St. Joseph Health, Santa Rosa Memorial Hospital

Fiscal Year 2017 COMMUNITY BENEFIT REPORT
PROGRESS ON FY15 - FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT
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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 -- Service, Excellence, Dignity 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 critical care, cardiovascular care, stroke care, women’s and children’s services, cancer care, and orthopedics. SRMH is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

Community Benefit Investment
SRMH invested $59,887,971 in community benefit in FY 2017 (FY17). For FY17, SRMH had an unpaid cost of Medicare of $29,463,667.

Overview of Community Health Needs and Assets Assessment
The FY17 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.


**Community Plan Priorities/Implementation Strategies**

The SRMH Community Benefit Plan/Implementation Strategy was developed based on the CHNA with input from community groups. FY17 priorities include:

- **Access to Health Care Services**

  Our Mobile Health 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, vaccinations, treatment of minor medical problems, health and nutritional education, and information and referrals. In FY17, the clinic saw 1,549 patients over 3,232 encounters at several
locations, including Cloverdale, Sonoma/Boyes Hot Springs, Santa Rosa, Healdsburg and Windsor.

- **Healthy Eating and Physical Fitness**
  The Promotores de Salud (Health Promoters) bridge language and culture, providing health information and referrals, conducting health screenings at health fairs and other community events, and presenting cooking and nutrition classes. In FY17, the Promotores de Salud served 455 low-income individuals through 1,540 service encounters. Healthy for Life is a school-based physical activity and nutrition program that works to teach healthy behaviors at an early age and ensure good health for years to come. This year, 10 partner schools, 14 champion teachers and more than 1,368 students and parents participated in fitness and nutrition courses across 11,844 encounters.

- **Access to Mental Health and Substance Abuse Services**
  Circle of Sisters (COS) is a positive youth development after-school program for 9- to 12-year-old girls offered at no cost. Program participants attend schools with high rates of eligibility for the free and reduced lunch program. In FY17, COS served 162 young women in 5,393 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 managers, and home health assistants, provided 7,007 patient encounters during FY17, which help to prevent unnecessary emergency department visits and to more effectively manage chronic disease for 143 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 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 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 FY17 5,196 individuals received 8,576 service encounters at the SJH Dental Clinic. Our Mobile Dental Clinic and Mighty Mouth school-based program saw 5,388 mostly
education and prevention visits with a total of 4,099 patients. Mighty Mouth also provided education for an additional 3,789 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 more than 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, 3 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 Petaluma Valley Hospital (PVH), an 80-bed acute care hospital, and SRMH, a full service 278-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 Community Benefit (CB) Plan strongly aligns: population health management and network of care.

**Community Benefit Investment**
SRMH invested $59,887,971 in community benefit in FY17. For FY17, SRMH had an unpaid cost of Medicare of $29,463,667.

**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 tithes 10% of its net income (net unrealized gains and losses) to the SJH Community Partnership Fund. The 10% tithing is allocated as follows: 7.5% is used to support local hospital Care for the Poor programs; 1.75% is used to support SJH Community Partnership Fund grant initiatives targeted in the communities served by SJH ministries system-wide; and the remaining 0.75% is designated toward reserves, which helps ensure the Fund's sustainability (See Figure 1).

Furthermore, SRMH endorses local nonprofit organization partners to apply for funding through the SJH Community Partnership Fund. Local nonprofit organizations 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 Community Partnership Manager are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members 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 and employee participation.

A charter approved in 2007 established the formulation of the SRMH/PVH Community Benefit Committee (CBC). The CBC acts in accordance with this Board-approved charter and 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 and investments.

The CBC has a minimum of eight members including three members of the Board of Trustees. Current membership includes ten members of the SRMH and PVH Boards of Trustees and nine 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
The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as well as patients who do have insurance but are unable to pay the portion of their bill that insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment.

At SRMH, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they
lack health insurance or are worried about their ability to pay for their care. This is why we have a Financial Assistance Program for eligible patients. In FY17, SRMH provided $5,028,713 free (charity care) and discounted care and 4,937 persons served.

For information on our Financial Assistance Program click HERE

**Medi-Cal (Medicaid)**

SRMH provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY17, SRMH provided $48,594,654 in Medicaid shortfall.

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 FY17, SRMH provided $5,028,713 in free and discounted care.

One way SRMH informs the public of the 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.

**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)\textsuperscript{2}. 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)\textsuperscript{3}. There are 6,888 civilian residents in this area, which is 307.5 total square miles.

SRMH provides Sonoma County communities with access to advanced care and advanced caring. The hospital 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](https://www.stjoesonoma.org/documents/Community-Benefit/2014-SRMH-Community-Health-Needs-Assessment-Report.pdf) or see: https://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><strong>Ethnicity</strong></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>
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<tr>
<td><strong>Age</strong></td>
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<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>
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</table>

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

\textsuperscript{2} Medically Underserved Areas designations are used to qualify for state/local and federal programs aimed at increasing health services to underserved areas and populations.

\textsuperscript{3} Primary Care Health Professional Shortage Areas (PC-HPSA) are designated based on primary care physician availability.
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>Cities</td>
<td>ZIP codes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Rohnert Park</td>
<td>94928</td>
</tr>
<tr>
<td></td>
<td><strong>Secondary Service Area</strong></td>
</tr>
<tr>
<td>Cloverdale</td>
<td>95425</td>
</tr>
<tr>
<td>Healdsburg</td>
<td>95448</td>
</tr>
<tr>
<td>Petaluma</td>
<td>94952, 94954</td>
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<tr>
<td>Sonoma</td>
<td>95476</td>
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<tr>
<td>Unincorporated Sonoma County</td>
<td>94515, 94546, 94546, 94922, 94923, 94972, 94971, 94540, 94545, 94541, 95412</td>
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<tr>
<td>City of Ukiah, Mendocino County</td>
<td>95482</td>
</tr>
<tr>
<td>Unincorporated Mendocino County</td>
<td>95445, 95494, 95499</td>
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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 out of 25 total, Forestville has one with highest need out of 6, while Windsor has two with high need and four with highest need out of a total of 33 (18%). Cotati has two block groups with high need out of a total of six block groups.

<table>
<thead>
<tr>
<th>IHI Hardship Index</th>
<th>Least Need</th>
<th>Less Need</th>
<th>Average Need</th>
<th>High Need</th>
<th>Highest Need</th>
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<tr>
<td>Cotati</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Santa Rosa</td>
<td>19</td>
<td>24</td>
<td>38</td>
<td>34</td>
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<td>162</td>
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<td>Sebastopol</td>
<td>9</td>
<td>10</td>
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<td>Forestville</td>
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<td>Rohnert Park</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>46</strong></td>
<td><strong>55</strong></td>
<td><strong>53</strong></td>
<td><strong>55</strong></td>
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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 HEALTH NEEDS AND ASSETS 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.

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>
</table>
| Low income Families | • Access to health care  
• Access to affordable prescription drugs  
• Information about health insurance  
• Oral health care for children and low income adults  
• Childhood obesity prevention and awareness programs  
• Food security and access to healthy food  
• Secure neighborhoods and access to safe recreation activities  
• Adequate stock of affordable housing for low income families | • SJH Mobile Health Clinic, Dental Health Clinic, Neighborhood Care Staff, House Calls, Promotores de Salud  
• Community clinics access to care for low-income families  
• Medical services for uninsured  
• Limited availability of affordable housing for low income families  
• Emergency shelters for homeless women and children/families such as Committee on the Shelterless and Catholic Charities  
• Resident-led actions regarding quality of life concerns  
• Community garden, food pantries  
• Local faith-based and community agencies  
• Employment, education, and family support programs  
• Coalitions addressing substance abuse and obesity |
| Latino Community    | • Information about health insurance access  
• Access to culturally and linguistically sensitive health services, e.g., patient centered medical home  
• Substance abuse prevention  
• Nutrition education about healthy eating and foods  
• Access to healthy food  
• Gang prevention measures  
• Family violence prevention                                                                 | • SJH Mobile Medical Clinic, Neighborhood Care Staff, Promotores de Salud  
• Drug Abuse Alternative Center (DAAC)-substance abuse resources  
• Law enforcement, support for residents addressing gang graffiti, traffic calming, crime prevention education  
• Food pantries  
• Local churches, community agencies  
• Employment, education (literacy, GED, language), health and family support programs  
• Media outlets provide bilingual and bicultural programming  
• Transitional housing for homeless; fair housing information and tenant’s rights  
• Coalitions addressing substance abuse and |

19
<table>
<thead>
<tr>
<th>DUHN Population</th>
<th>Community Needs</th>
<th>Community Assets</th>
</tr>
</thead>
</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 |                                                                                                                                                                                                                  |
| **Undocumented immigrants who do not speak English** | • Information about health insurance  
• Processes that facilitate access to medical care | • SJH Mobile Medical Clinic, Promotores de Salud  
• Media outlets provide bilingual & bicultural programming |
<table>
<thead>
<tr>
<th>DUHN Population</th>
<th>Community Needs</th>
<th>Community Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Assistance accessing immigration resources</td>
<td>• Immigration forums</td>
</tr>
<tr>
<td></td>
<td>• Wider outreach &amp; access to healthy food through food pantries</td>
<td>• Healthcare services for undocumented &amp; uninsured</td>
</tr>
<tr>
<td></td>
<td>• Affordable housing for single persons</td>
<td>• Food pantry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local churches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Employment, education, and family support programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Housing assistance addressing needs of undocumented and low income residents</td>
</tr>
</tbody>
</table>

**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 programming and by funding other nonprofit organizations through our Care for the Poor Program managed by SRMH.

Furthermore, St. Joseph Health, SRMH will endorse local nonprofit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Organizations that receive funding provide specific services, resources to meet the identified needs of underserved communities through St. Joseph Health communities.
In addition to the programs and activities described on pages 4-6 above to address the priority needs identified in the CHNA, the following community health needs identified in the larger CHNA are also addressed as described 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 Health 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).** Five members of the Community Benefit Department staff have been 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 support the Santa Rosa Community Health Centers with an annual $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.

## 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:

<table>
<thead>
<tr>
<th>Selection Criteria</th>
<th>Magnitude/scale of the problem</th>
<th>Severity of problem</th>
<th>SRM Hospital Assets</th>
<th>Existing/promising approaches</th>
<th>Health disparities</th>
<th>Ability to leverage</th>
<th>Community prioritization</th>
<th>Prevention opportunity</th>
</tr>
</thead>
</table>

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 prevention, though we are seeing positive trends in community health centers in this arena.

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.
### 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 (FY15)</th>
<th>FY17 Target</th>
<th>FY17 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of patients without a medical home who are linked to a Primary Care Provider (PCP)</td>
<td>In FY16, the % of patients who came to these SJH programs without a medical home were linked to a PCP: (only included patients who completed the release of information form) 16% for Petaluma Valley Hospital (PVH) ED 45% for Santa Rosa Memorial (SRM) ED &amp; ED Diversion Program 27% for Urgent Care Departments 31% for SJH Medical Group After Hours Clinics</td>
<td>% of patients who come to these SJH programs without a medical home are linked to a PCP: (Includes all patients who present in these programs) 15% for PVH ED 7.5% for SRM ED &amp; ED Diversion Program 5% for Urgent Care Departments 30% for SJH Medical Group After Hours Clinics</td>
<td>9% (908 / 9661) PVH ED: 9% (68 / 720) SRM ED &amp; ED Diversion: 11% (617 / 5,708) Urgent Care: 5% (134 / 2,816) SJH Medical Group After Hours Clinics: 22% (91 / 417)</td>
</tr>
<tr>
<td>Strategy</td>
<td>Strategy Measure</td>
<td>Baseline</td>
<td>FY17 Target</td>
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<td>-------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Establish a MHC Patient Scholarship Fund to subsidize patients’ out-of-pocket costs in accessing care at FQHCs.</td>
<td>Number of recipients of MHC Patient Scholarships who established a medical home and received ongoing care.</td>
<td>N/A (new strategy in FY17)</td>
<td>10 MHC patients receive a scholarship and establish care at FQHC</td>
</tr>
<tr>
<td>Proactively identify and serve the Disproportionate Unmet Health Needs (DUHN) population.</td>
<td>Number of sites and amount of utilization of services by DUHN population.</td>
<td>Mobile Health Clinic: 5 sites</td>
<td>Add 3 new sites for Mobile Health Clinic to visit.</td>
</tr>
<tr>
<td>Serve patients in their communities and provide medical care to the underserved</td>
<td>Number of patients and encounters in the Mobile Health Clinic</td>
<td>Mobile Health Clinic: 971 patients, 2,519 encounters (FY14); 838 patients, 2,372 encounters (FY16)</td>
<td>10% increase over FY16 in number of patients and encounters</td>
</tr>
</tbody>
</table>

Key Community Partners: Multiple 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, Operation Access, and Portrait leadership committee.

FY17 Accomplishments: Access to Health Care Coverage
Our Mobile Health Clinic serves patients in their communities at no cost. The program provides 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 FY17 in the SRMH service area, the clinic saw 1,549 patients over 3,232 encounters at numerous locations, including the addition of 5 new sites. The Mobile Dental Clinic and the Mobile Health Clinic offered health screenings to a combined 1,138 persons at health fairs and community events throughout the county.
 Initiative 2 (community need being addressed): Healthy Eating and Physical Fitness

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 (FY15)</th>
<th>FY17 Target</th>
<th>FY17 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>80% of <em>Your Heart, Your Life</em> (<em>YHYL</em>) participants and 44% of <em>Healthy for Life</em> (<em>H4L</em>) participants demonstrated improved knowledge of healthy living principles</td>
<td>80% <em>YHYL</em> participants show improvement in behavioral changes</td>
<td>85% of <em>Your Heart, Your Life</em> participants and 40% of <em>Healthy for Life</em> participants demonstrated improved knowledge of healthy living principles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Measure</th>
<th>Baseline</th>
<th>FY17 Target</th>
<th>FY17 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>H4L</em>, <em>YHYL</em>, and <em>Promotores de Salud (Health Education)</em> programs</td>
<td>2,178 persons served and 19,570 encounters in <em>H4L</em> and 74 persons served in <em>YHYL</em> (FY16)</td>
<td>Maintain <em>H4L</em> 10% increase over baseline for <em>YHYL</em></td>
<td>2,395 persons served by <em>Healthy for Life</em> over 24,383 encounters, increases of 10% and 25%, respectively, over baseline. 71 persons served by the <em>Promotores de Salud ‘s Your Heart, Your Life</em> program (4% decrease)</td>
</tr>
<tr>
<td>Utilize improved data collection processes to track impacts of healthy eating active living programs</td>
<td>Percentage of families responding to survey</td>
<td>In <em>H4L</em> pilot of new survey format in FY16, 71% (Two Rock) and 82% (Sonoma Charter) return rates of parent-responder surveys</td>
<td>Maintain at least 70% response rate</td>
<td>Two Rock: 60% (6 / 10) Sonoma Charter: 76% (22 / 29)</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 Education Foundation, Healthcare Foundation of Northern Sonoma County, Northern California Center for Well Being, Community Action Partnership, Sonoma County Bike Coalition, Burbank Housing.

FY17 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 conducting health screenings at health fairs and other community events. In FY17 in the SRMH service area, 455 persons were served by the Promotores de Salud through 1,540 encounters. We continued our partnership with the Windsor Presbyterian Church in which we coupled our Your Heart, Your Life program (taught in Spanish) with a healthy-cooking class. Cooking classes and nutritional education were also presented to enthusiastic and appreciative audiences at the newly-renovated La Luz community center site in Boyes Hot Springs in Sonoma Valley, to the Roseland Parents Group in southwest Santa Rosa, and in community meeting rooms at SRMH and PVH. Late in the year, a new site for Your Heart, Your Life was established at the Logan Court housing project of Burbank Housing in Petaluma. The Promotores de Salud also conducted Spanish-language trainings on Advanced Care Directives to more than 100 community residents.

In partnership with our own Neighborhood Care Staff, our Promotores also continued to work closely with community residents in the Roseland neighborhood of southwest Santa Rosa, one of the county’s most underserved areas. The aforementioned Roseland Parents Group has become a hub for various efforts related to health in the neighborhood. The parent group, with support from our staff, has organized regular daily exercise classes in the neighborhood, a weekly nutrition education and cooking class, community outings to regional parks, and regular...
cleanup days on the County multi-use trail that runs through the neighborhood and is used extensively by residents. As the year drew to a close, plans were underway to transition the group into a self-sustaining organization through the assistance of an organizational development consultant who will shepherd the group through a strategic planning and leadership development process.

Our Neighborhood Care Staff also work in targeted communities of need throughout the county, organizing community engagement by residents at the neighborhood level. These efforts included the ongoing development of the result in residents identifying issues of concern and need for them in their neighborhoods and developing strategies for creating and advocating for solutions. In Cloverdale, the “Familias en Accion Positiva,” through support provided by our NCS organizer, formalized itself as an ongoing community resident group with an established leadership structure and began partnering with the Cloverdale Community Partnership to form a Sonoma County Health Action Chapter. In Guerneville, the NCS organizer has organized an ongoing poetry group at West County Community Services’ Empowerment Center, a drop-in site for local homeless and mentally ill residents. Building on this, the local community health center has partnered with the group we have organized at the Center in an opioid addiction project.

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, 1,368 persons were served in over 11,884 encounters throughout the SRMH service area. Two new sites were added, one in Geyserville and the other in Santa Rosa, that were pilot programs of our “lite” version of the Healthy for Life program. Both schools had existing complementary programs in place but benefited greatly with the supplemental nutrition and physical education provided by Healthy for Life. The program will continue growth in the coming year adding a second school from the Roseland School District.
Initiative 3 (community need being addressed): Access to Mental Health and Substance Abuse Services
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 (FY15)</th>
<th>FY17 Target</th>
<th>FY17 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of client population receiving mental health screening</td>
<td>17% of Mobile Health Clinic patients screened for depression principles</td>
<td>Sustain screening rates at or above at least 90% of patients in the Mobile Health Clinic and in the House Calls program</td>
<td>97% of patients in the Mobile Health Clinic and 80% in the House Calls program</td>
</tr>
<tr>
<td>Successful continuation of pilot program serving homeless population</td>
<td>Project Nightingale serves patients of high- and low-level of acuity in 13-bed facility</td>
<td>Continue Project Nightingale program and investigate further improvements</td>
<td>Project Nightingale expanded capacity to 26 beds.</td>
</tr>
</tbody>
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</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>Percentage of client population receiving mental health screening</td>
<td>90% of Mobile Health Clinic patients were screened for depression (FY16)</td>
<td>Sustain screening rates at or above 90% of patients in the MHC and in the House Calls program</td>
<td>97% of patients in the Mobile Health Clinic and 80% in the House Calls program</td>
</tr>
<tr>
<td>Partner with community based organizations working to address mental health and substance use needs among vulnerable populations</td>
<td>Successful community partnerships resulting in services to vulnerable populations</td>
<td>Project Nightingale serves patients of high- and low-level of acuity in two 13-bed facilities</td>
<td>Continue Project Nightingale program and investigate further improvements Partner with</td>
<td>Project Nightingale expanded capacity to 26 beds.</td>
</tr>
</tbody>
</table>
**Key Community Partners:** Catholic Charities of the Diocese of Santa Rosa, Sutter Medical Center Santa Rosa, Kaiser Permanente Medical Center Santa Rosa, County of Sonoma Department of Health Services, LifeWorks, Social Advocates for Youth, California Parenting Institute, Latino Service Providers, Humanidad, Family Justice Center, Sonoma County Task Force for the Homeless.

**FY17 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 Health Clinic routinely screens for depression or mental illness using a validated tool known as the Patient Health Questionnaire (PHQ-9 & PHQ-2). Screening rates have improved from 60% to more than 97%. 80% of appropriate patients were screened through the House Calls program in FY17. Protocols that House Calls follows include evaluating and understanding the history of the depression and partnering with Accent Home Health as necessary to get referrals and medication suggestions. Qualifying patients are then referred to the proper program, such as the Older Adult Services Program, for care and medication management.

*Circle of Sisters* has also been working to help address mental and behavioral health issues that present in the program. With age-appropriate curriculum that stresses positive body image, career goals, anti-bullying strategies and other relevant topics, COS provides girls the tools they need for positive mental health. In FY17, in the SRMH service area, *Circle of Sisters* served 162 young women in 5,393 encounters.
In partnership with a countywide collaborative led by Catholic Charities of the Diocese of Santa Rosa, our Community Benefit Department granted $205,000 in FY17 for ongoing operating support of Project Nightingale, a homeless respite shelter. This follows last year’s similar grant allowing for a doubling of the program’s bed capacity. In addition, we provided $84,000 in funding to our affiliated Home Health program to provide direct health care services to the Project Nightingale patients at their respite site.

Many clients at the Committee on the Shelterless (COTS) agency struggle with mental health and substance use issues, and we provided $15,000 in grant funding to the Unmet Needs Fund in FY17, which helped over 150 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): Barriers to 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>
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<tbody>
<tr>
<td>Number of seniors receiving advance health care planning education</td>
<td>Reached 80 clients and partnered with several key community organizations regarding the importance of advanced care planning (FY14)</td>
<td>100 clients reached and 20% completed AHCDs</td>
<td>112 clients reached and 75% completed AHCDs</td>
</tr>
<tr>
<td>Number of frail elderly patients served</td>
<td>118 unduplicated patients served and completed over 5,760 encounters (FY14)</td>
<td>10% increase over baseline</td>
<td>152 unduplicated patients served during the course of 7,347 encounters; increases of 22% and 22%, respectively, over FY14 baseline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Measure</th>
<th>Baseline</th>
<th>FY17 Target</th>
<th>FY17 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>142 unduplicated patients served during the course of 6,674 encounters. (FY16)</td>
<td>Maintain FY16 Baseline</td>
<td>152 unduplicated patients served during the course of 7,347 encounters; increases of 7% and 9%, respectively, over FY16 baseline.</td>
</tr>
<tr>
<td>Perform internal and external education and outreach, ensuring that community benefit programs reach seniors in a systematic and strategic manner</td>
<td>Number of community members provided with advanced health care planning education</td>
<td>Reached 174 clients; 59 completed AHCDs (FY16)</td>
<td>100 clients reached and 20% completed AHCDs</td>
<td>112 clients reached and 75% completed AHCDs within the <em>House Calls</em> program. In addition, another 104 Spanish-speaking community residents were provided the AHCD training by the <em>Promotores de Salud</em> program.</td>
</tr>
</tbody>
</table>
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), Sonoma County Human Services Department, Adult and Aging Division, Sonoma County Council on Aging, West County Community Services Agency.

FY17 Accomplishments: 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. In the SRMH service area, the program team, which includes nurse practitioners, nurses, case management, and home health assistance, provided service to 143 unduplicated patients and completed over 7,007 service encounters, helping to prevent unnecessary emergency department visits and to more effectively manage chronic disease.
Initiative 5 (community need being addressed): Disparities in Oral Health  
Goal (anticipated impact): Identify and treat children with decay and prevent caries in the SJH-SC Service area.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline (FY14)</th>
<th>FY17 Target</th>
<th>FY17 Result</th>
</tr>
</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)</td>
<td>Maintain Decay rates lower than baseline.</td>
<td>Dental programs treated 9295 patients with a decay rate of 25% (n=2309)</td>
</tr>
<tr>
<td></td>
<td>Completed treatment on 34% (n=983) 23% were new patients (n=1679)</td>
<td>Complete treatment on 34% of patients.</td>
<td>Completed treatment on 56% (n=1290)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Measure</th>
<th>Baseline</th>
<th>FY17 Target</th>
<th>FY17 Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serve patients in the fixed site dental clinic</td>
<td>Number of patients served</td>
<td>5,729 patients served and completed 8,535 encounters (FY16)</td>
<td>Maintain Baseline</td>
<td>5,196 patients served and completed 8,576 encounters</td>
</tr>
<tr>
<td>Serve patients in the Mobile Dental Clinic and Mighty Mouth school-based program</td>
<td>Number of patients served</td>
<td>5,729 patients served; 11,702 encounters (including 5,578 education only visits) (FY16)</td>
<td>Maintain Baseline</td>
<td>4,099 patients served and completed 9,177 encounters (including 3,789 education only visits).</td>
</tr>
<tr>
<td>Intervene early to encourage prevention-oriented behaviors</td>
<td>Number of Mommy and Me participants with decreased decay rates compared to non- Mommy and Me.</td>
<td>Decay rates for Mommy and Me program participants vs non-participants = 1% vs 5% for one-year-olds; for returning 2-5 year-olds = 13% vs 22% (FY16)</td>
<td>Maintain Decay Rates for Mommy and Me participants lower than Non-Mommy and Me participants.</td>
<td>Mommy and Me program participants demonstrated a 1% decay rate among one-year-olds, compared to non-participating children in the same age group with 10% decay rate; program participants demonstrated a 14% decay rate among returning 2-5 year-olds, compared to non-participating children in the same age group with 22% 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), Community Action Partnership, Kaiser Pre-natal education, other nonprofit service providers.”

**FY17 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 FY17, 4,099 patients were served over 8,576 encounters at the SJH Dental Clinic. Our *Mobile Dental Clinic* and *Mighty Mouth* school-based prevention program saw 5,729 patients and completed over 9,177 encounters countywide. FY17, there was a 1% decay rate among one-year-olds, compared to 10% decay rate among patients in the clinic who did not participate in the program. We saw a 14% decay rate among returning 2-5 year-olds in *Mommy and Me* program, compared to non-participating children in the same age group with 30% decay rate.
## FY17 Other Community Benefit Program Accomplishments

<table>
<thead>
<tr>
<th>Initiative (community need being addressed):</th>
<th>Program</th>
<th>Description (insert Target for)</th>
<th>FY16 Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Eating and Physical Fitness</td>
<td>Community Grant Making Program</td>
<td>Increase level of services provided to community by partner organizations</td>
<td>Awarded 7 separate grants to community partners totaling $119,264</td>
</tr>
<tr>
<td>Access to Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Awarded 1 grant to a community partner totaling $50,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Awarded 5 separate grants to community partners totaling $563,246</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Awarded 2 separate grants to community partners totaling $44,100</td>
</tr>
</tbody>
</table>
FY17 Community Benefit Investment
In FY17, SRMH invested a total of $59,887,971 Care for the Poor dollars in key community benefit programs (excluding Medicare). In FY17, Medicaid shortfall was $38,699,394, however, when hospital fee was accounted for it was $48,594,654.

<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 Populations</td>
<td>Financial Assistance Program (FAP) (Traditional Charity Care-at cost)</td>
<td>$5,028,713</td>
</tr>
<tr>
<td></td>
<td>Unpaid cost of Medicaid</td>
<td>$48,594,654</td>
</tr>
<tr>
<td></td>
<td>Unpaid cost of other means-tested government programs</td>
<td>$314,546</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>$2,419,971</td>
</tr>
<tr>
<td></td>
<td>Cash and in-kind contributions for community benefit</td>
<td>$2,222,528</td>
</tr>
<tr>
<td></td>
<td>Community Building</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Subsidized Health Services</td>
<td>$51,868</td>
</tr>
<tr>
<td>Total Community Benefit for the Vulnerable</td>
<td>$38,632,280</td>
<td></td>
</tr>
<tr>
<td>Other benefits for the Broader Community</td>
<td>Community Benefit Operations</td>
<td>$898,207</td>
</tr>
<tr>
<td></td>
<td>Community Health Improvements Services</td>
<td>$229,233</td>
</tr>
<tr>
<td></td>
<td>Cash and in-kind contributions for community benefit</td>
<td>$7,500</td>
</tr>
<tr>
<td></td>
<td>Community Building</td>
<td>$120,751</td>
</tr>
<tr>
<td></td>
<td>Subsidized Health Services</td>
<td>$0</td>
</tr>
<tr>
<td>Total Community Benefit for the Broader Community</td>
<td>$1,255,691</td>
<td></td>
</tr>
<tr>
<td>TOTAL COMMUNITY BENEFIT (excluding Medicare)</td>
<td>$59,887,971</td>
<td></td>
</tr>
<tr>
<td>Medical Care Services for the Broader Community</td>
<td>Unpaid cost to Medicare (not included in CB total)</td>
<td>$29,463,667</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 IRS Form 990, Schedule H, we use the Medicare cost report.
Telling Our Community Benefit Story: Non-Financial\textsuperscript{8} Summary of Accomplishments

Community Benefit and other hospital staff played leadership roles in many community collaborative initiatives and nonprofit organizations. Among these were the following:

Sonoma County Health Action Leadership Council  
Sonoma County Health Action Sustainable Financing Catalyst Team  
Sonoma Health Alliance  
Mendonoma Health Alliance  
Covered Sonoma  
Age Friendly Sonoma  
Redwood Community Health Network  
Early Childhood Education and Care Consortium  
Hearts of Sonoma  
Homes For All  
Committee on the Shelterless  
Health and Wellness Workforce Development Roundtable  
Sonoma County Upstream Investment Portfolio Review Committee  
Project Nightingale Steering Committee  
Purple Binder Project  
Sonoma County Funders’ Circle  
Santa Rosa Gang Prevention Task Force  
Sonoma County Health Care for the Homeless Collaborative  
Petaluma Sober Circle  
Sober Sonoma Serial Inebriate Program  
Russian River Area Resources and Advocates  
Community Health Initiative of the Petaluma Area  
Jewish Community Free Clinic  
Sonoma County Accountable Communities for Health Steering Committee  
Northern California Center for Well-Being

\textsuperscript{8} Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.
Governance Approval

This FY17 Community Benefit Report was approved at the August 22, 2017 meeting of the SRMH Community Benefit Committee of the Board of Trustees.

[Signature]

Chair’s Signature confirming approval of the FY17 Community Benefit Annual Report

8-22-17
Date