics in the Unites States](#)

Resource Commitment

Healdsburg Hospital is deeply committed to enhancing access to health and dental care in our community through various initiatives and partnerships. Through these initiatives, Healdsburg Hospital endeavors to bridge the gap in access to health and dental care, promoting the overall health and vitality of our community.

Community Health Worker Program

Our community health worker program, known as Promotores de Salud, plays a pivotal role in providing free culturally responsive screenings and health education. Through site visits and health fairs, these dedicated individuals cater to the needs of Latino and other vulnerable populations, ensuring equitable access to essential health services.

CARE Network and Enhanced Care Management

The CARE Network and Enhanced Care Management team delivers comprehensive case management services in both English and Spanish. By addressing social determinants of health needs and providing chronic disease management support, they strive to enhance the well-being of individuals requiring specialized assistance.

Staff and Grant Allocation

To address gaps in access to care, Healdsburg Hospital will allocate staff from its Community Health Investment department and leverage grants to support targeted interventions.

Key Community Partners

- Aliados Health
- Alexander Valley Healthcare
- Alliance Medical Center
- Botanical Bus
- Buckelew Programs
- Burbank Housing
- Ceres Community Project
- Corazón Healdsburg
- County of Sonoma, Department of Health Services
- Give Kids a Smile
- Healdsburg Day Labor Center
- Healdsburg Unified School District
- Healthcare Foundation of Northern Sonoma County
- Humanidad Therapy and Education Services
- Kaiser Permanente, North Bay
- Legal Aid of Sonoma County
- NAMI Sonoma
- North Bay Children's Center
- North Sonoma County Healthcare District
- Nuestra Comunidad

- On the Margins
- Operation Access
- Reach for Home
- Santa Rosa Community Health
- Santa Rosa Junior College
- Sonoma County Public Health
- Sutter Health, North Bay
- The Key Private Duty Caregiving
- Windsor Unified School District

COMMUNITY NEED ADDRESSED #3: HOMELESSNESS AND HOUSING INSTABILITY

Long-Term Goal(s)/ Vision

A sufficient supply of safe, affordable, and equitable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs. A coordinated and holistic community approach to providing increased linkages to supportive services for people experiencing homelessness.

Table 4. Strategies and Strategy Measures for Addressing Homelessness and Housing Instability

Strategy	Population Served	Strategy Measure	Baseline	2026 Target
1. Invest in the maintenance and expansion of existing recuperative beds and services	Individuals experiencing homelessness, including older adults	# of recuperative beds	2023 = contributed to 44 recuperative beds	Commit to funding that maintains the operation at full capacity of recuperative care programs
2. Prioritize funding towards homelessness prevention and service navigation	Individuals experiencing homelessness and those at risk of homelessness, including families, BBIPOC, transitional-age youth, and older adults	Amount invested	No contributions made in 2023	25% of grant dollars invested in homelessness prevention and service navigation in North County
3. Provide comprehensive case management to unhoused	Patients identified by CN or referred through	# of patients enrolled in CN's ECM program	35% of individuals referred are unhoused	Work in coordination with care partners and organizations to

population through Care Network's (CN) Enhanced Care Management (ECM) program Providence Program: CARE Network	Partnership HealthPlan as being unhoused or at risk of homelessness			increase county-wide ECM enrollment by 10%
4. Provide support to community-based organizations (CBOs) focused on advocating for housing initiatives with the goal of increasing the supply and affordability of homes in Sonoma County*	Current and future Sonoma County residents	Amount invested # of endorsements	\$250,000 in 2023 0 endorsements	Commit to continue funding to CBOs focused on housing policy advocacy Increase endorsements related to housing policy and supply

* Indicates a strategy focused on addressing Racism and Discrimination

Evidence Based Sources

- [County of Sonoma 2022 Point-in-Time Count Results](#)
- [National Institute for Medical Respite Care - National Institute for Medical Respite Care](#)
- [State of Housing in Sonoma County 2023 Report](#)

Resource Commitment

Healdsburg Hospital is committed to addressing homelessness and housing instability in our community through targeted initiatives and collaborations.

Enhanced Care Management Program

Our Community Health Investment's CARE Network team will allocate dedicated staff time to work with the identified population of "Chronically Homeless" individuals within the Enhanced Care Management program. This initiative, in partnership with Partnership Health Plan, aims to increase enrollment and enhance support for individuals experiencing chronic homelessness.

Support for Respite Shelters

Community Health Investment will continue to provide vital support to Project Nightingale and Committee on the Shelterless (COTS) respite shelters. This commitment ensures the provision of safety and support for individuals transitioning out of hospital care and facing housing insecurity.

Medical Legal Partnership

In addition to supporting shelter initiatives, Community Health Investment will continue funding for our Medical Legal Attorney program. This initiative provides free legal services to our most vulnerable community members who are often at risk of discrimination, contributing to efforts to address systemic barriers to housing stability.

Providence Government Affairs

Community Health Investment will work in collaboration with Providence Government Affairs leadership to identify appropriate endorsements related to aligned housing policy and advocacy efforts in Sonoma County.

Key Community Partners

- Burbank Housing
- Catholic Charities of the Diocese of Santa Rosa
- Committee on the Shelterless (COTS)
- Community Support Network
- County of Sonoma, Community Development Commission
- Generation Housing (Gen H)
- HomeFirst
- Kaiser Permanente, North Bay
- Legal Aid of Sonoma County
- The Living Room Center, Inc.
- Reach for Home
- Sonoma County Continuum of Care
- Sutter Health, North Bay

COMMUNITY NEED ADDRESSED #4: AGING ISSUES

Long-Term Goal(s)/ Vision

To provide direct services and funding to address unique needs of vulnerable older adults in Sonoma County, including transportation, healthcare, resource navigation, and in-home support services.

Table 5. Strategies and Strategy Measures for Addressing Aging Issues

Strategy	Population Served	Strategy Measure	Baseline	2026 Target
1. Support community -based organizations through grants and partnerships to increase transportation access	Older adults (60 and over) who are most at risk for experiencing access barriers	# of grants and amount of dollars invested	0 transportation-related grants in 2023	Administer 1 transportation-related grant in North County
2. Serving seniors through direct service programs Providence Program: Mobile Health Clinic	Older adults (60 and over) who are most at risk for experiencing access barriers	# of senior housing or resource sites	0 senior sites in North County	Add 1 senior site in North County
3. Private duty caregiving	Older adults unable to perform activities of daily living independently	% of seniors served through caregiving contract annually	2023 = 76% of patients receiving private duty caregiving are 60 years or older	Maintain services to at least 70% of eligible patients
4. Administer community grants to address aging issues	Older adults in Sonoma County	# of grants and amount of dollars invested	No contributions made in 2023	Administer 2 grants that address aging issues in North County

Evidence Based Sources

- [Sonoma County Area Agency on Aging 2020-2024 Area Plan](#)
- [AAA Needs Assessment](#)
- [Master Plan for Aging](#)

Resource Commitment

Healdsburg Hospital is committed to supporting the health and well-being of older adults in our community through targeted initiatives and strategic partnerships. Through these commitments, Healdsburg Hospital aims to enhance the quality of life and promote the independence of older adults, ensuring they receive the necessary support and resources to age with dignity.

Direct Service Programming

Through our Community Health Investment department, Healdsburg Hospital will dedicate staff resources to support direct service programming, including initiatives such as the Mobile Health Clinic and CARE Network for healthcare services and navigation for adults over 60.

"We Care" Fund


Community Health Investment allocates budgeted funding to the "We Care" fund, which is dedicated to providing Private Duty Caregiving services for community members, with a particular focus on older adults. This initiative aims to support older adults who are unable to perform activities of daily living independently, enabling them to remain healthy and independent at home while awaiting long-term care solutions.


Key Community Partners


- AgeWell PACE
- Alliance Medical Center
- Alexander Valley Healthcare
- Area Agency on Aging
- Council on Aging
- Emergency Prep Help
- Legal Aid of Sonoma County
- Petaluma People Services
- Reach for Home
- The Key Private Duty Caregiving

2024- 2026 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Benefit Committee of the hospital on April 15, 2024. The final report was made widely available by May 15, 2024.

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Date
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Providence

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Chair, Petaluma Valley Hospital and Healdsburg Hospital Community Benefit Committee

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