St. Joseph Health, Santa Rosa Memorial Hospital

Fiscal Year 2015 COMMUNITY BENEFIT REPORT
PROGRESS ON FY15 - FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT
# TABLE OF CONTENTS

**EXECUTIVE SUMMARY** 3  
**MISSION, VISION AND VALUES** 3  
**INTRODUCTION – WHO WE ARE AND WHY WE EXIST** 7  
**ORGANIZATIONAL COMMITMENT** 8  
Community Benefit Governance and Management Structure  
**PLANNING FOR THE UNINSURED AND UNDERINSURED** 10  
**COMMUNITY** 11  
Defining the Community  
**COMMUNITY NEEDS & ASSETS ASSESSMENT PROCESS AND RESULTS** 20  
Summary of Community Needs and Assets Assessment Process and Results 20  
Identification and Selection of DUHN Communities 20  
Priority Community Health Needs 23  
**COMMUNITY BENEFIT PLANNING PROCESS** 25  
Summary of Community Benefit Planning Process 25  
Addressing the Needs of the Community:  
FY15 – FY17 Key Community Benefit Initiatives and Evaluation Plan 28  
Other Community Benefit Programs and Evaluation Plan 39  
**FY15 COMMUNITY BENEFIT INVESTMENT** 42  
Governance Approval 43
EXECUTIVE SUMMARY

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
St. Joseph Health, Santa Rosa Memorial Hospital (SRMH), founded by the Sisters of St. Joseph of Orange, has been serving the healthcare needs of families in the community for more than 60 years. During this time, its mission has remained the same: to continually improve the health and quality of life of people in the communities served. Part of a larger healthcare system known as St. Joseph Health (SJH), SRMH is part of a countywide ministry 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 Petaluma Valley Hospital (PVH), an 80-bed acute care hospital, and SRMH, a full service, state of the art 278-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 cardiac care, critical care, diagnostic imaging, and a wide range of specialty services, emergency medicine and obstetrics.

Community Benefit Investment
During fiscal year 2015 (FY15), SRMH invested a total of $42,978,865 in community benefit, providing service to 11,681 persons. In addition, SRMH invested an additional $33,401,522 in unpaid cost to Medicare, ensuring needed care to low-income patients.
Overview of Community Needs and Assets Assessment

The FY15 priorities and programs were based on the findings of the Fiscal Year 2014 Sonoma County Community Health Needs Assessment (CHNA). SJH completed this needs assessment in partnership with Sutter Medical Center of Santa Rosa, Kaiser Permanente Medical Center – Santa Rosa and the Sonoma County Department of Health Services to assess the health status of Sonoma County residents and to identify critical areas for health improvement in Sonoma County. The CHNA continues a successful collaboration between the hospital partners and local health department, begun in 2000, to identify and jointly address significant community health issues.

The goal of the CHNA data development process was to gather, analyze and summarize current local data on the residents of Sonoma County, their health status and the variety of features and conditions which impact their health, healthy development and quality of life. To accomplish this, the CHNA partners developed and utilized both primary and secondary data sources. The partners conducted the following activities to create the CHNA:

- **Demographic Summary:** Developed a demographic summary of Sonoma County’s current population along with population growth projections when available. Information is provided on a variety of demographic indicators including population distribution, age, ethnicity, income, healthcare coverage, education and employment.

- **Secondary Sources:** Assembled summary data from a variety of secondary sources identifying health behaviors and conditions that compromise the health and healthy development of children and contribute most prominently to illness and injury, disability and death for Sonoma County adults and children. Where known, information on contributing factors is presented along with each health indicator. Health disparities are highlighted.

- **Key Informant Interviews and Focus Groups:** Conducted key informant interviews, community-based focus groups and a countywide random telephone survey to gather data on health status and elicit information on community health issues of greatest concern and perspectives on local opportunities to improve population health and/or the healthcare delivery system.

The CHNA is available online at http://www.stjosephhealth.org/.

Community Plan Priorities/Implementation Strategies

The SRMH Community Benefit Plan/Implementation Strategy was developed based on the CHNA with input from community groups. FY15 priorities include:
• **Access to Health Care Services**
  
  Our *Mobile Medical Clinic* serves patients in their communities at no cost. The program seeks to provide care to those who fall through the traditional primary care safety net, and for reasons related to transportation, poverty, or other factors, face insurmountable barriers to accessing care at community health centers or other medical homes. The clinic offers health screenings, treatment of minor medical problems, health and nutritional education, and information and referrals. In FY15, the clinic saw 870 patients over 2,318 encounters at several locations, including the cities of Sonoma/Boyes Hot Springs, Santa Rosa, and Windsor.

• **Healthy Eating and Physical Fitness**
  
  The *Promotores de Salud* (Health Promoters) bridge language and culture, providing health information and referrals, conducting cooking and nutrition classes, and training community volunteer health promoters in heart health. In FY15, the *Promotores de Salud* served 1,369 low-income individuals through 3,434 service encounters. The program encouraged participants to be more physically active, participated in health fairs, and taught health education and healthy cooking classes. *Healthy for Life* is a school-based physical activity and nutrition program that works to teach behaviors at an early age and ensure good health for years to come. This year, 6 partner schools, 9 champion teachers and over 496 students and parents participated in fitness and nutrition courses across 7,514 encounters.

• **Access to Mental Health and Substance Abuse Services**
  
  *Circle of Sisters* (COS) is a positive youth development after-school program for girls ages 9 to 14 offered at no cost. Program participants attend schools with high rates of eligibility for the free and reduced lunch program. In FY15, COS served 191 young woman in 6,765 encounters. The program helps with self-esteem and making good choices about the future, and addresses mental health issues such as self-harm, the risks of substance use, and the value of building strong and resilient relationships.

• **Barriers to Healthy Aging**
  
  Our *House Calls* program tends to the physical, spiritual and emotional needs of frail elderly seniors and adults with chronic diseases by providing primary medical care at home. Eligible seniors have limited access to care due to impaired mobility, under-insurance, and lack of funds. The *House Calls* team, which includes nurse practitioners, nurses, case management, and home health assistance, provided 5,525 patient encounters during FY15, which help to prevent unnecessary emergency department visits and to more effectively manage chronic disease for 112 individuals.
Disparities in Oral Health

Our continuum of oral health services include a fixed site dental clinic located in Santa Rosa that serves children from all over the county, the Mobile Dental Clinic, the Mighty Mouth school-based dental disease prevention program, and Mommy and Me, which teaches good dental health practices to children zero to five years old and their mothers. The clinics prioritize service to children ages 0-16 years, but also serve adults with urgent needs. They provide basic, preventive, emergency and comprehensive dental care with a strong focus on prevention and education. During FY15 3,689 individuals received 7,863 service encounters at the SJH Dental Clinic. Our Mobile Dental Clinic and Mighty Mouth school-based program saw 9,724 mostly education and prevention visits with a total of 4,697 patients. Mighty Mouth also provided education for an additional 4,287 encounters.
INTRODUCTION

Who We Are and Why We Exist
As a ministry founded by the Sisters of St. Joseph of Orange, SRMH 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 throughout 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 SJH ministry.

Mission, Vision and Values and Strategic Direction

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.

SRMH has been meeting the health and quality of life needs of the local community for over 60 years. As part of its integrated network of acute and non-acute services in Sonoma County, St. Joseph Health, Sonoma County (SJH-SC) operates 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. Its core facilities are PVH, an 80-bed acute care hospital, and SRMH, a full service 289-bed acute care hospital that includes a Level II trauma center for the coastal region from San Francisco to the Oregon border.
Strategic Direction
As we move into the future, SRMH is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over five years (FY14-18) SJH and SRMH are strategically focused on two key areas with which the CB Plan strongly aligns: population health management and network of care.

Community Benefit Investment

During FY15, SRMH invested a total of $42,978,865 in community benefit, providing service to 11,681 persons. In addition, SRMH invested an additional $33,401,522 in unpaid cost to Medicare, ensuring needed care to low-income patients.

ORGANIZATIONAL COMMITMENT
Community Benefit Governance Structure
SRMH 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.

Figure 1. Fund distribution
In 1986, SJH created the SJH Community Partnership Fund (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities served by SJH hospitals.

Each year, SRMH allocates 10% of its net income (net unrealized gains and losses) to the SJH Community Partnership Fund; 7.5% of those contributions are used to support local hospital Care for the Poor programs; 1.75% is used to support SJH Community Partnership Fund grant initiatives; and the remaining 0.75% is designated toward reserves, which helps ensure the Fund’s sustainability (See Figure 1).

Furthermore, SRMH endorses local non-profit organization partners to apply for funding through the SJH Community Partnership Fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout SJH hospitals’ service areas.

**Community Benefit Governance and Management Structure**

SRMH 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 Director of Community Benefit 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 and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit Management Team provides orientation for all new SRMH employees on Community Benefit programs and activities, including opportunities for community participation.

A charter approved in 2007 established the formulation of the SRMH Community Benefit Committee (CBC). The role of the CBC is to support the Board of Trustees in overseeing community benefit issues. The CBC acts in accordance with a Board-approved charter. The CBC is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the CHNA, CB Plan, and Implementation Strategy Reports, as well as overseeing and advising on Community Benefit activities.

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

Roles and Responsibilities

Senior Leadership

- The President, Vice President of Mission Integration and other senior leaders are directly accountable for CB performance.

Community Benefit Committee

- The CBC serves as an extension of trustees to provide direct oversight for all charitable program activities. It includes diverse community stakeholders. Trustee members on the CBC serve as board-level champions and share information and learnings with their colleagues through regular reports.
- The Committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit Department

- Manages CB programs 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.
- Advocates for CB-related matters to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health related issues on a city, county, or regional level.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

We believe that no one should delay seeking needed medical care because they lack health insurance. That is why SRMH has a Patient Financial Assistance Program (FAP) that provides free or discounted services to eligible patients. In FY15, SRMH provided $3,267,805 in free and discounted care.
One way SRMH 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 FAP application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

**Medicaid and Other Means-Tested Government Programs**

SRMH provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other means-tested government programs. In FY15, the SRMH ministry provided $35,219,430 in Medicaid shortfall and $18,732 in other means-tested government programs.

**COMMUNITY**

**Defining the Community**

Sonoma County is a large, urban-rural county encompassing 1,575 square miles. Sonoma County residents inhabit nine cities and a large unincorporated area, including many geographically isolated communities. The county’s total population was estimated at 487,011 at the time of the CHNA. Since 2006, the county population has grown at an overall rate of 1.8% with the cities of Sonoma, Santa Rosa and Windsor experiencing the fastest growth rates. According to projections from the California Department of Finance, the county population is projected to grow by 8.3% to 546,204 in 2020. This rate of growth is less than that projected for California as a whole (10.1%).

The majority of the county’s population resides within its cities, the largest of which are clustered along the Highway 101 corridor. Santa Rosa is the largest city with a population estimated to be nearly 171,000 in 2012 and is the service hub for the entire county and the location of the county’s three major hospitals. At least part of Sonoma County, California, is designated as a Medically Underserved Area (MUA)\(^1\). The area is 0.8 square miles and is located near downtown Santa Rosa. The Cloverdale area in Sonoma County is a designated Primary Care Health Professional Shortage Area (PC-HSPA)\(^2\). There are 6,888 civilian residents in this area, which is 307.5 total square miles.

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\(^1\) Medically Underserved Areas designations are used to qualify for state/local and federal programs aimed at increasing health services to underserved areas and populations.

\(^2\) Primary Care Health Professional Shortage Areas (PC-HPSA) are designated based on primary care physician availability.
SRMH provides Sonoma County communities with access to advanced care and advanced caring. The hospital’s service area is located in downtown Santa Rosa, about 55 miles north of San Francisco just off the Highway 101 corridor in central Sonoma County. SRMH’s primary service area is limited to a tight radius, but its secondary service area comprises the entire county, plus northern Marin County and southern Mendocino County. The CHNA process and data gathering addresses Sonoma County. For a complete copy of the 2014 SRMH CHNA click [here](http://www.stjoesonoma.org/documents/Community-Benefit/2014-SRMH-Community-Health-Needs-Assessment-Report.pdf).

<table>
<thead>
<tr>
<th>Community</th>
<th>Sonoma County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>65.4</td>
<td>40.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>25.5</td>
<td>37.6</td>
</tr>
<tr>
<td>Asian</td>
<td>4.1</td>
<td>13.0</td>
</tr>
<tr>
<td>African American</td>
<td>1.9</td>
<td>6.6</td>
</tr>
<tr>
<td>All Others</td>
<td>8.2</td>
<td>12.5</td>
</tr>
<tr>
<td>Speak a language other than English at home</td>
<td>25.0</td>
<td>43.5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>21.4</td>
<td>25.0</td>
</tr>
<tr>
<td>65 and older</td>
<td>15.2</td>
<td>11.4</td>
</tr>
<tr>
<td>Income under Federal Poverty Line</td>
<td>11.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Has high school diploma</td>
<td>86.7</td>
<td>81.0</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, and [http://quickfacts.census.gov/qfd/states/06/06097.html](http://quickfacts.census.gov/qfd/states/06/06097.html)

Sonoma County’s unincorporated areas are home to 146,739 residents, 30.1% of the total population. A significant number of these individuals live in locations that are very rural and geographically remote. Residents of these areas may experience social isolation and significant barriers in accessing basic services and supports such as transportation, health care, nutritious food and opportunities to socialize. Low-income and senior populations living in remote areas may face special challenges in maintaining health and quality of life. Of the county’s total senior population, age 60 and older, 12,144 (12%) are considered “geographically isolated” as defined
by the Older Americans Act. (Source: California Dept. of Aging, California Aging Population Demographic Projections for Intrastate Funding Formula (2011))

**SRMH Total Service Area**

The community served by SRMH is defined based on the geographic origins of SRMH’s inpatients. The SRMH Total Service Area is 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 PSA is the geographic area from which the majority of SRMH’s patients originate. The cities and towns in the SRMH PSA include Santa Rosa, Sebastopol, Windsor, Forestville, Rohnert Park and Cotati/Penngrove. The SSA is where an additional population of the Hospital’s inpatients reside. The SSA includes all of Sonoma County, Ukiah to the north in Mendocino County, and northern Marin County to the south. The population of the service area is 835,741, of which 328,005 are in the PSA and 507,736 reside in the SSA.

**Table 1. Cities and ZIP codes**

<table>
<thead>
<tr>
<th>Cities</th>
<th>ZIP codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Service Area</strong></td>
<td></td>
</tr>
<tr>
<td>Santa Rosa</td>
<td>95407, 95401, 95403</td>
</tr>
<tr>
<td></td>
<td>95404, 95405, 95409</td>
</tr>
<tr>
<td>Sebastopol</td>
<td>95472</td>
</tr>
<tr>
<td>Windsor</td>
<td>95492</td>
</tr>
<tr>
<td>Forestville</td>
<td>95436</td>
</tr>
<tr>
<td>Cotati</td>
<td>94931</td>
</tr>
<tr>
<td>Penngrove</td>
<td>94951</td>
</tr>
<tr>
<td><strong>Secondary Service Area</strong></td>
<td></td>
</tr>
<tr>
<td>Sonoma County</td>
<td></td>
</tr>
<tr>
<td>City of Ukiah, Mendocino County</td>
<td></td>
</tr>
</tbody>
</table>

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 SJH.
Figure 1. Santa Rosa Memorial Hospital Total Service Area
Community Need Index (Zip Code Level) Based on National Need

The Community Need Index (CNI) was developed by Dignity Health and Truven Health Analytics. The 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 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, making it a High Need community.

Figure 2 (below) depicts the CNI 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 SJH.
Figure 2. Santa Rosa Memorial Hospital Community Need Index (Zip Code Level)
**Intercity Hardship Index (Block group level) Based Geographic Need**

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. The IHI was used by SJH to identify block groups with the greatest need.

The IHI combines six key social determinants that are often associated with health outcomes:

1. Unemployment (the percent of the population over age 16 that is unemployed)
2. Dependency (the percent of the population under the age of 18 or over the age of 64)
3. Education (the percent of the population over age 25 who have less than a high school education)
4. Income level (per capita income)
5. Crowded housing (percent of households with seven or more people)
6. Poverty (the percent of people living below the federal poverty level)

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on *relative need within a geographic area*, allowing for comparison across areas. According to IHI, most of the service area has average, less or least need (137/245). However, Rohnert Park has four block groups with highest need and twelve with high need, out of a total of 33 block groups. Santa Rosa has 47 block groups with highest need and 34 with high need out of a total of 162 (50%). Sebastopol has 2 block groups with high need and 4 with highest need out of a total of 25 (18%). Cotati has two block groups with high need out of a total of six block groups. Therefore, the IHI provides a valuable tool for identifying areas with significant needs and guiding resource allocation.
Figure 3 (below) depicts the **Intercity Hardship Index** for the hospital’s geographic service area and demonstrates *relative need*. 
Figure 3. Santa Rosa Memorial Hospital Intercity Hardship Index (Block group Level)
COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

SJH completed a needs assessment in FY14 in partnership with Sutter Medical Center of Santa Rosa, Kaiser Permanente Medical Center–Santa Rosa and the Sonoma County Department of Health Services, to assess the health status of Sonoma County residents and to identify critical areas for health improvement in Sonoma County. The FY14 CHNA continues a successful collaboration between the hospital partners and local health department, begun in 2000, to identify and jointly address significant community health issues. The goal of the CHNA data development process was to gather, analyze and summarize current local data on the residents of Sonoma County, their health status and the variety of features and conditions which impact their health, healthy development and quality of life. To accomplish this, the CHNA partners developed and utilized both primary and secondary data sources. The partners conducted the following activities to create the FY14 Sonoma County CHNA:

- **Demographic Summary**: Developed a demographic summary of Sonoma County’s current population along with population growth projections when available. Information is provided on a variety of demographic indicators including population distribution, age, ethnicity, income, healthcare coverage, education and employment.

- **Secondary Sources**: Assembled summary data from a variety of secondary sources identifying health behaviors and conditions that compromise the health and healthy development of children and contribute most prominently to illness and injury, disability and death for Sonoma County adults and children. Where known, information on contributing factors is presented along with each health indicator. Health disparities are highlighted.

- **Key Informant Interviews and Focus Groups**: Conducted key informant interviews, community-based focus groups and a countywide random telephone survey to gather data on health status and elicit information on community health issues of greatest concern and perspectives on local opportunities to improve population health and/or the healthcare delivery system.

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

**Identification and Selection of DUHN Communities**

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry service area.

Communities with DUHN generally meet one of two criteria: *either* there is a high prevalence or severity for a particular health concern to be addressed by a program activity, or there is
evidence that community residents are faced with multiple health problems and have limited access to timely, high quality health care.

The following table lists the DUHN communities/groups and identified community needs and assets.

### DUHN Group and Community Needs and Assets Summary Table

<table>
<thead>
<tr>
<th>DUHN Population</th>
<th>Community Needs</th>
<th>Community Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low income Families</strong></td>
<td>• Access to health care&lt;br&gt;• Access to affordable prescription drugs&lt;br&gt;• Information about health insurance&lt;br&gt;• Oral health care for children and low income adults&lt;br&gt;• Childhood obesity prevention and awareness programs&lt;br&gt;• Food security and access to healthy food&lt;br&gt;• Secure neighborhoods and access to safe recreation activities</td>
<td>• SJH Mobile Health Clinic, Dental Health Clinic, Neighborhood Care Staff, House Calls, Promotores de Salud&lt;br&gt;• Community clinics access to care for low-income families&lt;br&gt;• Medical services for uninsured&lt;br&gt;• Affordable housing for low income families&lt;br&gt;• Emergency shelters for homeless women and children/families such as Committee on the Shelterless and Catholic Charities&lt;br&gt;• Resident-led actions regarding quality of life concerns&lt;br&gt;• Community garden, food pantries&lt;br&gt;• Local faith-based and community agencies&lt;br&gt;• Employment, education, and family support programs&lt;br&gt;• Coalitions addressing substance abuse and obesity</td>
</tr>
<tr>
<td><strong>Latino Community</strong></td>
<td>• Information about health insurance access&lt;br&gt;• Access to culturally and linguistically sensitive health services, e.g., patient centered medical home&lt;br&gt;• Substance abuse prevention&lt;br&gt;• Nutrition education about healthy eating and foods&lt;br&gt;• Access to healthy food&lt;br&gt;• Gang prevention measures&lt;br&gt;• Family violence prevention</td>
<td>• SJH Mobile Medical Clinic, Neighborhood Care Staff, Promotores de Salud&lt;br&gt;• Drug Abuse Alternative Center (DAAC)-substance abuse resources&lt;br&gt;• Law enforcement, support for residents addressing gang graffiti, traffic calming, crime prevention education&lt;br&gt;• Food pantries&lt;br&gt;• Local churches, community agencies&lt;br&gt;• Employment, education (literacy, GED, language), health and family support programs&lt;br&gt;• Media outlets provide bilingual and bicultural programming&lt;br&gt;• Transitional housing for homeless; fair</td>
</tr>
<tr>
<td>DUHN Population</td>
<td>Community Needs</td>
<td>Community Assets</td>
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<td>-----------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>housing information and tenant’s rights</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coalitions addressing substance abuse and obesity</td>
</tr>
</tbody>
</table>
| **Children and Youth** | • Health education and awareness  
 • STD education and awareness  
 • Injury prevention education  
 • Obesity prevention education and programs, including nutrition education, and access to healthy foods  
 • Substance abuse prevention  
 • Gang prevention measures  
 • Higher education mentorship programs  
 • Student retention  
 • After school programs  
 • Libraries  
 • Fitness training  
 • Sports Teams and Resources  
 • Civic engagement opportunities  
 • Organized youth activities | • Free or low cost children’s health insurance  
 • SJH Dental Clinic, Mobile Medical Clinic, Mighty Mouth Dental Health Education Program, Circle of Sisters, Healthy for Life  
 • Schools’ ESL classes for parents  
 • Spanish & English classes for youth  
 • After school programs for youth, grassroots groups leadership development and social engagement opportunities, community agencies opportunities for youth to build resiliency, work skills, tutoring  
 • Drug Abuse Alternative Center, substance abuse resources  
 • Local sports clubs’ recreation opportunities for youth  
 • City Parks & Recreation Departments’ recreation opportunities  
 • City libraries’ computers & tutors for youth in need of homework help  
 • Head Start, early childhood education programs |
| **Seniors** | • Access to health services; health screenings  
 • Balance training to prevent falls  
 • Obesity prevention: access to healthy foods and fitness training; recreational activities; food security  
 • Transportation  
 • Affordable housing  
 • Home care  
 • Senior center resources  
 • Informational forums | • SJH House Calls  
 • Community Health Centers offer services for low income, uninsured and undocumented people  
 • Senior Center offers classes and courses |
<p>| <strong>Undocumented immigrants who</strong> | • Information about health insurance | • SJH Mobile Medical Clinic, Promotores de Salud |</p>
<table>
<thead>
<tr>
<th>DUHN Population</th>
<th>Community Needs</th>
<th>Community Assets</th>
</tr>
</thead>
</table>
| do not speak English | • Processes that facilitate access to medical care  
• Assistance accessing immigration resources  
• Wider outreach & access to healthy food through food pantries  
• Affordable housing for single persons | • Media outlets provide bilingual & bicultural programming  
• Immigration forums  
• Healthcare services for undocumented & uninsured  
• Food pantry  
• Local churches  
• Community agencies  
• Employment, education, and family support programs  
• Housing assistance addressing needs of undocumented and low income residents |

**PRIORITY COMMUNITY HEALTH NEEDS**

The prioritized community health needs identified through the FY14 CHNA process include the following,

1. Healthy eating and physical fitness
2. Gaps in access to primary care
3. Access to services for substance use disorders
4. Barriers to healthy aging
5. Access to mental health services
6. Disparities in educational attainment
7. Cardiovascular disease
8. Adverse childhood experiences or exposure to stress (ACES)
9. Access to health care coverage
10. Tobacco use
11. Coordination and integration of local health care system
12. Disparities in oral health
13. Lung, breast, and colorectal cancer

**Needs Beyond the Hospital’s Service Program**

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through community benefit programs and by funding other non-profits through our Care for the Program managed by SRMH.
Furthermore, SRMH endorses local non-profit organization partners to apply for funding through the SJH Community Partnership Fund. Organizations that receive funding provide specific services or resources to meet the identified needs of underserved communities through SJH communities.

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

1. **Gaps in access to primary care.** SRMH approaches this issue in conjunction with the identified need of access to health care coverage. Through our **Mobile Medical Clinic** and **House Calls** programs, we directly provide primary care, and also actively partner with community health centers and other service providers to refer our patients to medical homes whenever possible. We know that referral to medical homes, with all their associated wraparound services, is critically important to keeping vulnerable communities well.

2. **Disparities in educational attainment.** We participate in a number of countywide efforts that are working to address this important need, including Sonoma Health Action, which is a collective action initiative in the county. Todd Salnas, President of SJH-SC, sits on the Health Action Council, and Cradle to Career is one key initiative of Health Action and is focused on educational attainment and workforce development.

3. **Cardiovascular disease.** Our **Promotores de Salud** program follows a proven model of peer education, connecting with underserved communities in a culturally appropriate manner. The **Your Heart, Your Life** course we teach at no cost to anyone who chooses to enroll takes place over 10 weeks and allows staff to build relationships with participants, and leverage those relationships to drive real and sustained behavioral changes. Our program is supported by volunteers, many of whom are course graduates themselves and whose lives have been deeply affected by the program; they are inspired to share that experience with others and share the benefits of healthy living.

4. **Adverse childhood experiences or exposure to stress (ACES).** In FY15, four of our staff became certified in the **Positive Parenting Program**, an international evidence-based model that is widely understood as an effective program to help prevent the occurrences of ACES and spread positive and supportive parenting practices. By becoming certified, our staff members who work directly with parents can offer information and brief interventions, educating about and supporting parents in making good decisions.

5. **Tobacco use.** We collaborate with and support through sponsorships several organizations that perform screening for tobacco use and smoking cessation, including the Petaluma Health Center, West County Health Centers, and Santa Rosa Community
Health Centers. We also have a CB staff liaison on the Board, and provide core funding to the Healthy Communities Consortium, which is active in various tobacco control initiatives.

6. **Coordination and integration of local health care system.** We participate in the Health System Improvement initiative of Sonoma Health Action, and have been active in both the *My Care, My Plan: Speak Up Sonoma County* initiative as well as the *Hearts of Sonoma County* initiative, both of which seek to leverage integration and coordination of effort. The former initiative is focused on advance care planning and the latter on cardiovascular health. We also supported the Santa Rosa Community Health Centers with an $80,000 grant to support the coordination of care for underserved patients, co-locating a staff member of theirs within our facility to assist with transitions and discharge planning.

7. **Lung, breast, and colorectal cancer.** We offer charity care support for mobile medical patients who require diagnostics and make significant efforts to connect patients to specialty cancer care, coordinating care and referrals when appropriate.

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**COMMUNITY BENEFIT PLANNING PROCESS**

*Summary of Community Benefit Planning Process*

The FY15-17 CB Plan was developed in response to findings from the FY14 CHNA and is guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs:** Seek to accommodate the needs to communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care:** Establishing operational links between clinical services and community health improvement activities where possible.
- **Build Community Capacity:** Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

In order to select the health needs that SRMH will address, the SJH-SC Community Benefit Leadership Team met to review the CHNA and to develop consensus recommendations on a narrowed set of health priorities for the FY15-17 CB Plan. Team members used the following criteria to rank the health priorities:
Selection Criteria

- Magnitude/scale of the problem
- Severity of problem
- SRM Hospital Assets
- Existing/promising approaches

- Health disparities
- Ability to leverage
- Community prioritization
- Prevention opportunity

Based on review of prioritized significant health needs and a thoughtful priority setting process, SRMH plans to address the following priority areas as part of its FY15-17 CB Plan:

1. **Access to health care coverage.** 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. While a significant portion of Sonoma County’s uninsured population is recently eligible for health care coverage under The Affordable Care Act, financial barriers still exist for low-wage earners who are unable to meet premium requirements. Even with insurance, for some populations – those with Medicare, individuals with geographic or language barriers – access is not guaranteed. Continued growth in the county population coupled with a dwindling physician supply has created significant pressure on the county’s current primary care and specialist workforce. Undocumented adults continue to be ineligible for publicly-funded coverage, leaving many individuals and families vulnerable.

2. **Healthy eating and physical fitness.** Poor nutrition and lack of physical activity are driving a national and local obesity epidemic and are contributing to increasing rates of chronic disease, disability, and premature mortality in Sonoma County. In every age category, Sonoma County residents do not meet Healthy People 2020 goals for weight. Low-income children and families are especially at risk when they reside in neighborhoods that offer few options to obtain healthy, nutritious food or engage safely in physical activity. Expansion of current efforts in schools and communities to improve nutrition and fitness among youth and adults can help to reduce the growing burden of disease.

3. **Access to mental health and substance abuse services.** Many mental health and substance abuse problems can be effectively treated and managed with access to assessment, early intervention, and linkages to ongoing treatment and support. In Sonoma County, however, many low income individuals with mental health concerns and substance abuse issues do not have access to the treatment they need. Insufficient private insurance coverage for these services and limited availability of publicly-funded treatment services are significant barriers. Limited integration of mental health services within the health care system also leads to missed opportunities for early problem identification and
4. **Barriers to healthy aging.** People over 60 now make up a larger proportion of the population of Sonoma County than ever before. The county’s lowest income senior populations are clustered around Santa Rosa, the Sonoma Valley and the Russian River. Geographic and social isolation create significant barriers in accessing basic services such as transportation, safe housing, health care, nutritious food and opportunities for socialization. These barriers are compounded for seniors living in poverty. Current senior service systems are fragmented, under-funded and often difficult for seniors and their families to understand and utilize. Low-income seniors are especially at risk for neglect, abuse and isolation. Further development of community-based systems of services and supports for seniors can improve health outcomes and quality of life and significantly reduce costs for long-term institutional care.

5. **Disparities in oral health.** Poor oral health status can threaten the health and healthy development of young children and compromise the health and wellbeing of adults. Low-income children suffer disproportionately from dental caries in Sonoma County. Low-income residents have few options for affordable oral health care and even those with insurance find access to preventive services severely limited. Fluoridated drinking water has proven to be an effective public health measure for prevention of tooth decay, yet only 3% of the public water supply in Sonoma County is fluoridated. Stronger prevention initiatives and expanded access to prevention-focused oral health care are critical to protecting the health and wellbeing of low-income children and adults.

Due to the fast pace at which the community needs and health care industry practices change, SRMH anticipates that implementation strategies may evolve and therefore, a flexible approach is best suited in its response to the CHNA. On an annual basis, SRMH evaluates its CB Plan and makes adjustments as needed to achieve its goals/outcomes measures and to adapt to changes in resource availability.
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan

FY15 Accomplishments

**Initiative 1 (community need being addressed):** Access to Health Care Coverage

**Goal (anticipated impact):** Increase access to quality, culturally competent care for vulnerable and uninsured populations in the SJH-SC service area.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline</th>
<th>FY15 Target</th>
<th>FY15 Result</th>
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<tbody>
<tr>
<td>Percent of patients served who are of the remaining uninsured population&lt;sup&gt;3&lt;/sup&gt;</td>
<td>85% of patients served by <em>Mobile Medical Clinic</em> in FY14 were of the remaining uninsured population</td>
<td>90% or more of the patient population should be of the remaining uninsured population</td>
<td>94% of patients served by <em>Mobile Medical Clinic</em> in FY15 are of the remaining uninsured population</td>
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<tr>
<th>Strategies</th>
<th>Strategy Measure</th>
<th>FY15 Result</th>
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</table>
| Link those who are eligible for insurance coverage to a medical home | Perform warm handoffs to community health centers to ensure patients can be linked to a medical home | - *Mobile Medical Clinic* made 139 referrals to community health centers, specialists, other services / programs  
- Dental program *Mommy and Me* made 63 warm handoffs to Santa Rosa Community Health Centers for pregnant woman; of those 26 were confirmed to be seen  
- Co-located with a certified enrollment counselor at a mobile medical site in Windsor |
| Proactively identify and serve the remaining uninsured population | Addition of new sites based on a survey of need and location of the remaining uninsured population | - Two new sites added for the *Mobile Medical Clinic*, one at the Fulton Day Labor Center in Santa Rosa and one at the Petaluma Library downtown  
- The dental programs provided treatment to 317 uninsured patients |
| Serve patients in their communities and provide medical care to the underserved | Number of patients and encounters in the *Mobile Medical Clinic* | - 971 patients served by the *Mobile Medical Clinic* over 2,519 encounters |

<sup>3</sup>This is a term commonly used to describe patients who remain uninsured following the expansion of access to insurance coverage as a result of the federal Patient Protection and Affordable Care Act legislation of 2010.
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments (Continued)

**Key Community Partners:** Community health centers, community-based organizations that act as hosts to and collaborators with our mobile clinics, community coalitions and local leaders who advise us on the location of the greatest need, County of Sonoma Department of Health Services, A Portrait of Sonoma County report findings, and Portrait leadership committee.

**FY15 Accomplishments: Access to Health Care Coverage**
Our Mobile Medical Clinic serves patients in their communities at no cost. The program seeks to provide care to those who fall through the traditional primary care safety net, and for reasons related to transportation, poverty, or other factors, face insurmountable barriers to accessing care at community health centers or other medical homes. The clinic offers health screenings, treatment of minor medical problems, health and nutritional education, and information and referrals. In FY15 in the SRMH service area, the clinic saw 870 patients over 2,318 encounters at several locations, including the cities of Sonoma/Boyes Hot Springs, Santa Rosa, and Windsor.

After conducting a survey of vulnerable populations in Sonoma County and consulting *A Portrait of Sonoma County*, the clinic identified two new sites: downtown Petaluma and a site on Fulton Road in Santa Rosa near a location where many day laborers congregate. The goal of both sites is to continue to connect our services and outreach with the remaining uninsured population and those who are most vulnerable despite the recent expansion of access to health insurance coverage. In partnership with Santa Rosa Community Health Centers, we funded an $80,000 grant to support the coordination of care for underserved patients, co-locating a staff member of theirs within our emergency department to assist with transitions of care and discharge planning. This innovative partnership seeks to ensure that all patients are connected to a medical home and ensure that the most needy patients can be matched to supportive services.
**Initiative 2 (community need being addressed):** Healthy Eating and Active Living

**Goal (anticipated impact):** Promote healthy eating and physical activity education in the SJH-SC service area.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline</th>
<th>FY15 Target</th>
<th>FY15 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of participants who report improvement in behavioral changes related to healthier eating and increased physical activity</td>
<td>n/a</td>
<td>Demonstrate improved knowledge of healthy living principles in the majority (50% or more) of Healthy for Life and Your Heart, Your Life program participants</td>
<td>80% of Your Heart, Your Life participants and 44% of Healthy for Life participants demonstrated improved knowledge of healthy living principles</td>
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## FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
### FY15 Accomplishments (Continued)

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Strategy Measure</th>
<th>FY15 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide evidence-based education and programming that promotes healthy eating and active living</td>
<td>- Number of persons served in the <em>Healthy for Life</em> program</td>
<td>- 1,053 persons served by <em>Healthy for Life</em> over 11,712 encounters &lt;br&gt; - 1,404 persons served by the <em>Promotores de Salud</em> over 3,925 encounters &lt;br&gt; - 85 persons served by the <em>Your Heart, Your Life</em> program</td>
</tr>
<tr>
<td>Improve data collection processes and methodologies to better track impacts of healthy eating active living programs</td>
<td>n/a</td>
<td>- Redesigned all demographic data collection to ensure consistency between programs</td>
</tr>
<tr>
<td>Expand <em>Healthy for Life</em> program in partnership with collaborative agencies and supporters</td>
<td>- New partnerships formed and new sites added</td>
<td>- In partnership with the Petaluma Health Care District, Petaluma Educational Foundation, and Old Adobe Union School District, three new <em>Healthy for Life</em> sites were added</td>
</tr>
<tr>
<td>Demonstrate improved knowledge of healthy living principles in <em>Your Heart, Your Life</em> and <em>Circle of Sisters</em> programs</td>
<td>- Percent of <em>Circle of Sisters</em> participants reporting increased self-esteem and improved health habits</td>
<td>- 58% of <em>Circle of Sisters</em> participants reported increased self-esteem and improved health habits</td>
</tr>
</tbody>
</table>

**Key Community Partners:** Community Activity and Nutrition Coalition (CAN-C), Sonoma Health Action, area school districts, Healthy Communities Consortium, Petaluma Health Care District, Petaluma Educational Foundation, Healthcare Foundation of Northern Sonoma County.
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments (Continued)

FY15 Accomplishments: Healthy Eating and Physical Fitness
The Promotores de Salud (Health Promoters) bridge language and culture, providing health information and referrals, conducting cooking and nutrition classes, and training community volunteer health promoters in heart health. In partnership with our own Neighborhood Care Staff, our Promotores focused particularly on the area identified in A Portrait of Sonoma County as being the highest need: Roseland, in Southwest Santa Rosa. Our staff worked closely with community residents to organize and facilitate a parent group, which has gone on to act as a hub for various efforts related to health in the neighborhood (see news article featuring our work here). The parent group, with support from our staff, organized regular donation-only exercise classes in the neighborhood, community outings to regional parks, and trail cleanup days. Our work engaging residents in Roseland has helped to build significant community capacity and has built a network of grassroots leaders who have become key stakeholders and voices in a variety of important matters including neighborhood redevelopment, city annexation of county “islands”, and other matters identified as relevant or important by the residents.

In FY15 in the SRMH service area, 1,404 persons served by the Promotores de Salud over 3,925 encounters. In an effort to tailor our programs to suit the needs and interests of the communities we serve, we piloted an innovative program in partnership with the Windsor Presbyterian Church in which we coupled our Your Heart, Your Life program (taught in Spanish) with a healthy-cooking class. Participants were able to access the traditional educational modules in combination with a fun and informative class in the kitchen, using healthy ingredients in easy and fast recipes. Healthy for Life is a school-based physical activity and nutrition program that works to teach behaviors at an early age and ensure good health for years to come. This year in the PVH service area, 4 partner schools (including 3 in the Old Adobe Union School District), 8 champion teachers, and over 557 students and parents participated in fitness and nutrition courses across 4,198 encounters. We have been working with the Sonoma Upstream Investments initiative to recertify the Healthy for Life program to ensure sustainability in the program and recognize it as a best practice. Soon after the close of FY15 recertification of this program was achieved and it remained on the Upstream portfolio, where funders and others can look to find established, proven programs that have evaluation plans and clear outcomes attached.
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments (Continued)

Initiative 3 (community need being addressed): Mental Health and Substance Abuse

Goal (anticipated impact): Improve coordination of behavioral health and substance use disorder care for high-risk populations in the SJH-SC Service area.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline</th>
<th>FY15 Target</th>
<th>FY15 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve awareness and understanding of behavioral health and substance abuse issues faced by our client population through regular screening</td>
<td>17% of Mobile Medical Clinic patients screened for depression</td>
<td>Sustain screening rates at or above at least 70% of patients in the Mobile Medical Clinic</td>
<td>67% of Mobile Medical Clinic patients screened for depression</td>
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<tr>
<th>Strategies</th>
<th>Strategy Measure</th>
<th>FY15 Result</th>
</tr>
</thead>
</table>
| Partner with community based organizations working to address mental health and substance use needs among vulnerable populations | - Distributed $80,000 in funding Catholic Charities of the Diocese of Santa Rosa to support the Nightingale Program homeless respite beds  
- Approved $250,000 in funding and collaborated with Catholic Charities of the Diocese of Santa Rosa, Kaiser Permanente, Sutter Health, and the County Department of Health Services to support the development of Phase Two of the Nightingale Program—a doubling in bed capacity for this homeless respite shelter for those who are medically ready for discharge from hospital but need a safe place to continue recovery. Phase Two also includes additional wraparound case management services to link clients to programs and services |
FY15 Accomplishments: Access to Mental Health and Substance Abuse Services

As part of our effort to better understand the scale of the needs related to mental and behavioral health, the Mobile Medical Clinic began systematic screening for depression or mental illness using a validated tool known as the Patient Health Questionnaire (PHQ-9 & PHQ-2). One opportunity our staff has identified in attempting to link needy patients to care is the dearth of qualified bilingual service providers in the County who are available and affordable for our patient population. As a result of this and so we could best understand the current need in our patient population, we have improved screening rates from 17% to over 60% each month and are providing regular feedback on screening performance to our provider team. Circle of Sisters has also been working with our providers to help address mental and behavioral health issues that present in the program. Circle of Sisters has also been working with our providers to help address mental and behavioral health issues that present in the program. The program has seen an uptick in girls who are experiencing self-harming behavior, so we leveraged our internal resources to bring a primary medical provider into the classroom to talk about healthy behaviors and how to best seek help when needed. This additional component to the curriculum helps connect program participants to community resources and accurate information about mental and behavioral health. In FY15 in the PVH service area, COS, at its Petaluma site, served 16 young women in 473 encounters. The program helps with self-esteem and making good choices about the future, and addresses mental health issues such as self-harm, the risks of substance use, and the value of building strong and resilient relationships.

In partnership with a countywide collaborative led by Catholic Charities of the Diocese of Santa Rosa, our Community Benefit Committee of the Board pledged $250,000 to be allocated in FY16 for the expansion of Project Nightingale, a homeless respite shelter. The additional 13 beds in the program, which is operated by Catholic Charities, will be elevated to accommodate a higher level of acuity and wraparound case management services will be added. We contributed $80,000 to the existing Nightingale and collaborated closely to complete the necessary strategic and logistical planning to ensure the program expansion could occur. Many clients at the Committee on the Shelterless (COTS) agency struggle with mental health and substance use issues, and we provided $10,000 in grant funding to the Unmet Needs Fund in FY15, which helped over 100 clients access critical supplies and services including eyeglasses, medications, and taxi vouchers. Without our support of this Fund, the lack of available dollars for these clients would mean that many would fail to have critical needs met.
### Initiative 4 (community need being addressed): Healthy Aging

**Goal (anticipated impact):** Improved coordination of care for senior clients in the SJH-SC Service area.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline</th>
<th>FY15 Target</th>
<th>FY15 Result</th>
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</thead>
</table>
| Increased collaboration with senior services agencies to reach isolated frail elderly and partner to reach underserved seniors. | n/a | Participate in an advance health care directive collaborative that seeks to educate residents about the importance of advance planning. | - Participated in a community collaborative to provide advance care planning education and workshops at no cost to community members.  
- Reached 80 clients and partnered with several key community organizations |

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<tr>
<th>Strategies</th>
<th>Strategy Measure</th>
<th>FY15 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the <em>House Calls</em> program, serve the frail elderly in their homes with medical care and case management</td>
<td>Number of clients served in the <em>House Calls</em> program</td>
<td>- 118 unduplicated patients served and completed over 5,760 encounters</td>
</tr>
</tbody>
</table>
| Perform internal and external education and outreach, ensuring that community benefit programs reach seniors in a systematic and strategic manner | - Provide staff with training in advance health care directive  
- Provide community members with advance care planning education | - Hosted steering committee faculty members from countywide advance care planning collaborative known as *My Care, My Plan: Speak Up Sonoma County* to educate department staff on advance care planning  
- Participated in an Advance Care Planning Collaborative to provide education in the community regarding advance care planning to 80 individuals in southern Sonoma County |
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan

FY15 Accomplishments (Continued)

**Key Community Partners**: Petaluma Advance Care Planning Collaborative (Petaluma Health Center, Petaluma Health Care District, My Care, My Plan: Speak Up Sonoma County, Petaluma People Services Center, Petaluma Senior Center, St. Joseph Health Memorial and Petaluma Hospice), Sonoma County Healthy Aging Collaborative (Aging Together).

**FY15 Accomplishments: Barriers to Healthy Aging**

Countywide, there have been efforts to address needs related to healthy aging and we have been active collaborators in this work. We have participated in collaboratives that seek to bring additional services including advance care planning education and technical assistance to community members. Our work in this area has led us to additional collaboratives that extend to other parts of the county and that will continue to grow in FY16. As part of our ongoing community engagement and collaboration strategies, we participated in a countywide Healthy Aging Collaborative, which seeks to support all people to thrive across the lifespan and achieve their life potential. The Collaborative pivoted to form Aging Together, which is working under the collective impact model and has identified a series of key metrics on which several agencies and community based organizations are focusing. Our *House Calls* program tends to the physical, spiritual and emotional needs of frail elderly seniors and adults with chronic diseases by providing primary medical care at home. Eligible seniors have limited access to care due to impaired mobility, under-insurance, and lack of funds. The program team, which includes nurse practitioners, nurses, case management, and home health assistance, provided service to 118 unduplicated patients and completed over 5,760 encounters countywide, helping to prevent unnecessary emergency department visits and to more effectively manage chronic disease.
**Initiative 5 (community need being addressed)**: Oral Health

**Goal (anticipated impact)**: Identify and treat children with decay and prevent caries in the SJH-SC Service area.

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<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline (FY14)</th>
<th>FY15 Target</th>
<th>FY15 Result</th>
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</thead>
<tbody>
<tr>
<td>Continue to serve as an access clinic, bringing new patients into care and completing treatment plans.</td>
<td>- Dental programs treated 7,433 patients with a decay rate of 39% (n=2898) - Completed treatment on 34% (n=983) - 23% were new patients (n=1679)</td>
<td>Sustain 20% new patient rate and complete treatment on 40% of patients</td>
<td>- Dental programs treated 8,574 patients with a decay rate of 33% (n=2816) - Completed treatment on 45% (n=1252) - 23% of patients were new (n=1916)</td>
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<tr>
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<th>Strategy Measure</th>
<th>FY15 Result</th>
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<tbody>
<tr>
<td>Serve patients in the fixed site dental clinic</td>
<td>Number of patients served</td>
<td>- 3,748 patients served and completed over 8,058 encounters</td>
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<tr>
<td>Serve patients in the <em>Mobile Dental Clinic</em> and <em>Mighty Mouth</em> school-based program</td>
<td>Number of patients served</td>
<td>- 4,697 patients served and completed over 9,724 encounters</td>
</tr>
<tr>
<td>Educate pregnant women and intervene early to encourage prevention-oriented behaviors</td>
<td>Number of pregnant women educated</td>
<td>- 124 Pregnant women were educated; 91 returned for treatment at dental clinic - <em>Mommy and Me</em> program participants demonstrated a 1% decay rate among one-year-olds, compared to non-participating children in the same age group with 15% decay rate - Returning 2-5 year-olds in <em>Mommy and Me</em> program demonstrated a 15% decay rate compared to non-participating children in the same age group with 35% decay rate</td>
</tr>
</tbody>
</table>
Key Community Partners: Sonoma County Dental Health Network, community health fairs, school districts, community health centers, Sonoma County Women, Infants and Children (WIC), other nonprofit service providers.

FY15 Accomplishments: Addressing Disparities in Oral Health
Our continuum of oral health services include a fixed site dental clinic located in Santa Rosa that serves children from throughout the county, the Mobile Dental Clinic, the Mighty Mouth school-based dental disease prevention program, and Mommy and Me, which teaches good dental health practices to very young children zero to five years old and their mothers. The clinics prioritize service to children ages 0-16 years, but also serve adults with urgent needs. They provide basic, preventive, emergency and comprehensive dental care with a strong focus on prevention and education. During FY15 3,748 patients were served over 8,058 encounters at the SJH Dental Clinic. Our Mobile Dental Clinic and Mighty Mouth school-based prevention program saw 4,697 patients and completed over 9,724 encounters countywide. Of the 416 Mommy and Me participants throughout the county, there was a 1% decay rate among one-year-olds, compared to 15% decay rate among patients in the clinic who did not participate in the program. We saw a 15% decay rate among returning 2-5 year-olds in Mommy and Me program, compared to non-participating children in the same age group with 35% decay rate. We entered into an innovative partnership with Santa Rosa Community Health Centers and the Southwest Medical Center, which is co-located with our fixed site dental clinic. The partnership allows us to better coordinate oral health care with patients’ medical home, so that our two agencies can more seamlessly communicate and share information.
Other Community Benefit
In addition to the preceding priority areas, SJH provided other community benefit programs responsive to the health needs identified in the FY14 CHNA.

<table>
<thead>
<tr>
<th>Initiative (community need being addressed)</th>
<th>Program</th>
<th>Description</th>
<th>FY15 Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many initiatives identified in the Community Health Needs Assessment including access to health care services, gaps in access to primary care, disparities in educational attainment.</td>
<td>A Portrait of Sonoma County report on disparities in Sonoma County related to health, educational attainment, and economic wellness.</td>
<td>A Portrait of Sonoma County is an in-depth look at how residents of Sonoma County are faring in three fundamental areas of life: health, access to knowledge, and living standards.</td>
<td>Served on the Portrait leadership team, integrated the report into the new employee orientation for all St. Joseph Health incoming employees, familiarizing staff with issues related to disparities, social determinants of health, and place-based interventions to improve outcomes.</td>
</tr>
<tr>
<td>Access to mental health and substance abuse services, tobacco use</td>
<td>Healthy Communities Consortium</td>
<td>Board service for this community-based organization and core support funding.</td>
<td>CB department Director served on the Board and directed $15,000 of core operating support funding to this community-based nonprofit organization, which supports community members in working together on projects that impact quality of life and facilitates community coalitions and initiatives.</td>
</tr>
<tr>
<td>Healthy aging</td>
<td>Sonoma County Healthy Aging Collaborative or Aging Together.</td>
<td>Participated in the Healthy Aging Collaborative with various other community-based stakeholders.</td>
<td>Supported the vision that Sonoma County is a healthy place to live, work and play; a place that supports all people to thrive across the lifespan and achieve their life potential.</td>
</tr>
</tbody>
</table>
### Other Community Benefit (Continued)

<table>
<thead>
<tr>
<th>Initiative (community need being addressed):</th>
<th>Program</th>
<th>Description</th>
<th>FY15 Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Many initiatives identified in the Community Health Needs Assessment including access to health care services, gaps in access to primary care, disparities in educational attainment, barriers to healthy aging, disparities in oral health, others.</strong></td>
<td><strong>Sonoma Health Action</strong></td>
<td>Health Action is the framework for a community engagement effort to get people involved in creating a healthier Sonoma County. It starts at home with a personal commitment. It continues at work and school with wellness-focus policies and opportunities that encourage healthy living. It culminates in the community with a shared vision for overall good health.</td>
<td>Our President served on the Health Action Council, Community Benefit staff participated in the Economic Wellness Initiative, and the Hearts of Sonoma County - Cardiovascular Disease Risk Reduction Initiative. Supported Collective Action principles and provided input and leadership in a variety of other areas.</td>
</tr>
<tr>
<td><strong>Many initiatives identified in the Community Health Needs Assessment; community engagement and collaboration.</strong></td>
<td><strong>Sonoma County Funders’ Circle</strong></td>
<td>The Sonoma County Funders’ Circle helps create healthy communities with widespread equity through collective investing. All members are committed to social investment for systemic change that includes leadership in advocacy, research, collaborative learning, capacity building, and applied practice.</td>
<td>Community Benefit staff chaired the Governance Committee, participated in the formulation of Governance Guidelines and helped to build the capacity of this collaborative workgroup.</td>
</tr>
</tbody>
</table>
### Other Community Benefit (Continued)

<table>
<thead>
<tr>
<th>Initiative (community need being addressed):</th>
<th>Program</th>
<th>Description</th>
<th>FY15 Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating and Active Living</td>
<td>Community Activity and Nutrition Coalition</td>
<td>The Community Activity and Nutrition Coalition (CAN-C) of Sonoma County is a group of individuals, professionals and community based organizations concerned about the nutritional health, activity level and well-being of the residents of our community.</td>
<td>Community Benefit staff served on Steering Committee, made several presentations on related programs and updates to CAN-C membership, attended regular meetings and subcommittee meetings for Healthy Students Initiative, Physical Activity Subcommittee.</td>
</tr>
<tr>
<td>Many initiatives identified in the Community Health Needs Assessment; community engagement and collaboration.</td>
<td>Los Cien</td>
<td>Latino leaders dedicated to building a better future for Sonoma County.</td>
<td>Participated in regular monthly meetings of Los Cien and committed one staff member as a formal liaison to Los Cien, providing support and assistance the group.</td>
</tr>
<tr>
<td>Many initiatives identified in the CHNA including access to mental health and substance abuse services, preventing adverse childhood exposure to stress.</td>
<td>Committee on the Shelterless (COTS) Unmet Needs Fund</td>
<td>The Unmet Needs Fund is used for basic needs that this homeless shelter is not otherwise able to meet for its vulnerable clientele. This may include medications, taxi vouchers, eyeglasses, or other necessities for homeless clients.</td>
<td>Made a $10,000 grant to support over 100 families and individuals in obtaining goods and services required to satisfy a basic level of unmet needs.</td>
</tr>
</tbody>
</table>
### FY15 Community Benefit Investment

In FY15 Santa Rosa Memorial Hospital invested a total of $42,978,865 in key community benefit programs. In FY15, Medicaid shortfall was $35,219,430.

#### FY15 COMMUNITY BENEFIT INVESTMENT

**Santa Rosa Memorial Hospital**

*(ending June 30, 2015)*

<table>
<thead>
<tr>
<th>CA Senate Bill (SB) 697 Categories</th>
<th>Community Benefit Program &amp; Services</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care Services for Vulnerable(^4) Populations</td>
<td>Financial Assistance Program (FAP) (Traditional Charity Care-at cost)</td>
<td>$3,267,805</td>
</tr>
<tr>
<td></td>
<td>Unpaid cost of Medicaid(^5)</td>
<td>$35,219,430</td>
</tr>
<tr>
<td></td>
<td>Unpaid cost of other means-tested government programs</td>
<td>$18,732</td>
</tr>
<tr>
<td>Other benefits for Vulnerable Populations</td>
<td>Community Benefit Operations</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Community Health Improvements Services</td>
<td>$1,420,290</td>
</tr>
<tr>
<td></td>
<td>Cash and in-kind contributions for community benefit</td>
<td>$2,275,164</td>
</tr>
<tr>
<td></td>
<td>Community Building</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Subsidized Health Services</td>
<td>$111,694</td>
</tr>
<tr>
<td><strong>Total Community Benefit for the Vulnerable</strong></td>
<td></td>
<td>$42,313,115</td>
</tr>
<tr>
<td>Other benefits for the Broader Community</td>
<td>Community Benefit Operations</td>
<td>$398,616</td>
</tr>
<tr>
<td></td>
<td>Community Health Improvements Services</td>
<td>$138,036</td>
</tr>
<tr>
<td></td>
<td>Cash and in-kind contributions for community benefit</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Community Building</td>
<td>$129,098</td>
</tr>
<tr>
<td></td>
<td>Subsidized Health Services</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Community Benefit for the Broader Community</strong></td>
<td></td>
<td>$665,750</td>
</tr>
<tr>
<td><strong>TOTAL COMMUNITY BENEFIT (excluding Medicare)</strong></td>
<td></td>
<td>$42,978,865</td>
</tr>
<tr>
<td>Medical Care Services for the Broader Community</td>
<td>Unpaid cost to Medicare(^7) <em>(not included in CB total)</em></td>
<td>$33,401,522</td>
</tr>
</tbody>
</table>

\(^4\) Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

\(^5\) CA SB697: “Vulnerable Populations” means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid (referred to as Medi-Cal in California), Medicare, California Children’s Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

\(^6\) Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

\(^7\) Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.
Governance Approval

This FY15 Community Benefit Report was approved at the October 27th meeting of the St. Joseph Health—Sonoma County Community Benefit Committee of the Board of Trustees.

Pamela Chauter
Chair’s Signature confirming approval of the FY15 Community Benefit Report

Oct. 29, 2015
Date